Texas Health and Human Services Commission (HHSC)

Deliverable 7 – Rider Report 61

Final Comprehensive Report

Rider 61: Evaluation of Medicaid and CHIP Managed Care

August 17, 2018

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The 85th Legislature of the State of Texas required the Texas Health and Human Services Commission (HHSC) to develop and report on its findings for **Rider 61, Evaluation of Medicaid Managed Care**. HHSC engaged Deloitte Consulting LLP[1] to develop four studies in response to this request including:

1. **Rider 61(a):** A review of the current Medicaid and Children's Health Insurance Program (CHIP) managed care delivery system and an assessment of the performance of managed care, including an analysis of the following elements as they relate to Medicaid Managed Care:
    - Costs
    - Cost savings
    - Cost trends, including how cost trends for Texas managed care programs compare to other states to Texas. Such comparisons recognize, as necessary, the differences among comparative states with respect to services provided, populations covered, benefits, administrative requirements, and any other relevant factors.
    - Impact of caseload growth
    - Cost containment initiatives
    - Contractual mandates
    - A comparison of cost trends for managed care programs in Texas to other states
    - Recommendations on additional operational efficiencies, delivery system reforms, and cost containment initiatives
2. **Rider 61(b)**: An assessment of Medicaid and CHIP managed care contract review and oversight. The assessment considers the effectiveness and frequency of audits, the data necessary to evaluate

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existing contract requirements and enforcement, including penalties, and the need for additional training and resources for effective contract management. This includes:

- Quarterly performance report and deliverables
- A review of contract amendments and the procurements process
- Trends and non-compliances
- A review of most recent Agreed-Upon Procedures (AUPs) for each Managed Care Organizations (MCO)

3. **Rider 61(c)**: A study of Medicaid Managed Care rate setting processes and methodologies in other states. State Medicaid Managed Care programs use varying approaches in selecting vendors and establishing managed care capitation rates. The report includes detailed information regarding:
   - the funding method(s) used by the state (insured, self-funded, hybrid);
   - the method(s) used to select participating MCOs (administered, competitively bid, negotiated); and,
   - the methodology(s) used to establish managed care capitation rates, including sources of experience data, the length of the experience period used in rate setting, approach to selecting cost trend assumptions, administrative cost assumptions and use of rate ranges.

   The reported findings identify current rate setting methods, reported results and lessons learned from the states included in the study.
4. **Rider 61(d)**: An analysis of MCO administrative costs, including a survey (reviewed and approved by HHSC) of each MCO to determine the nature and scale of administrative resources devoted to the Texas Medicaid and CHIP programs and the identification of cost reduction opportunities.

This comprehensive report has four sections that correspond to Rider 61 sections (a), (b), (c), and (d). The following table of contents identifies the start of each section. A more detailed table of contents can be found within each of the individual sections.

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1. Rider 61(a) Executive Summary

The 85th Legislature of the State of Texas commissioned Rider 61(a) to evaluate the Texas Medicaid Managed Care Program. Pursuant to Rider 61(a), this evaluation assesses Health and Human Services Commission's (HHSC) managed care program's performance regarding cost, quality, member satisfaction, and access, while considering the impact of caseload increases and case mix changes. Further analysis was conducted to estimate the cost savings realized by continuing to expand the managed care program versus operating under the previous fee-for-service (FFS) delivery model.

1.1. Enrollment and Expenditures

As of 2017, 92 percent of the Texas Medicaid enrollees and all Children's Health Insurance Program (CHIP) enrollees were enrolled in managed care. Since the commencement of managed care in Texas in 1993, managed care has grown to encompass seven different programs, including specific programs for low-income individuals and families, elderly individuals, adults and children with disabilities, and foster children.

Total managed care enrollment increased by approximately 600,000 from State Fiscal Year 2014 (SFY2014) to SFY2017. Over this same period, the aggregate per member per month (PMPM) costs increased by more than 10 percent annually. The implementation of the Dual-Eligible Integrated Care Demonstration Project (the "Dual Demonstration") program in SFY2015 and the STAR Kids program in SFY2017 had a considerable impact on the aggregate cost increase; if those programs are removed from the calculation, aggregate PMPM costs increased by 5.9 percent. When accounting for other service expansions, program changes, administrative expense changes, and population shifting from SFY2009 to SFY2017, the managed care program PMPM cost trended at 2.1 percent, slightly higher than the annualized Medicaid PMPM cost trend rate of 1.8 percent from the CMS National Health Expenditure (NHE) Report for Medicaid. Additionally, the estimated managed care PMPM cost trend, when accounting for other service expansions, program changes, administrative changes, and population shifting, is lower than the SFY2012 President's Budget Medicaid Baseline trends, ranging from 4.6 percent to 5.8 percent, that were used to

project the without-waiver PMPM costs within the Federal approval letter of the 1115 Transformation Waiver.[2]

1.2. Quality Improvement

From a quality perspective, a select set of Healthcare Effectiveness Data and Information Set (HEDIS®) measures and scores were reviewed for the Medicaid and CHIP managed care programs. The scores assessed showed slight improvement from calendar year 2014 through 2016. For most HEDIS® measures, HHSC has established high and low benchmark standards for the managed care organizations (MCOs). This report analyzed Texas MCO performance in relation to the HHSC high standards. While the report analyzed 19 unique HEDIS® measures, each managed care program that was reviewed only analyzes a subset of these measures. For adults in the STAR program, of the eight measures that were reviewed, performance on two of the measures surpassed the HHSC high standard. For adults in the STAR+PLUS program, of the 10 measures that were reviewed, two did not have an HHSC high standard and performance and two of the measures surpassed the HHSC high standard. For children in the STAR program, of the seven measures that were reviewed, one did not have an HHSC high standard and performance on two measures surpassed the HHSC high standard. For children in the CHIP program, of the seven measures that were reviewed, one did not have an HHSC high standard and performance on four measures surpassed the HHSC high standard.

Comparing Texas's HEDIS® results to the national Medicaid 50th percentile and other comparable states' 50th percentile for the same 19 unique measures that were analyzed above, Texas's results were above the national benchmark for nine measures and below the national benchmark for 10 measures. Texas scored the highest out of all comparable states in the Pharmacotherapy Management of COPD Exacerbation – Bronchodilator measure and both the Child and Adolescent Immunizations HEDIS® measures, while Texas performed the lowest of all comparable states in Medication Management for People with Asthma, HbA1c Control, and Medical Attention for Nephropathy.

[2] *Center for Medicare and Medicaid Services, "Texas Healthcare Transformation and Quality Improvement Program", https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8393.*

1.3. Access

Each state requires their MCOs to abide by certain timeliness requirements for setting provider appointments for their members. Through an analysis of comparable states' access requirements, Texas's methodology to determine access requirements was found to be similar to the methodologies used by other states. Regarding the program's compliance with these requirements, the STAR, STAR+PLUS, and CHIP programs saw improvement in appointment availability metrics from 2015 to 2016. One area of low compliance was OB/GYN appointment availability in the STAR program, with compliance rates below 50 percent for third trimester and for High-Risk OB/GYN appointments. MCO variation was present for both OB/GYN and Behavioral Health appointment availability, while Primary Care appointments typically saw high compliance and low variation across MCOs.

1.4. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Based on an analysis of the CAHPS® surveys from 2014 to 2016, the managed care programs experienced improvements across all consumer satisfaction composite measures that were reviewed.

Comparing Texas's CAHPS® results to the national Medicaid 50th percentile, Texas performed lower than the national benchmark for four out of the five CAHPS® composite measures that were reviewed: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Personal Doctor Rating. Only results for the Health Plan Rating composite measure were above the national 50th percentile. Reviewing Texas's results with other comparable states, Texas's results were the lowest of the comparable states for three of the five CAHPS® composite measures that were reviewed, including Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate. Texas had the third highest score of five for both the Personal Doctor Rating and Health Plan Rating composite measures.

1.5. Estimated Managed Care Program Savings

An important component in assessing the current Medicaid and CHIP managed care delivery system and managed care performance is understanding its financial impact. Understanding the financial impact requires comparing actual expenditures against an estimate of Medicaid and CHIP expenditures if HHSC had kept Medicaid and CHIP enrollees in the FFS program. Expenditure trends are driven by a large number of factors,

including program and service expansions, changes in administrative expenses, changes in the number and mix of enrolled populations, and health care cost and utilization trends. To evaluate savings across the Medicaid Managed Care program, a retrospective evaluation was conducted to derive estimated savings associated with managed care from the period SFY2009 to SFY2017.

This analysis estimates the financial impact that the managed care program has had by comparing the actual historical managed care program payments to hypothetical expenditures under a FFS arrangement. To estimate the hypothetical expenditures under a FFS arrangement, an assumption was made that the base year of SFY2009 managed care payments was the starting point for FFS expenditures PMPM. While this assumption does not incorporate any managed care cost savings from SFY2009 and prior, it allows for assessment of program trends from SFY2009 to SFY2017 and how that compares to an estimated FFS trend during that period. Further information regarding how the pharmacy carve-in in 2012 was modeled can be found in **Section 8.1 Estimated Managed Care Program Savings Methodology**.

Through discussions with HHSC, it is understood that the State built managed care savings assumptions into the managed care capitation rates during the initial years of managed care and during program expansions. For acute services and prescription drug benefits, the State noted that, during transition years or managed care expansion years, the assumed managed care savings in shifting from FFS to managed care built into the premium was at least budget neutral, if not greater than, to any additional costs associated only under a managed care program. The FFS to managed care transition-year savings assumptions have varied depending on the program, service delivery area, and population. Thus, while it is difficult to generalize managed care savings assumptions, for the purposes of this analysis, it was assumed that in the managed care capitation rate, the managed care savings would more than offset administrative costs, risk margins, and other expenses built into the rates.

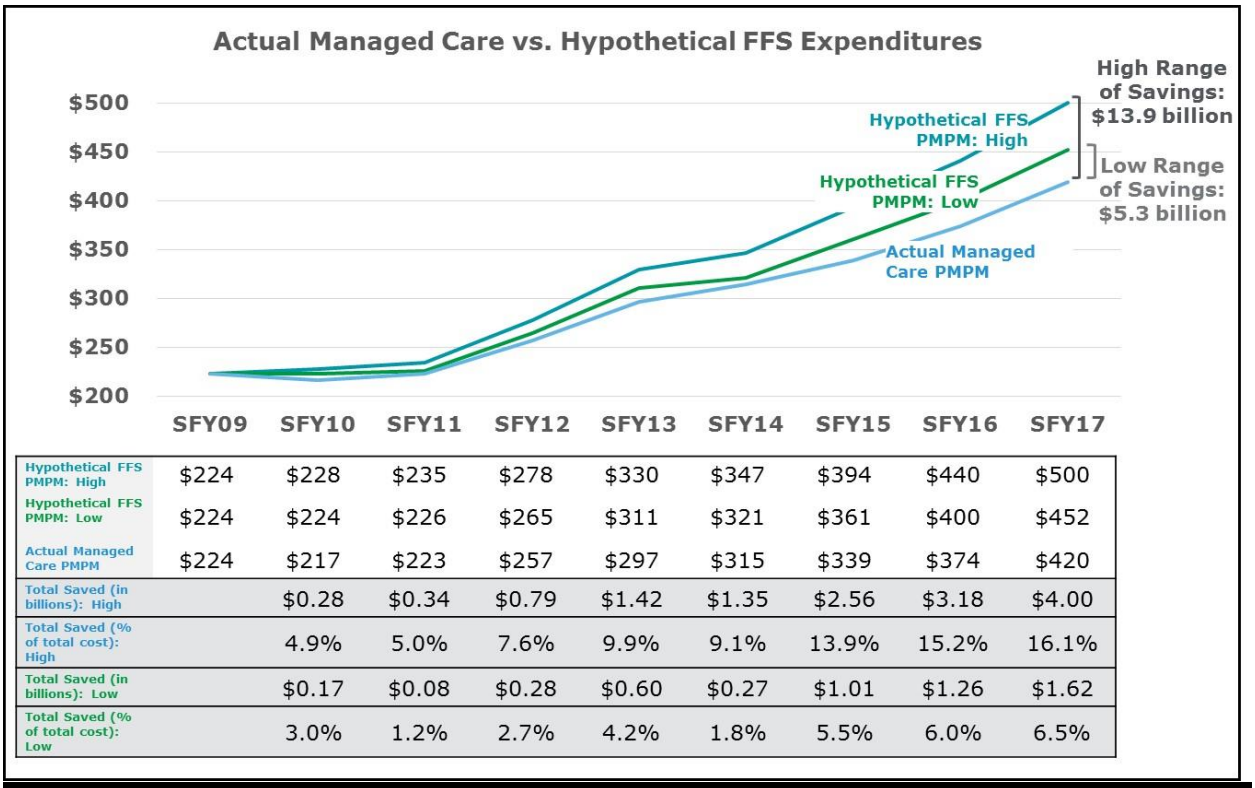
The hypothetical FFS expenditures use the SFY2009 base year, an estimated FFS trend rate, and adjust for Medicaid program changes such as benefit changes and population additions that occurred to the managed care program to develop a representative FFS annual expenditure for each year from SFY2010 to SFY2017.

The managed care savings were then estimated by comparing the hypothetical FFS PMPM to the historical managed care PMPM payments. Cost

savings were reviewed by program, risk group, and medical and pharmacy costs.

Figure 1 represents the estimated savings achieved by the managed care program, compared to hypothetical expenditures under a FFS structure from the time period of SFY2009 through SFY2017.

Figure 1. 2009–2017 Managed Care Cost Savings Results.



	SFY09	SFY10	SFY11	SFY12	SFY13	SFY14	SFY15	SFY16	SFY17
Hypothetical FFS PMPM: High	$224	$228	$235	$278	$330	$347	$394	$440	$500
Hypothetical FFS PMPM: Low	$224	$224	$226	$265	$311	$321	$361	$400	$452
Actual Managed Care PMPM	$224	$217	$223	$257	$297	$315	$339	$374	$420
Total Saved (in billions): High		$0.28	$0.34	$0.79	$1.42	$1.35	$2.56	$3.18	$4.00
Total Saved (% of total cost): High		4.9%	5.0%	7.6%	9.9%	9.1%	13.9%	15.2%	16.1%
Total Saved (in billions): Low		$0.17	$0.08	$0.28	$0.60	$0.27	$1.01	$1.26	$1.62
Total Saved (% of total cost): Low		3.0%	1.2%	2.7%	4.2%	1.8%	5.5%	6.0%	6.5%

	SFY 09	SFY 10	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17
Hypothetical FFS PMPM: High	$224	$228	$235	$278	$330	$347	$394	$440	$500
Hypothetical FFS PMPM: Low	$224	$224	$226	$265	$311	$321	$361	$400	$452
Actual Managed Care PMPM	$224	$217	$223	$257	$297	$315	$339	$374	$420
Total Saved (in Billions): High		$0.28	$0.34	$0.79	$1.42	$1.35	$2.56	$3.18	$4.00
Total Saved (Percent of total cost): High		4.9%	5.0%	7.6%	9.9%	9.1%	13.9%	15.2%	16.1%
Total Saved (in Billions): Low		$0.17	$0.08	$0.28	$0.60	$0.27	$1.01	$1.26	$1.62
Total Saved (Percent of total cost): Low		3.0%	1.2%	2.7%	4.2%	1.8%	5.5%	6.0%	6.5%

Overall, this analysis suggests that expanding managed care in the Texas Medicaid and CHIP programs between SFY2009 and SFY2017 has resulted in cost savings ranging from approximately $5.3 billion to $13.9 billion, or 4.7 percent to 11.5 percent, from the previous FFS model. Note that this analysis does not assess the reimbursement level of MCOs to providers or make assumptions on the impact of difference between the level of care, access to care, or quality of care (QOC) between FFS and managed care programs. The analysis compares the actual Texas managed care trends to hypothetical Medicaid FFS trends to estimate the savings between SFY2009 and SFY2017.

When accounting for other service expansions, program changes, administrative expense changes, and population shifting from SFY2009 to SFY2017, the managed care program PMPM cost trended at 2.1 percent across the analysis period of SFY2009 through SFY2017. The realized trend rate is lower than the FY2012 President's Budget Medicaid Baseline trends, ranging from 4.6 percent to 5.8 percent, that were used to project the without-waiver PMPM costs within the Federal approval letter of the 1115 Transformation Waiver.[3]

At the same time Rider 61 was commissioned, a second Rider 60 (Conference Committee Report Rider 219) was also requested. The Texas Legislature commissioned Rider 60 to study the potential savings from implementing certain changes to HHSC's current method of administering prescription drug benefits for Medicaid and CHIP. Since the two Riders are related in terms of estimating the potential cost savings associated with the managed care programs, it is necessary to delineate the topics addressed in Rider 61(a) versus those contained in Rider 60.

Rider 61 includes an assessment of the performance of Medicaid and CHIP managed care including an analysis of costs, cost savings, cost trends, caseload growth, and cost containment initiatives. Rider 60 compares HHSC's actual historical pharmacy costs from FY2015 through FY2017 incurred under a managed care delivery model to the costs developed under a number of scenarios that may have occurred under a pharmacy carve-out model. The findings documented in the report for Rider 60 do not constitute an evaluation of Texas MCOs' effectiveness in administering pharmacy benefits. The results and findings from Rider 60 are documented in a separate report.

[3] *Center for Medicare and Medicaid Services, "Texas Healthcare Transformation and Quality Improvement Program", https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8393.*

2. Introduction

According to the General Appropriations Act for the 2018-19 Biennium, Senate Bill No. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, **Rider 61, Subsection (a)**):

"From funds appropriated above and pursuant to its authority under general law, the Health and Human Services Commission (HHSC) shall contract with an independent organization to conduct a comprehensive evaluation of managed care in the Texas Medicaid program. The evaluation must include a review of the current delivery system and an assessment of the performance of managed care, including analysis of costs, cost savings, cost trends, the impact of caseload growth, cost containment initiatives, and contractual mandates. HHSC shall also include in the evaluation how cost trends for managed care programs in Texas compare to other states and recommendations on additional operational efficiencies, delivery system reforms, and cost containment initiatives."

2.1. Background and Purpose

The evolution of managed care in Texas dates back to 1993 when the first small regional Medicaid Managed Care pilot began. Over the past 25 years, managed care has transformed how Medicaid services are delivered in Texas. The State now maintains one of the largest Medicaid Managed Care programs in the country.

Over the past 25 years, there have been many changes to the overall managed care program, including new programs, discontinued programs, geographical expansions, and changes to covered services. In the past eight years, the percentage of the Texas Medicaid population enrolled in a managed care program has increased from approximately 70 percent in 2009 to more than 90 percent in 2017. In 2017, Texas's managed care programs covered more than 4.1 million Texans across the State's managed care programs of STAR, STAR+PLUS, Dual Demonstration, STAR Health, STAR Kids, and CHIP.

Pursuant to Rider 61(a), this evaluation has assessed Texas's performance regarding cost, quality, member satisfaction, and access, while considering the impact of caseload increases and case mix changes. Further analysis was conducted to estimate the cost savings realized by continuing to expand the managed care program versus operating under the previous delivery model of FFS.

2.2. Approach

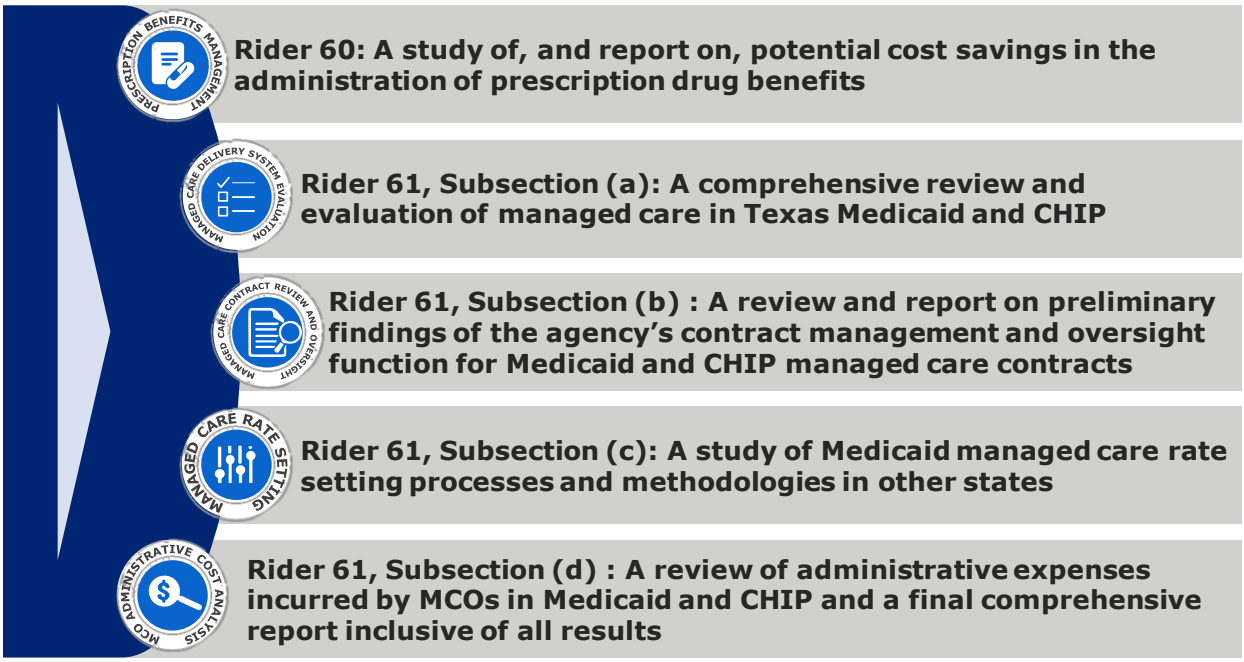
To evaluate managed care in the Texas Medicaid program, an assessment of performance across enrollment, costs, quality, member satisfaction, access, and managed care cost savings was conducted. In addition, potential opportunities for additional operational efficiencies, delivery system reforms, and cost containment initiatives have been documented.

To help frame the analysis, the following is a simplified version of the steps taken to conduct the evaluation:

1. First, the current program was analyzed through existing documentation to evaluate its design, successes, and challenges. An overview of the different managed care programs is provided in **Section 3 Program Background and Structure**.
2. Next, the summarized data was assessed and interviews were conducted with key personnel across HHSC to supplement insights gained from the data and documentation.
3. Analysis was then performed to evaluate trends, caseload growth, and savings realized with the managed care program. **Section 4 Enrollment and Expenditures** and **Section 8 Estimated Managed Care Program Savings** provide details on these components.
4. Lastly, a summary of managed care program outcomes and initiatives other states have used to contain costs and improve program effectiveness was created.

At the same time Rider 61 was commissioned, a Rider 60 (Conference Committee Report Rider 219) was also approved. Through Rider 61, the Texas Legislature commissioned a four-part study of costs and operations of the managed care program in Texas, as delineated in **Figure 2** below. HHSC included Riders 60 and 61 in a single request due to the overlap in their topics of review, as well as HHSC's interest in incorporating the information related to Rider 60 into the report to be developed for Rider 61.

Figure 2. Focus of Riders 60 and 61.



Rider 61(a) includes an assessment of the performance of Medicaid and CHIP managed care including the analysis of costs, cost savings, cost trends, caseload growth, and cost containment initiatives. Since the two Riders are related in terms of estimating potential cost savings associated with the managed care programs, it is necessary to delineate the topics addressed in Rider 60 from those contained in the separate report developed for Rider 61.

This report addresses only the Rider 61(a) assessment of Medicaid and CHIP managed care enrollment, costs, quality, member satisfaction, access, and managed care cost savings. The report studies the actual managed care program trends over FY2009 through FY2017 (inclusive of medical, pharmacy, administrative, and risk margin costs) compared to hypothetical FFS trend levels estimated based on historical Texas FFS experience, industry reports, and national benchmarks. The assessment then calculates a range of potential savings observed through the managed care program by comparing the actual historical managed care trends to the hypothetical FFS trend range. As noted in this report, during transition years within the managed care program (including years in which new managed care programs were introduced or existing programs were expanded), the assumed savings in shifting from FFS to managed care incorporated into the premium were at least budget neutral to, if not greater than, any additional costs associated under a managed care arrangement.

The Rider 60 report does not constitute an evaluation of Texas MCOs' effectiveness in administering pharmacy benefits. The Rider 60 study compares HHSC's actual historical pharmacy costs from FY2015 through FY2017 incurred under a managed care delivery model to the costs developed under a number of scenarios that may have occurred under a pharmacy carve-out model. Other than the potential impact on prescription drug utilization of carving out pharmacy benefits from managed care, the Rider 60 study does not incorporate potential upfront transition costs or the potential impact from changes in the coordination of care or data reporting.

Finally, while the Rider 60 report does not evaluate the effectiveness of the MCOs, the report does highlights potential impacts to the pharmacy program and the populations covered by MCOs today if HHSC were to carve out its pharmacy benefits.

2.3. Data Sources

The analysis relied on data provided by HHSC, as well as publicly available data. From the data provided by HHSC, some of these data sources were developed by HHSC, while others were prepared or created by third parties and delivered to HHSC.

As part of the analysis, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues. In certain cases, the data is audited or reviewed by other sources, and this analysis considered the results and any conclusions from those reviews in determining whether the data was reasonable for use in this report.

The following is a summary of key data items received from HHSC or located via publicly available sources and used in the study performed under Rider 61(a): [4,5,6]

[4] *HEDIS® is a registered trademark of NCQA. See* ***Appendix 10.1*** *for NCQA Copyright notice and Disclaimer.*

[5] *Quality Compass® is a registered trademark of NCQA. See* ***Appendix 10.1*** *for NCQA Copyright notice and Disclaimer.*

[6] *CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. See* ***Appendix 10.1*** *for NCQA Copyright notice and Disclaimer.*

Figure 3. Data Sources.

Report Section	Data Sources	Description
Program Background	Medicaid.gov	Online resource by Centers for Medicare and Medicaid Services (CMS)
Enrollment and Expenditures	2009–2017 Enrollment and Expenditure data for Texas	Internal data from HHSC containing detailed expenditure and enrollment information from 2009 to 2017
Enrollment and Expenditures	Medicaid.gov Managed Care Enrollment Reports	Nationwide data of Medicaid enrollment by state and program
Enrollment and Expenditures	CMS 64 Expenditures Data	State-specific Medicaid and CHIP summarized expenditure data.
Quality	Uniform Managed Care Contracts and Uniform Managed Care Manual	Documents provided by HHSC of the binding contracts and procedures/requirements for the Texas MCOs
Quality	Nationwide Quality Comparison Data	Nationwide and state-specific HEDIS benchmarks from the National Committee for Quality Assurance (NCQA) Quality Compass® Tool
Quality	MCO Report Cards	2014–2016 summary of the external quality review organization's (EQRO) review of Texas's quality measures and compliance
Quality	Texas Healthcare Learning Collaborative (THLC) Portal	Online portal that contains Texas quality data for all programs, years, and MCOs
Access	Appointment Availability Study	2015–2016 data from the appointment availability study performed by the EQRO
CAHPS	MCO Report Cards	2014–2016 summary of the EQRO's review of Texas's CAHPS composite measures and compliance
CAHPS	Nationwide Quality Comparison Data (NCQA)	Nationwide and state-specific CAHPS® benchmarks from the NCQA Quality Compass® Tool
Cost Savings	Texas Actuarial Rate Setting Certifications	Document required annually by CMS that details the rate setting process
Cost Savings	2009–2017 Enrollment and Expenditure data for Texas	Internal data from HHSC containing detailed expenditure and enrollment data from 2009 to 2017
Cost Savings	Industry Trend Data	Industry trend data collected from the CMS NHE reports and annual Express Scripts Drug Trend Report
Summary of Opportunities	All analyses of data sources used above	-

3. Program Background and Structure

3.1. Texas's Managed Care Programs

Medicaid and CHIP provide medical coverage for more than four million low-income individuals in Texas. These programs cover half of all children in the State and help cover the cost of care for two-thirds of people in nursing homes. All CHIP services and most Medicaid services, approximately 92 percent, are delivered through MCOs under contract with the State.

Since the inception of managed care in Texas in 1993, the HHSC has implemented several risk-based capitated managed care programs across Medicaid populations and services. The current Medicaid and CHIP managed care programs include STAR, STAR+PLUS, STAR Health, Dual Demonstration, STAR Kids, CHIP, and CHIP Perinatal.

3.2. STAR

STAR is the largest Medicaid Managed Care program in Texas in terms of members, covering children, newborns, pregnant women, and some families and children. STAR was Texas's first managed care program, implemented in SFY1994 to cover primary and acute services in Travis county and the Tri-County area. The STAR program continued to expand geographically from SFY1996 to SFY2011, when statewide coverage was approved by the CMS through a Medicaid 1115 transformation waiver. In March 2012, prescription drug benefits were carved into the STAR program and all other managed care programs in place at that time. By SFY2017, nearly three million people were enrolled in the STAR program.

3.3. STAR+PLUS

STAR+PLUS provides acute, primary, behavioral health, and LTSS to seniors and persons with disabilities; provides medical services to persons with intellectual and developmental disabilities (IDD); and covers women in the Medicaid for Breast and Cervical Cancer Program (BCCP). Individuals in this program receive all Medicaid benefits as well as help in the home with basic daily activities, help in making changes to the home, and short-term care to provide a break for caregivers.

The STAR+PLUS program was created as a pilot program in December 1997 that integrated acute care and LTSS for Supplemental Security Income (SSI) and SSI-related Medicaid beneficiaries in Harris County. The program had no geographical expansions until SFY2007 when the program expanded to the

Bexar, Travis, Harris, and Nueces service areas. The STAR+PLUS program continued geographical expansions in SFY2011 to the Dallas and Tarrant service areas, and in SFY2015, the program expanded to all areas of the State.

The program has also carved in additional services since its inception in 1997. In SFY2012, inpatient hospital services and prescription drug benefits were carved into the program. In September 2014, nondual enrollees with IDD began receiving acute care services through STAR+PLUS and Community First Choice was added as a state plan benefit. Additionally, employment assistance and supported employment were added to all waiver programs, including the STAR+PLUS Home and Community-Based Services (HCBS) waiver. In March 2015, individuals residing in a nursing facility began receiving services through the 1115 waiver, and in SFY2018, women in the Medicaid for BCCP were carved into STAR+PLUS.

Expansions of the STAR+PLUS program have resulted in the program covering more than 500,000 individuals in SFY2017. The program is also the costliest Medicaid Managed Care program, accounting for more than $8.5 billion, or more than 40 percent, of the $20.9 billion total Medicaid and CHIP managed care costs.

3.4. STAR Health

The STAR Health program was implemented in April 2008. The program was designed to better coordinate the health care of children in foster care and kinship care through one statewide MCO. The STAR Health MCO, Superior Health, provides members with comprehensive and integrated physical health, LTSS, behavioral health, vision, and dental benefits. Beginning in March 2012, prescription drug benefits were carved into the STAR Health Program, and on November 1, 2016, STAR Health began providing benefits for the Mentally Dependent Children Program (MCDP). STAR Health members also receive service coordination, service management, and value-added services, as well as a 24/7 nurse hotline for foster care parents, caregivers, and caseworkers.

Throughout SFY2017, approximately 32,000 children were enrolled in the STAR Health program.

3.5. Dual Demonstration

Under the CMS Financial Alignment Demonstration Program, Texas was one of 13 states approved to integrate Medicare and Medicaid funding for dual-

eligible members, with the goal to better coordinate the care these members receive.

In March 2015, the Dual Demonstration program began in six Texas counties, including Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant. At the program's inception, dual-eligible members were passively enrolled in the Dual Demonstration program. The program provides members with both Medicare and Medicaid services, including prescription drug benefits, integrating acute care, and long-term care.

Membership in the program continued to grow after it was created, reaching nearly 40,000 members in SFY2017.

3.6. STAR Kids

The STAR Kids program is a managed care program tailored for children with disabilities, including children receiving MDCP waiver benefits. Implemented statewide in November 2016, the STAR Kids program provides comprehensive benefits, including primary and specialty care, hospital care, prescription drugs, preventive care, and personal care services. STAR Kids also includes LTSS state plan services, such as personal care services and private duty nursing services.

During the first year of the program, in SFY2017, STAR Kids covered more than 163,000 children with disabilities.

3.7. CHIP and CHIP Perinatal

The CHIP program covers children under the age 19 who have been uninsured for at least 90 days and have family income at or below 201 percent of the Federal Poverty Level (FPL). In SFY2014, CHIP covered approximately 525,000 children. However, after the Affordable Care Act (ACA) required children from families with household income up to 133 percent FPL be covered by Medicaid, membership reduced to approximately 340,000 children in SFY2015, but increased to 390,000 covered children by SFY2017.

The CHIP Perinatal program is available to unborn children with household incomes up to 202 percent of the FPL and who do not qualify for Medicaid. CHIP Perinatal covers prenatal doctor visits, drugs ordered by a doctor, prenatal vitamins, labor and delivery, and checkups and other benefits for the baby after leaving the hospital. In SFY2017, CHIP perinatal covered approximately 37,000 unborn children.

3.8. Dental

Medicaid dental services transitioned from a FFS delivery model to a capitated managed care model in March 2012. Most children and youth age 20 and younger who are eligible for Medicaid or CHIP receive dental services through a managed care dental plan. Texas currently contracts with two dental plans for dental services.

3.9. Texas Managed Care Program Evolution

After the implementation of Texas's first Medicaid Managed Care program, STAR, in 1993, managed care has continued to grow across the State. In the initial geographic service areas of STAR, the program continued to expand from SFY1994 to SFY1997, reaching nearly 275,000 enrollees by SFY1997. In SFY1998, HHSC expanded managed care to the aged, blind, and disabled population through the STAR+PLUS pilot program.

Following implementation of the STAR+PLUS program in SFY1998, the STAR program expanded into two additional service areas in SFY1999 and SFY2000, followed by a period of no expansions from SFY2001 to SFY2005. However, even with no program expansions, the managed care enrollment grew from approximately 625,000 to 1.2 million during this time.

STAR and STAR+PLUS continued service area expansions in SFY2007, followed by implementation of the STAR Health program in SFY2008 and further STAR+PLUS service area expansions in SFY2011.

In 2012, Texas underwent its largest expansion of Medicaid Managed Care, including the following expansions:

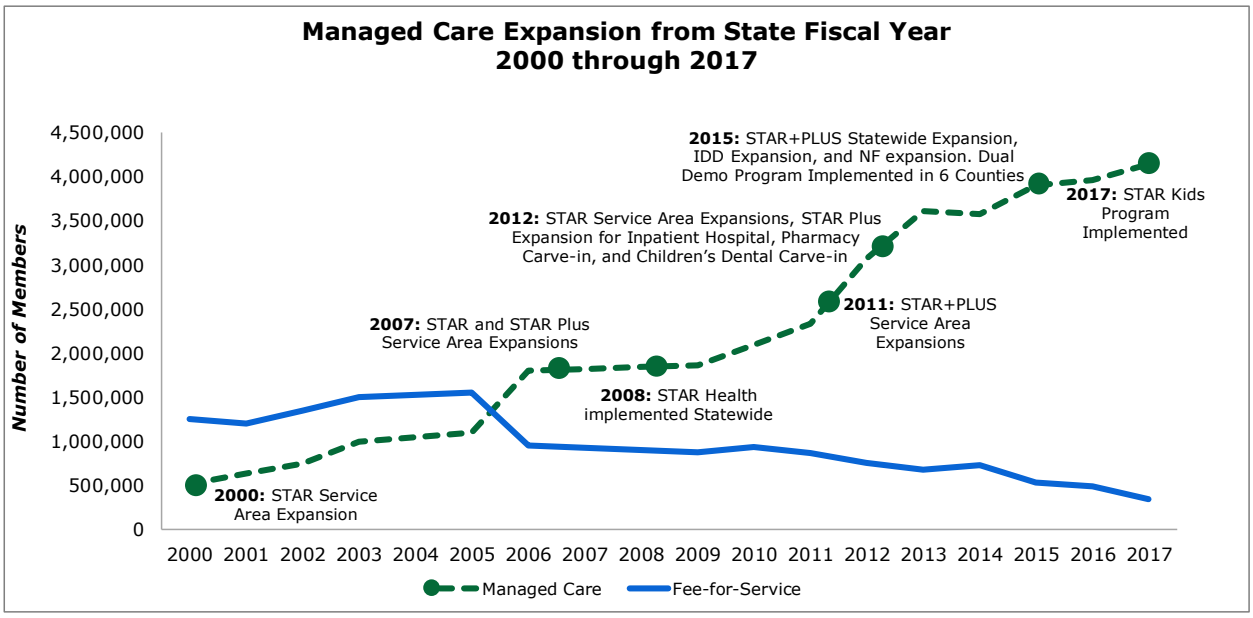
1. STAR expanded to two new service areas and the Medicaid Rural Service Areas (MRSA), resulting in statewide STAR implementation
2. STAR+PLUS expanded to three new service areas
3. Inpatient hospital benefits were carved into STAR+PLUS
4. Pharmacy services were carved into managed care
5. Medicaid dental services for children were carved into managed care

Further expansions to managed care programs occurred in SFY2015. There were several changes to the STAR+PLUS program, including expanding to all areas of the State, expanding to cover non-dual-eligible persons in IDD Waivers for acute care services, expanding to deliver nursing facility services, and adding Community First Choice as a state plan benefit. Additionally, employment assistance and supported employment were added

to all waiver programs, including the STAR+PLUS HCBS waiver. Across managed care programs, there were also expansions across mental health services, including carving mental health-targeted case management and mental health rehabilitative services into managed care.

In SFY2015, the Dual Demonstration program was implemented across six counties to cover dual-eligible members and better integrate their care across Medicare and Medicaid. In SFY2017, the STAR Kids program was implemented to cover children with disabilities, including children receiving MDCP waiver benefits.[7]

Figure 4. Managed Care Expansion from SFY2000 through SFY2017.[8]



[7] Additional Managed Care expansions occurred after SFY2017, including expanding to cover services for Adoption Assistance and Permanency Care Assistance.

[8] Based on Managed Care: Oversight and Monitoring presentation presented at the Texas House Committee on Human Services on April 24, 2018.

4. Enrollment and Expenditures

As the Texas Medicaid Managed Care program has evolved over time, various program changes and managed care expansions have resulted in increased managed care enrollment (as shown in **Figure 4** above). While membership continues to grow, further program changes and changes to covered services have affected medical and pharmacy expenditure trends.

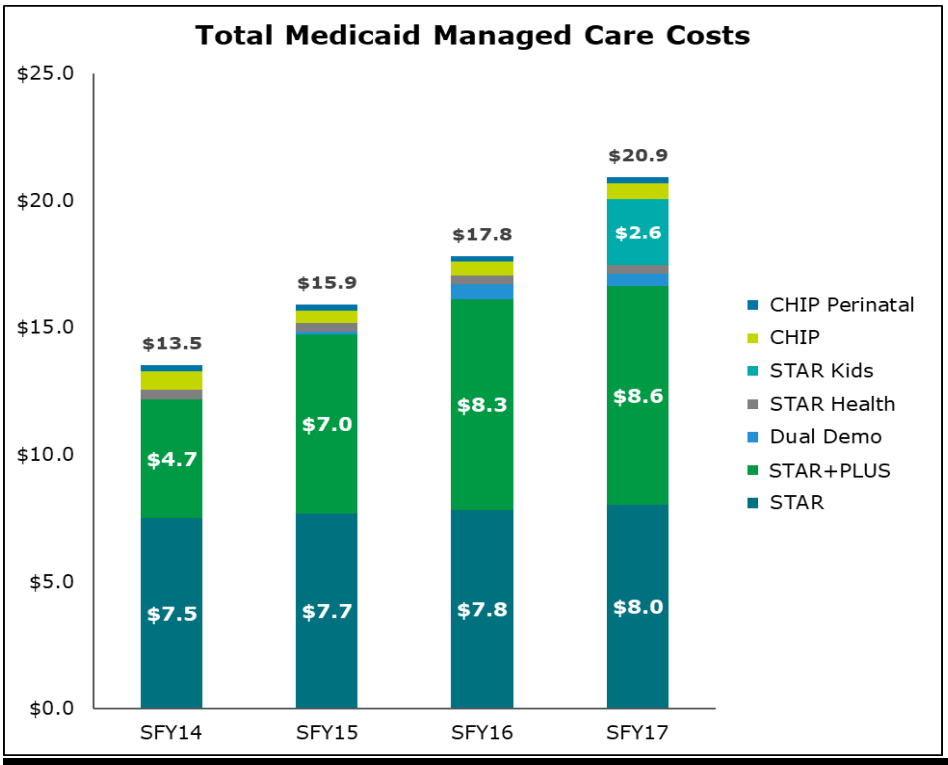
This section highlights the impacts and causes of the enrollment changes, as well as how these changes have affected overall expenditure trends. Additionally, expenditure trends are reviewed by medical and pharmacy service categories, as well as in aggregate, to identify expenditure drivers.

For comparison purposes, enrollment and expenditure trends across the states that were identified as comparable to Texas are presented to highlight key similarities and differences between managed care in Texas and in other states.

4.1. Total Medicaid Managed Care Expenditures

Total Medicaid and CHIP managed care expenditures, excluding dental expenditures, increased by nearly $7.3 billion from SFY2014 to SFY2017, reaching $20.9 billion in SFY2017. Expenditures increased by 18 percent in SFY2015, 12 percent in SFY2016, and 17 percent in SFY2017. From a total program expenditure perspective, in SFY2017, STAR+PLUS was the largest program with nearly $8.6 billion in expenditures, followed by STAR with more than $8.0 billion in expenditures. STAR Kids, a new program in SFY2017, is the third largest program, with nearly $2.6 billion in expenditures. The remaining programs have total expenditures of nearly $1.7 billion, with CHIP and the Dual Demonstration comprising two-thirds of the remaining expenditures.

Figure 5. Total Medicaid Managed Care Expenditures by Program (in billions).



Program	SFY2014	SFY2015	SFY2016	SFY2017
STAR	$7.5	$7.7	$7.8	$8.0
STAR+PLUS	$4.7	$7.0	$8.3	$8.6
Dual Demo	$0.0	$0.1	$0.6	$0.5
STAR Health	$0.4	$0.3	$0.3	$0.4
STAR Kids	$0.0	$0.0	$0.0	$2.6
CHIP	$0.8	$0.5	$0.6	$0.6
CHIP Perinatal	$0.2	$0.2	$0.2	$0.2
Total	**$13.5**	**$15.9**	**$17.8**	**$20.9**

4.2. Medicaid Managed Care Enrollment and Expenditure

4.2.1. Total Program Enrollment

Total enrollment has increased by nearly 600,000 from SFY2014 to SFY2017, reaching just under 4.2 million members in SFY2017. The largest enrollment increase occurred in SFY2015, driven by Medicaid Managed Care expansions and impacts related to the ACA.[9] Following SFY2015, enrollment has increased slightly, with a total increase of 259,000 members between SFY2015 and SFY2017. The STAR Kids program accounted for more than half of this increase, with 163,000 members at the program's commencement in SFY2017.[10]

[9] SFY2015 Dual Demonstration membership is a six-month average, as the program began in March 2015.

[10] SFY2017 STAR Kids membership is a 10-month average, as the program began in November 2017.

Figure 6. Average Membership and Average Membership Trends by Program.

Program	SFY 2014 Average Member-ship	SFY 2015 Average Member-ship	SFY 2016 Average Member-ship	SFY 2017 Average Member-ship	SFY 2014-SFY 2015 Average Member-ship Trend (% change)	SFY 2015-SFY 2016 Average Member-ship Trend (% change)	SFY 2016-SFY 2017 Average Member-ship Trend (% change)
STAR	2,570,545	2,941,333	2,956,310	2,986,242	14%	1%	1%
STAR+PLUS	410,994	538,385	536,668	527,364	31%	0%	-2%
Dual Demo	-	27,908	46,533	39,954	-	67%	-14%
STAR Health	30,727	30,909	30,900	32,094	1%	0%	4%
STAR Kids	-	-	-	163,228	-	-	-
CHIP	524,494	339,831	360,788	390,534	-35%	6%	8%
CHIP Perinatal	39,323	38,971	37,359	36,645	-1%	-4%	-2%
Total	**3,576,082**	**3,917,338**	**3,968,557**	**4,176,060**	**10%**	**1%**	**5%**
Total Excluding STAR Kids	3,576,082	3,917,338	3,968,557	4,012,833	10%	1%	1%
Total Excluding STAR Kids/ Dual Demo	3,576,082	3,889,430	3,922,024	3,972,879	9%	1%	1%

4.2.2. Total Program Expenditures

Program expenditures were evaluated on a PMPM basis to remove the changes in enrollment across the individual programs. However, PMPM calculations do not account for membership shifting between higher and lower expenditure risk groups, programs, or regions. The analysis within this section compares year-over-year changes (trends) in total medical and pharmacy PMPMs, as well as various factors that are driving these expenditure changes, including members shifting between risk groups due to program changes, managed care expansions into new geographic regions and populations, and impacts from the ACA. Throughout the analysis, the pharmacy expenditures reviewed are gross of rebates.

Program-specific PMPM trend rates have remained modest to flat throughout the analysis period for all programs, apart from STAR+PLUS. STAR program trend rates decreased by 11 percent from SFY2014 to SFY2015, then trended at 1 percent and 2 percent increases in the following two years. Similarly, STAR Health trends were negative or relatively flat in all years and CHIP trends did not exceed 5 percent. However, STAR+PLUS trends surpassed 15 percent in SFY2015 and SFY2016, due to multiple program changes, and then flattened out in SFY2017.

There was an annual PMPM increase of approximately 10.1 percent in aggregate across all the managed care programs from SFY2014 to SFY2017. During this period, there were two new programs added to Medicaid Managed Care. The addition of the STAR Kids program in SFY2017 had an impact on the overall PMPM increase during the analysis period. Removing the STAR Kids population from the PMPM calculation results in approximately 6.5 percent annual PMPM expenditure trend rate. When accounting for other service expansions, program changes, administrative expense changes, and population shifting from SFY2009 to SFY2017, the managed care program PMPM cost trended at 2.1 percent, slightly higher than the annualized Medicaid PMPM cost trend rate of 1.8 percent from the CMS NHE Report for Medicaid.

Figure 7. Total Expenditure PMPM and Total Expenditure PMPM Trends by Program.

Program	SFY 2014 Total Expenditure PMPM	SFY 2015 Total Expenditure PMPM	SFY 2016 Total Expenditure PMPM	SFY 2017 Total Expenditure PMPM	SFY 2015 Total Expenditure PMPM Trend (% change)	SFY 2016 Total Expenditure PMPM Trend (% change)	SFY 2017 Total Expenditure PMPM Trend (% change)
STAR	$244	$218	$221	$224	-11%	1%	2%
STAR +PLUS	$945	$1,088	$1,289	$1,357	15%	19%	5%
Dual Demo	-	$678	$1,053	$1,036	-	55%	-2%
STAR Health	$986	$926	$922	$922	-6%	0%	0%
STAR Kids	-	-	-	$1,590	-	-	-
CHIP	$120	$123	$127	$134	2%	3%	5%
CHIP Perinatal	$450	$466	$424	$461	4%	-9%	2%
Total	**$315**	**$339**	**$374**	**$419**	**8%**	**10%**	**12%**
Total Excl. STAR Kids	$315	$339	$374	$380	8%	10%	2%
Total Excl. STAR Kids / Dual Demo	$315	$338	$366	$373	7%	8%	2%

Figure 8 shows the makeup of total medical and pharmacy PMPM trend each year attributed to caseload versus expenditure, excluding the additions of the Dual Demonstration program in SFY2015 and the STAR Kids program in SFY2017. Membership growth has slowed as a contributor to overall program trends, and medical expenditure trends were volatile across the analysis period. Note that while the Dual Demonstration and STAR Kids programs have been removed from this analysis, adjustments for other factors affecting the medical trend, including program changes, program expansions, and caseload mix changes, have not been made.

Figure 8. Total Expenditure Attributable to Caseload and Expenditure.

	SFY2015	SFY2016	SFY2017
Total Expenditure Trend	17%	9%	3%
Membership Trend	9%	1%	1%
Total PMPM Trend	7%	8%	2%

4.2.3. STAR

The STAR program continues to have the largest enrollment of all the managed care programs, accounting for more than 70 percent of the total Medicaid Managed Care membership in Texas. The STAR program has the second lowest PMPM among Texas's managed care programs, while having the second highest total expenditure as of SFY2017. The program has seen an annual aggregate decrease in PMPMs of approximately 2.8 percent from SFY2014 to SFY2017, driven mostly by the impacts of ACA requirements and the MRSA expansion to STAR+PLUS in SFY2015. **Figure 9** below summarizes the STAR PMPMs and enrollment from SFY2014 to SFY2017.

Figure 9. STAR PMPM Trends for Medical and Pharmacy.

Services	SFY2014 STAR Total PMPM	SFY2015 STAR Total PMPM	SFY2016 STAR Total PMPM	SFY2017 STAR Total PMPM
Medical PMPM	$196	$180	$182	$183
Medical PMPM Trend	-	*-8%*	*1%*	*0%*
Pharmacy PMPM	$48	$37	$39	$41
Pharmacy PMPM Trend	-	*-22%*	*3%*	*7%*
Total PMPM	$244	$218	$221	$224
Total PMPM Trend	-	*-11%*	*1%*	*2%*
Average Members	2,570,545	2,941,333	2,956,310	2,986,242

4.2.3.1. STAR Enrollment

In SFY2015, STAR had a membership increase of approximately 370,000, or a 14 percent increase, from SFY2014. Changes in eligibility rules were because the ACA shifted membership to STAR from other programs, and membership also likely increased because of increased awareness of Medicaid due to the ACA.

- Children with household incomes up to 133 percent of the FPL who had been enrolled in CHIP shifted to Medicaid, resulting in an increase of 185,000 in Star enrollment.
- Increased awareness due to the ACA likely accounted for approximately 100,000 new members to the STAR program.
- Additional ACA requirements attributed to the remaining increase of 85,000 members:
  - Moving from six-month to 12-month recertification of Medicaid eligibility
  - Changes in Medicaid eligibility determination rules
  - Foster care coverage expanded up to age 26
- Enrollment increases occurred across all service delivery areas, with the MRSA having the smallest increases.

  - MRSA service delivery areas had enrollment increases ranging from 0 percent to 5 percent, while all other service delivery areas had increase ranging from 10 percent to 21 percent.
  - Membership increases also occurred across all MCOs, except for one, with changes ranging from a 4 percent decrease to a 47 percent increase.

In SFY2016, STAR enrollment had a small increase of less than 15,000 members, or a 0.5 percent increase, over SFY2015. Across service delivery areas, the largest increase occurred in the MRSA service delivery areas of Central Texas, Northeast Texas, and West Texas, as well as the Harris service delivery area, with 23,000 members added in these areas. Offsetting this increase was a decrease of approximately 8,000 members in the Dallas service delivery area. Membership impacts varied across MCOs ranging from a high of an increase of 9,000 members to a low of a decrease of 8,500 members.

In SFY2017, there was a small enrollment increase of approximately 30,000 members, or a 1.0 percent increase, from SFY2016. The enrollment changes realized across service delivery areas were relatively consistent, ranging from a 1 percent decrease to a 4 percent increase. Similarly, changes seen across MCOs were relatively consistent, except for one outlier, with a 12 percent decrease. All other MCOs had membership changes ranging from a 5 percent decrease to a 6 percent increase.

4.2.3.2. STAR Expenditures

In SFY2015, STAR had an 11 percent decrease in the total expenditure PMPM.

- MRSA expanding to STAR+PLUS had the largest impact on PMPM in the STAR program.
  - When MRSA expanded to STAR+PLUS in SFY2015, approximately 52,000 high-expenditure members from the Disabled and Blind risk group shifted from the STAR program to the STAR+PLUS program increasing acute services and prescription drug costs.
  - With an average SFY2014 PMPM of $585 PMPM for the Disabled and Blind STAR risk group, compared to an average expenditure of $244 for the STAR program, these members shifting out of STAR accounted for more than half of the decreased PMPM in SFY2015.
- Low-expenditure children shifting from CHIP to STAR due to the ACA accounted for more than one-third of the PMPM reduction in SFY2015.

- Pharmacy expenditures had a lower trend rate than medical expenditures, with a 22 percent decrease for pharmacy and an 8 percent decrease for medical.

The PMPM decrease seen by the STAR program in SFY2015 occurred across nearly all service delivery areas. The MRSA service delivery areas of Central Texas, Northeast Texas, and West Texas had the largest PMPM decreases, due to members shifting to STAR+PLUS, with decreases ranging from 28 percent to 34 percent. Across other service delivery areas, PMPM decreases ranged from a 3 percent decrease to a 9 percent decrease, apart from three service delivery areas, El Paso, Lubbock, and Nueces, that had increased PMPMs from SFY2014 to SFY2015. Similarly, most MCOs saw reduced PMPMs in SFY2015, except for two MCOs that had a small increase. However, the magnitude of PMPM change across MCOs varied widely, with MCOs seeing SFY2015 PMPM trend rates ranging from 22 percent decrease to a 3 percent increase.

After the PMPM decrease in SFY2015, PMPMs in SFY2016 and SFY2017 grew modestly with a 1 percent increase in SFY2016 and a 2 percent increase in SFY2017.

4.2.4. STAR+PLUS

STAR+PLUS is the second largest program after the STAR program in terms of membership, with nearly 530,000 members in SFY2017. The STAR+PLUS program has the highest total expenditure and the second highest PMPM of all the managed care programs. The program saw an annual aggregate increase in PMPMs of 13 percent from SFY2014 to SFY2017. Program changes were the main driver of these expenditures, with the highest expenditure increases occurring in SFY2015 and SFY2016. **Figure 10** below summarizes the STAR+PLUS PMPMs and enrollment from SFY2014 to SFY2017.

Figure 10. STAR+PLUS PMPM Trends for Medical and Pharmacy.

Services	SFY2014 STAR+ PLUS Total PMPM	SFY2015 STAR+ PLUS Total PMPM	SFY2016 STAR+ PLUS Total PMPM	SFY2017 STAR+ PLUS Total PMPM
Medical PMPM	$770	$899	$1,089	$1,135
Medical PMPM Trend	-	*17%*	*21%*	*4%*
Pharmacy PMPM	$175	$189	$201	$222
Pharmacy PMPM Trend	-	*8%*	*6%*	*11%*
Total PMPM	$945	$1,088	$1,289	$1,357
Total PMPM Trend	-	*15%*	*19%*	*5%*
Average Members	410,994	538,385	536,668	527,364

4.2.4.1. STAR+PLUS Enrollment

In SFY2015, enrollment grew by more than 127,000 members, or a 31 percent increase, over SFY2014. The increase in STAR+PLUS enrollment was a result of several services being transitioned from FFS to managed care and other program changes, which are summarized below:

- Service carve-ins
  - Prescription drug services were carved into STAR+PLUS and all managed care programs in March 2012.
  - Nursing Facility care was shifted in March 2015.
  - IDD waiver acute care services for non-dual-eligible members were shifted September 2014.
  - Community First Choice was added as a state plan benefit.
  - Employment assistance and supported employment were added to all waiver programs, including the STAR+PLUS HCBS waiver.
- Service delivery area expansions
  - MRSA service delivery areas of central Texas, northeast Texas, and west Texas were added to the STAR+PLUS program.

- Increased enrollment in MRSA service delivery areas resulted in approximately 105,000 new members, and was the largest contributor to increased enrollment in SFY2015.

- New managed care program
  - The Dual Demonstration program commenced in April 2015. As a result, some members shifted from STAR+PLUS to the new Dual Demonstration program.

In SFY2016, STAR+PLUS enrollment decreased by approximately 1,700 members, or 0.3 percent, over SFY2015. Across service delivery areas, five had decreased enrollment, while the remaining eight, including the newly expanded MRSA service delivery areas, had increased membership.

- Service delivery areas with the largest decreases in enrollment were Bexar, El Paso, Harris, and Hidalgo with enrollment decreases ranging from approximately 3,450 to 4,750.
- MRSA service delivery areas realized the largest increases in enrollment ranging from 2,500 to 3,600.
- Results across MCOs also varied with three MCOs realizing decreased membership and two MCOs realizing increased membership.

SFY2017 also saw a small decrease in STAR+PLUS enrollment of approximately 18,000 due to children shifting from STAR+PLUS to the new managed care program, STAR Kids. This decrease was offset by a small increase to the program, for a total decrease of 9,300 members. The decrease seen in SFY2017 was seen across all service delivery areas and MCOs, with exceptions of only one service delivery area and one MCO. The decreases by service delivery area ranged from 270 to 2,800 enrollees and the membership decreases by MCO ranged from 570 to 4,500.

4.2.4.2. STAR+PLUS Expenditures

In SFY2015, the STAR+PLUS PMPM increased by 15 percent. There were several program changes in SFY2015 that contributed to the expenditure increases, including those referenced in the STAR+PLUS enrollment section. These program changes had varying impacts on the large PMPM increase that occurred in SFY2015.

- Carving nursing facility services into managed care resulted in expenditure increases of nearly $1.2 billion in SFY2015.
- IDD waiver acute care services carve-in resulted in approximately $70 million in new expenditures, inpatient services resulted in

approximately $20 million in new expenditures, and prescription drug benefits resulted in approximately $100 million in new expenditures, totaling approximately $190 million in new expenditures

- MRSA service delivery areas resulted in $1.2 billion in new expenditures.

In SFY2016, the STAR+PLUS program saw a 19 percent increase in expenditures over SFY2015. The nursing facility carve in continued to be the driver of the expenditure increase in SFY2016. In SFY2016, nursing facilities continued to see increases in utilization resulting in an 11 percent increase in the nursing facility PMPM.

By SFY2017, the impact of the program changes in SFY2015 had been absorbed, and the PMPM increase was 6 percent. While the rate of increase for nursing facility utilization and PMPMs were lower than the previous year, there was still an increase of 1,500 members utilizing nursing facilities with a PMPM increase of 6.9 percent, resulting in a nursing facility PMPM of more than $4,300. In SFY2017, the changes seen across service delivery areas and MCOs were consistent, clustered closely to the average STAR+PLUS program increase of 6 percent.

4.2.5. Dual Demonstration

Beginning in March 2015, HHSC began offering a new Medicaid Managed Care program for people who are eligible for both Medicare and Medicaid. At the conception of the new Dual Demonstration program, dual-eligible members in each of six demonstration counties (Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant) were enrolled in the Dual Demonstration program. The new program provides members with a full array of Medicaid and Medicare services. After the commencement of the Dual Demonstration program in March 2015, cohorts of eligible populations were added on a month-to-month rolling basis over the following six months. Thus, expenditures continued to ramp up through SFY2016 when PMPMs steadied around $1,000 PMPM. **Figure 11** below summarizes the STAR+PLUS PMPMs and enrollment from SFY2014 to SFY2017.

Figure 11. Dual Demonstration PMPM Trends for Medical and Pharmacy.

Services	SFY2014 Dual Demo. Total PMPM	SFY2015 Dual Demo. Total PMPM	SFY2016 Dual Demo. Total PMPM	SFY2017 Dual Demo. Total PMPM
Medical PMPM	-	$674	$1,049	$1,033
Medical PMPM Trend	-	-	*56%*	*-2%*
Pharmacy PMPM	-	$4	$4	$4
Pharmacy PMPM Trend	-	-	*0%*	*-11%*
Total PMPM	-	$678	$1,053	$1,036
Total PMPM Trend	-	-	*55%*	*-2%*
Average Members	-	27,908	46,533	39,954

4.2.5.1. Dual Demonstration Enrollment

In SFY2015, the Dual Demonstration program was in place for six months and enrolled approximately 14,000 members during this time. The membership was relatively consistent across the six service delivery areas with average membership by service delivery area ranging from 1,700 to 4,300. Members enrolled in one of five MCOs, with relatively consistent membership across the MCOs participating in the program.

In SFY2016, the first full SFY of the program, enrollment increased by approximately 47,000 members. The Harris service delivery area saw the largest membership increase and had the highest membership in SFY2016, increasing from 4,300 in SFY2015 to 13,100 in SFY2016. Other service delivery areas had membership ranging from 4,200 to 8,200.

In SFY2017, enrollment decreased by 6,600 members or by 14 percent over SFY2016. This reduction occurred across all service delivery areas and MCOs, with decreases ranging from 10 percent to 17 percent by service delivery area and decreases ranging from 13 percent to 34 percent decrease by MCO.

4.2.5.2. Dual Demonstration Expenditures

After the commencement of the Dual Demonstration program in March 2015, expenditures continued to ramp up through SFY2016 when PMPMs steadied around $1,000 PMPM. PMPM growth in SFY2016 was inconsistent

across the six service delivery areas with the largest increases in Dallas and Tarrant, both more than doubling their PMPMs from the partial year of experience in SFY2015. Most of the remaining service delivery areas had PMPM growth between 17 percent and 39 percent. The variance in the PMPM growth by service delivery area can be attributed to the phase-in of Nursing Facility benefits to Dallas and Tarrant counties during this period. Expenditure growth was also inconsistent across MCOs, however, with slightly less variance than across the service delivery areas. MCO PMPM changes ranged from an 18 percent decrease to a 90 percent increase.

In SFY2017, PMPMs decreased by 2 percent. Trends across service delivery areas and MCOs were more consistent than in SFY2016, with trends by service delivery area ranging from -4 percent to 3 percent and trends by MCO ranging from -7 percent to 1 percent.

4.2.6. STAR Health

4.2.6.1. STAR Health Enrollment

The STAR Health program has consistently had the lowest enrollment across the Medicaid Managed Care programs in Texas, with 32,000 members in SFY2017. STAR Health enrollment has remained consistent across the analysis periods increasing by approximately 1,400 members from SFY2014 to SFY2017, with the largest increase in SFY2017 of 1,200 members. SFY2015 had a small increase of approximately 180 members and SFY2016 had a small decrease of approximately 10 members.

4.2.6.2. STAR Health Expenditures

Program expenditures have also remained relatively steady from a PMPM basis throughout SFY2014 to SFY2017. Program expenditures saw a slight decrease in PMPMs in SFY2015, with a 6 percent decrease on the medical PMPMs and an 8 percent decrease on the pharmacy drug PMPMs. Following SFY2015, PMPMs across both medical and pharmacy have remained consistent with a 0 percent aggregate PMPM changes in both SFY2016 and SFY2017.

4.2.7. STAR Kids

4.2.7.1. STAR Kids Enrollment

STAR Kids began in November 2016. The program covers children and adults of 20 years old and younger who have disabilities. Participation in the STAR Kids program is required for children who are 20 or younger, covered by

Medicaid, and meet at least one additional requirement such as receiving SSI or receiving services through the MDCP.

STAR Kids enrolled more than 163,000 members in the program's first year, SFY2017. Enrollment occurred across all of Texas's service delivery areas with the highest membership in the Dallas, Harris, and Hidalgo service delivery areas. Ten MCOs are participating in the program, with varied membership in the first year. Four MCOs enrolled more than 20,000 members each and the remaining six MCOs enrolled between 5,200 and 10,700 members each.

4.2.7.2. STAR Kids Expenditures

In SFY2017, the STAR Kids PMPM was higher than any other Medicaid Managed Care program at $1,590. Across service delivery areas, the PMPMs ranged from approximately $1,200 to $1,750 PMPM. The service delivery areas with the highest PMPMs were Dallas, Tarrant, and Travis. PMPMs by MCOs participating in the STAR Kids program range from approximately $1,400 to $2,000 PMPM due to regional variation in costs and case-mix differences across the MCOs.

4.2.8. CHIP

The CHIP program has the third highest enrollment across Medicaid Managed Care programs in Texas, with approximately 390,000 members in SFY2017. The program saw a significant decrease in enrollment in SFY2015, because of ACA eligibility changes, and realized steady increases in the following two years. The program has the lowest PMPM across all Medicaid Managed Care programs by nearly $100 PMPM and has seen an annual aggregate increase in PMPMs of approximately 3.6 percent from SFY2014 to SFY2017.

Figure 12. CHIP PMPM Trends for Medical and Pharmacy.

Services	SFY2014 CHIP Total PMPM	SFY2015 CHIP Total PMPM	SFY2016 CHIP Total PMPM	SFY2017 CHIP Total PMPM
Medical PMPM	$91	$93	$96	$99
Medical PMPM Trend	-	2%	3%	3%
Pharmacy PMPM	$29	$30	$31	$35
Pharmacy PMPM Trend	-	3%	3%	13%
Total PMPM	$120	$123	$127	$134
Total PMPM Trend	-	2%	3%	5%
Average Members	524,494	339,831	360,788	390,534

4.2.8.1. CHIP Enrollment

In SFY2015, the CHIP program had a decrease in enrollment of approximately 185,000 members, a result of the ACA-related eligibility changes shifting children from CHIP to Medicaid. The shift began in March 2014; however, the transition extended through February 2015. The enrollment reduction in SFY2015 occurred across all service delivery areas and nearly all MCOs, except for three MCOs. While the number of reduced members varied across service delivery areas and MCOs, the percentage changes were close to the average percentage change for both service delivery areas and MCOs.

In SFY2016, there was an increase in enrollment of 21,000 members, or a 6 percent increase from SFY2015. There was an increase in enrollment of nearly 11,000 across the MRSA service delivery areas and increases ranging from 5,100 to 5,700 across the service delivery areas of Dallas, Harris, and Tarrant. Across MCOs, five MCOs saw reduced membership, while 12 MCOs saw increased membership.

In SFY2017, enrollment increases continued, with nearly 30,000 new members to the CHIP program, an 8 percent increase from SFY2016.

- Harris, Dallas, and Tarrant service delivery areas continued to see enrollment increases of 6,900, 5,800, and 3,900, respectively.
- Other service delivery areas all saw modest increases

- There were varied changes across MCOs with four MCOs seeing reduced membership.
- The remaining 13 MCOs realized increased membership
  - The largest increase was 14,000 additional members.
  - Of the remaining MCOs with increased membership, seven MCOs had small increases of less than 1,000 members and the remaining five MCOs had increases ranging from approximately 1,700 members to 7,750 members.

4.2.8.2. CHIP Expenditures

In SFY2015, while PMPMs in total were consistent with the prior year, PMPMs across service delivery areas and MCOs varied. Six service delivery areas had increases in the high single digits ranging from approximately 6.0 percent to 9.3 percent. PMPMs across MCOs had even more variation than PMPMs across service delivery areas, ranging from an 87 percent decrease in PMPMs to a 25 percent increase in PMPMs.

In SFY2016, PMPMs increased by 3 percent, which was consistent across medical and pharmacy expenditures. Except for a few outliers with low membership, there was less variation across service delivery areas and MCOs in SFY2016. Excluding outliers, PMPM changes by service delivery area ranged from -6 percent to 9 percent and PMPM changes by MCO ranged from -14 percent to 10 percent.

SFY2017 had the largest PMPM increase across the analysis period of 5 percent. The higher expenditure increase in SFY2017 was driven by a 13 percent increase in pharmacy expenditures. Consistent with SFY2016, there was moderate variation on PMPMs across service delivery areas and MCOs.

4.2.9. CHIP Perinatal

4.2.9.1. CHIP Perinatal Enrollment

CHIP Perinatal enrollment has seen modest year-over-year decreases over each of the past three years with a 1 percent decrease in SFY2015, a 4 percent decrease in SFY2016, and a 2 percent decrease in SFY2017, when 34,000 members were covered.

4.2.9.2. CHIP Perinatal Expenditures

CHIP Perinatal PMPMs have been inconsistent across the analysis period with a 2 percent increase in SFY2015, a 10 percent decrease in SFY2016, and a 9

percent increase in SFY2017. Pharmacy expenditures were the main driver of the PMPM increase in SFY2015 with a 34 percent increase from the prior year, while medical expenditures were the main driver of the decrease in SFY2016 with a 10 percent decrease from the prior year. Pharmacy expenditures were the driver of the PMPM increase again in SFY2017, nearly doubling the PMPM pharmacy expenditure from SFY2016.

4.2.10. Medicaid and CHIP Dental

4.2.10.1. Medicaid and CHIP Dental Enrollment

After an increase in Medicaid enrollment in SFY2015 of nearly 400,000 members, dental membership has remained consistent for the past three years, with just under three million members in SFY2017.

CHIP Dental enrollment is aligned with total CHIP membership. Like CHIP membership, CHIP dental enrollment decreased by 35 percent in SFY2015, followed by a 6 percent increase in SFY2016 and an 8 percent increase in SFY2017.

4.2.10.2. Medicaid and CHIP Dental Expenditures

Medicaid dental PMPMs have decreased by 0.5 percent each year from SY2014 through SY2017. These decreases resulted in the dental PMPM decreasing from $36.20 in SFY2014 to $35.59 in SFY2017.

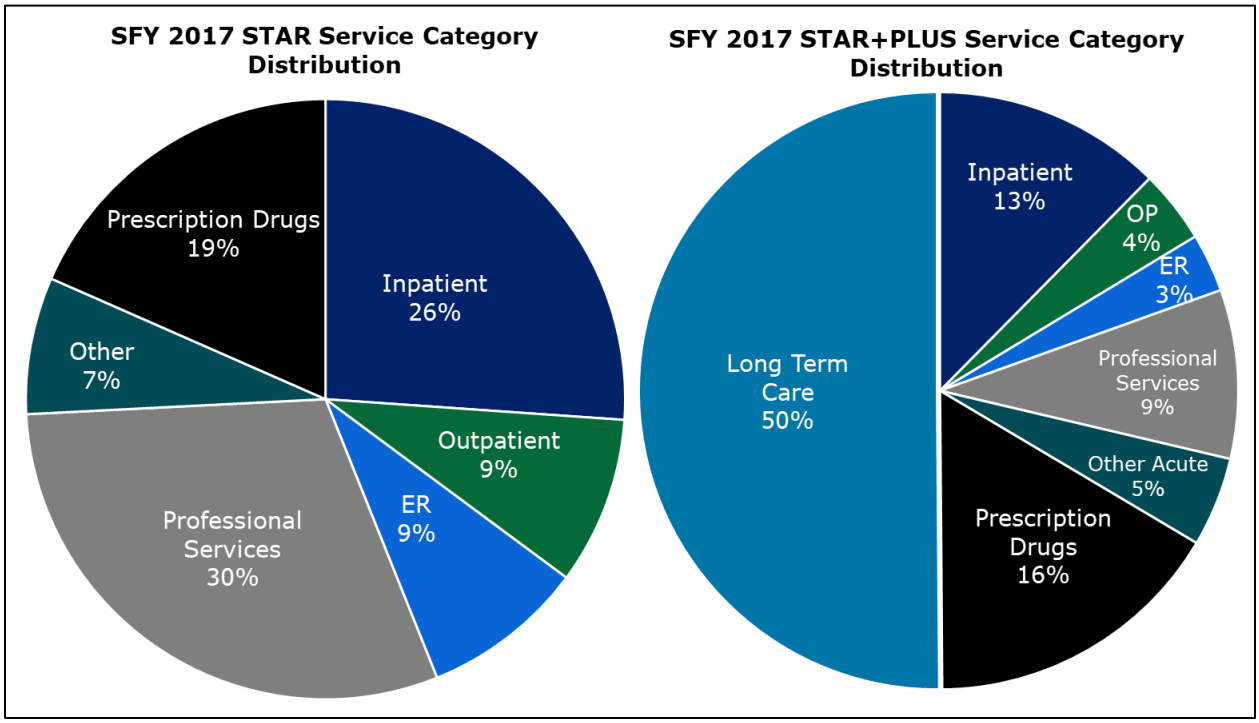
CHIP dental PMPMs, while having a lower total PMPM than Medicaid dental, increased at a much higher rate across the analysis period; 9 percent in SFY2015, 5 percent in SFY2016, and 7 percent in SFY2017. These increases resulted in the CHIP dental expenditures PMPM increasing from $20.71 in SFY2014 to $25.49 in SFY2017.

4.2.11. Total Medicaid Managed Care Expenditure Trends by Service Category

In addition to reviewing Texas managed care trends by medical versus prescription drug services, trends were also reviewed by service categories and prescription drug types. The annual actuarial rate setting certifications performed for HHSC for the STAR and STAR+PLUS programs include a detailed expenditure trend report. **Figure 13** represent the total expenditure

distribution by medical service category for the STAR and STAR+PLUS programs.[11]

Figure 13. SFY2017 STAR and STAR+PLUS Expenditure Distribution by Service Category.



Texas trend rates across service categories were also compared to national trend rates across service categories using CMS NHE reports for both medical and prescription drug trend rates. Prescription drug trend rates by service category were compared to the Express Scripts Annual Drug Trend Reports.

4.2.11.1. Texas Expenditure Trends by Service Category

For the STAR Program, inpatient expenditures had the lowest trend rate across all service categories, increasing in aggregate by 0.2 percent annually from SFY2014 to SFY2017. Outpatient nonemergency room expenditures realized the highest annualized increase of 7.6 percent across the analysis period. Other service categories saw low, single-digit annualized increases ranging from 1.5 percent to 5.0 percent. There was a steady increase in the

[11] *Service category distribution is based on total cost by service category from the annual actuarial rate setting certifications.*

aggregate trends ranging from 0.2 percent in SFY2014 to 3.5 percent in SFY2017.

Figure 14. STAR PMPM Trends by Service Category.

STAR PMPM Trends by Service Category	SFY 2014	SFY 2015	SFY 2016	SFY 2017	Annualized
Inpatient	-0.9%	1.3%	1.0%	-0.7%	**0.2%**
Outpatient (Non-ER)	12.9%	4.1%	5.1%	8.5%	**7.6%**
Emergency Room	-2.3%	3.9%	5.9%	13.1%	**5.0%**
Professional	-0.3%	1.0%	1.3%	8.1%	**2.5%**
Other	3.6%	5.3%	4.0%	1.2%	**3.5%**
Prescription Drugs	-2.7%	3.1%	4.6%	1.0%	**1.5%**
Total	0.2%	2.2%	2.5%	3.6%	**2.1%**

Across all service categories, except for outpatient service categories, the STAR+PLUS trend rates were higher than the STAR trend rates. In aggregate, the STAR+PLUS trend rate was 1.8 percent higher than the STAR trend rate. Aggregate trend rates were modest from SFY2014 through SFY2016, but in SFY2017, expenditures increased by 8.1 percent, mostly because of 10.7 percent increase in long-term care expenditures. Outpatient nonemergency room services had the largest increase with a 5.3 percent trend rate. Outpatient emergency room grew steadily over the four-year analysis period starting with 1.5 percent in SFY2014 and increasing to 9.5 percent in SFY2017.

Figure 15. STAR+PLUS PMPM Trends by Service Category.

STAR+PLUS PMPM Trends by Service Category	SFY 2014	SFY 2015	SFY 2016	SFY 2017	Annualized
Inpatient	6.3%	-4.6%	5.8%	2.8%	**2.5%**
Other Acute Care	-15.3%	6.3%	2.2%	4.5%	**-1.0%**
Outpatient (Non-ER)	13.3%	-3.1%	0.1%	11.8%	**5.3%**
Emergency Room	1.5%	0.9%	8.0%	9.5%	**4.9%**
Professional	0.0%	-1.7%	8.5%	4.8%	**2.8%**
Long-Term Care	2.3%	2.1%	0.3%	10.7%	**3.8%**
Prescription Drugs	2.1%	0.3%	10.7%	0.0%	**3.2%**
Total	2.8%	1.0%	3.7%	8.1%	**3.9%**

4.2.11.2. National Comparison of Expenditure Trends by Service Category

To compare Texas's expenditure trends by medical service category to national results, the service categories from the Texas trend report were aligned to the service categories from CMS NHE report. Note that the CMS NHE trends are displayed by calendar year, while the Texas trends are displayed by SFY. For example, 2017 is 1/1/2017 – 12/31/2018 for the CMS NHE trends and 9/1/2016 – 8/31/2017 for the Texas trends.

- Inpatient and Outpatient expenditures for Texas are compared to Hospital Care Expenditures from the CMS NHE report
- Professional Service expenditures for Texas are compared to aggregated trend rates for Physician and Clinical Service expenditures and Other Professional Services from the CMS NHE report.
- Other services for Texas are compared to Other Health, Residential, and Personal Care Expenditures from the CMS NHE report.
- Long-Term Care for Texas is compared to aggregated trend rates for Home Health Care Expenditures; Nursing Care Facilities/Continuing Care Retirement Communities; and Other Health, Residential, and Personal Care Expenditures from the CMS NHE report.

For the STAR program, the annualized aggregate trend rates for Texas were only slightly higher than annualized aggregate national trend rates. The

difference from national trend rates increased over the analysis period. In 2014 and 2015, Texas's aggregate trend rates were lower than national trend rates. However, in 2016, Texas's trend rates were 1.4 percent higher than national trend rates and, in 2017, Texas's trend rates were 1.7 percent higher than national trend rates. Annualized professional services trends and prescription drug trends were lower than the national averages, while hospital services trends and other services trends were higher than the national averages.[12]

Figure 16. STAR Service Category Comparison to National PMPM Trends.

STAR Comparison to National PMPM Trends	2014	2015	2016	2017	Annualized
Hospital Services - Texas	1.2%	2.2%	2.3%	1.9%	**1.9%**
Hospital Services - National	-2.2%	3.5%	1.9%	2.3%	**1.3%**
Professional Services - Texas	-0.3%	1.0%	1.3%	8.1%	**2.5%**
Professional Services - National	9.7%	3.7%	3.7%	3.5%	**5.1%**
Other Services - Texas	3.6%	5.3%	4.0%	1.2%	**3.5%**
Other Services - National	-4.9%	4.0%	-0.2%	2.1%	**0.2%**
Prescription Drugs - Texas	-2.7%	3.1%	4.6%	1.0%	**1.5%**
Prescription Drugs - National	12.6%	7.3%	4.8%	4.5%	**7.3%**
Aggregate Trends - Texas	0.2%	2.2%	2.5%	3.6%	**2.1%**
Aggregate Trends - National	0.6%	3.6%	1.1%	1.9%	**1.8%**

In aggregate, annualized STAR+PLUS trend rates were 2.1 percent higher than the annualized national trend rates. The STAR+PLUS program realized the largest differences from national trend rates in the most recent years, coming in 3.6 percent higher in 2016 and 6.2 percent higher in 2017.[13]

- Hospital services trend rates were higher than national averages.
- Professional services and prescription drug trend rates were lower than national averages.
- Long-term care trend rates, representing 30 percent of total STAR+PLUS expenditures in SFY2017, were higher than the annualized national trend rate by 4.8 percent.

[12] *National benchmark from CMS NHE reports for Medicaid.*

[13] *National benchmark from CMS NHE reports for Medicaid.*

Figure 17. STAR+PLUS Service Category Comparison to National PMPM Trends.

STAR+PLUS Comparison to National PMPM Trends	2014	2015	2016	2017	Annualized
Hospital Services - Texas	2.4%	-1.4%	4.4%	5.5%	**2.7%**
Hospital Services - National	-2.2%	3.5%	1.9%	2.3%	**1.3%**
Professional Services - Texas	0.0%	-1.7%	8.5%	4.8%	**2.8%**
Professional Services - National	9.7%	3.7%	3.7%	3.5%	**5.1%**
Long-Term Care - Texas	2.3%	2.1%	0.3%	10.7%	**3.8%**
Long-Term Care - National	-5.9%	0.8%	-0.4%	1.7%	**-1.0%**
Prescription Drugs - Texas	6.2%	2.6%	10.5%	6.0%	**6.3%**
Prescription Drugs - National	12.6%	7.3%	4.8%	4.5%	**7.3%**
Aggregate Trends - Texas	2.8%	1.0%	3.7%	8.1%	**3.9%**
Aggregate Trends - National	0.6%	3.6%	1.1%	1.9%	**1.8%**

4.2.11.3. Texas Expenditure Trends by Prescription Drug Service Category

Texas pharmacy expenditure trends gross of rebates by prescription drug service category were reviewed for both the STAR and STAR+PLUS programs. The trend rates utilized in this analysis are based on gross prescription drug costs and do not consider federal or supplemental rebates, thus these trend rates do not represent the net cost to HHSC. Additionally, the analysis did not adjust for case-mix changes over the review period, so any service carve-ins or population shifts during the review period have an impact on the program trend rates in the analysis.

For the STAR program, in aggregate, drug expenditures had an annualized trend rate of 1.5 percent.

- Generic drugs PMPM trend rates declined over the four-year analysis period. While generic drug trend rates had small increases in 2014 and 2015, there was a 5.6 percent decrease in 2016 and a 7.4 percent decrease in 2017, resulting in an annualized decrease of 1.6 percent across the analysis period.
- Brand name drug PMPMs had fluctuating year-over-year trend rates across the analysis period, with an annualized increase of 0.2 percent.

- Specialty drug PMPMs had an annual increase of 12.7 percent across the analysis period, with the highest increase of 23.0 percent in 2017.
- Generic drug dispensing rates had consistent year-over-year increases, achieving a rate of 73.3 percent in 2017.

Figure 18. STAR Prescription Drug PMPM Trends by Service Category.

SFY	Generic Drugs	Brand Drugs	Specialty Drugs	All Drugs	Generic Dispensing Rate
2014	4.1%	-7.7%	9.7%	**-2.7%**	**68.7%**
2015	3.0%	2.4%	6.9%	**3.1%**	**71.0%**
2016	-5.6%	7.7%	11.9%	**4.6%**	**71.8%**
2017	-7.4%	-0.8%	23.0%	**1.0%**	**73.3%**
Annualized	-1.6%	0.2%	12.7%	**1.5%**	**71.2%**

The STAR+PLUS program had an annualized trend rate of 6.3 percent, which was nearly 5 percent higher than the annualized trend rate for the STAR program.

- Generic drug PMPM trend rates were higher than for the STAR program, with an annualized trend rate of 10.9 percent across the analysis period. While generic drug expenditure trends in most years were in the high single digits, 2016 had a 20.4 percent trend rate.
- Brand drugs had a much lower annualized PMPM trend rate of 4 percent and, like generic drugs, 2016 had the highest trend rate.
- Specialty drug PMPM trend rates were in the low double digits in most years, with the lowest trend occurring in SFY2015. While the STAR program saw a significant increase in specialty drugs of 23.0 percent in SFY2016, the STAR+PLUS program saw an increase of 13.6 percent.
- Like the STAR program, the STAR+PLUS program had consistent year-over-year increases in the generic dispensing rate. However, by 2017, the STAR+PLUS program had achieved a generic dispensing rate that was nearly 10 percent higher than the STAR program.

Figure 19. STAR+PLUS Prescription Drug Trends by Service Category.

SFY	Generic Drugs	Brand Drugs	Specialty Drugs	All Drugs	Generic Dispensing Rate
2014	9.7%	3.7%	10.4%	**6.2%**	**75.8%**
2015	6.1%	2.0%	2.2%	**2.6%**	**78.5%**
2016	20.4%	8.3%	10.0%	**10.5%**	**80.8%**
2017	7.9%	2.1%	13.6%	**6.0%**	**82.4%**
Annualized	**10.9%**	**4.0%**	**9.0%**	**6.3%**	**79.4%**

4.2.11.4. National Comparison of Expenditure Trends by Prescription Drug Service Category

To compare Texas's expenditure trends by prescription drug service category to national results, the service categories from the Texas trend report were aligned to the service categories from the Express Scripts Annual Drug Trend Reports for the Medicaid population. Total trend from the Express Scripts Annual Drug Trend Reports measures the rate of change in gross costs, which include ingredient costs, taxes, dispensing fees, and administrative fees. Gross cost includes member cost and is net of rebates received by plans. Note that trends from the Express Scripts Annual Drug Trend Reports are displayed by calendar year, while the Texas trends are displayed by SFY. For example, 2017 is 1/1/2017 – 12/31/2018 for the CMS NHE trends and 9/1/2016 – 8/31/2017 for the Texas trends.

- Both generic and brand drug expenditures for Texas are compared to Traditional Drug expenditures from the Express Scripts Annual Drug Trend Reports.
- Specialty Drug expenditures for Texas are compared to Specialty Drug expenditures from the Express Scripts Annual Drug Trend Reports.
- Aggregate Prescription Drug expenditures for Texas are compared to the Overall Drug expenditure from the Express Scripts Annual Drug Trend Reports.

For the STAR program, generic and brand drug expenditure trends for Texas appear to be consistent with the traditional drug trends from the national benchmark across the three years that traditional drug trends were available.

- For generic drugs, in 2014, the Texas expenditure trend rate was slightly higher than the national rate for traditional drugs, while in 2015 and 2016, the Texas expenditure trend rates were lower.
- For brand drugs, in 2014 and 2015, the Texas expenditure trend rates were lower than the national trend rates for traditional drugs, while in 2017, the Texas trend rate was higher.
- For specialty drugs, the Texas expenditure trend rates were lower than the national expenditure trend rates in 2014 and 2015, but higher in 2016 and 2017.
- In 2016, the Texas expenditure trend rate for specialty drugs surpassed the national expenditure trend rate by 4.6 percent and, in 2017, the Texas trend rate was more than 15 percent higher than the national trend rate.

Comparing the Texas expenditure trend rate across all prescription drugs to the Express Script national average, Texas's expenditure trend rate was lower in all years of the analysis period and Texas's annualized expenditure trend rate was 4.7 percent lower than the annualized national expenditure trend rate.[14]

Figure 20. STAR Prescription Drug Service Category Expenditure Trend Comparison to National Expenditure Trends.

STAR Prescription Drug Expenditure Trends Compared to National Benchmark	SFY 2014	SFY 2015	SFY 2016	SFY 2017	Annualized
Generic Drugs - Texas	4.1%	3.0%	-5.6%	-7.4%	**-1.6%**
Brand Drugs - Texas	-7.7%	2.4%	7.7%	-0.8%	**0.2%**
Generic & Brand Drugs - National	2.8%	3.4%	4.8%	N/A	**3.7%**
Specialty Drugs - Texas	9.7%	6.9%	11.9%	23%	**12.7%**
Specialty Drugs - National	35.8%	10.1%	6.6%	7.4%	**14.4%**
Aggregate Prescription Drug Trends - Texas	-2.7%	3.1%	4.6%	1.0%	**1.5%**
Aggregate Prescription Drug Trends - National	10.2%	5.7%	5.5%	3.7%	**6.2%**

[14] *National benchmark from Express Scripts Annual Drug Trend Reports for Medicaid.*

For the STAR+PLUS program, comparing the Texas trend rate across all drugs to the Express Script national averages, Texas's annualized expenditure trend rate was in line with the annualized national average, coming in 0.1 percent higher. In 2016, the Texas trends had the largest difference from the national trend rates, coming in 5 percent higher than the national expenditure trend rate.

- Generic and brand drug expenditure trends for Texas were higher than traditional drug trends from Express Scripts in most years.
- The generic drug expenditure trend was higher than the national drug trends in all years, with 2016 having the largest difference where Texas's expenditure trend rate was more than 12 percent higher than the national average.

Specialty drugs, similar to the STAR program, had trend rates that were lower than the national trend rates in 2014 and 2015, but higher in 2016 and 2017. In 2016, the Texas expenditure trend rate for specialty drugs surpassed the national trend rate by 3.4 percent and in 2017, the Texas expenditure trend rate was more than 6.2 percent higher than the national expenditure trend rate.[15]

Figure 21. STAR+PLUS Prescription Drug Service Category Expenditure Trend Comparison to National Expenditure Trends.

STAR+PLUS Prescription Drug Expenditure Trends Compared to National Benchmark	SFY 2014	SFY 2015	SFY 2016	SFY 2017	Annualized
Generic Drugs - Texas	9.7%	6.1%	20.4%	7.9%	**10.9%**
Brand Drugs - Texas	3.7%	2.0%	8.3%	2.1%	**4.0%**
Generic & Brand Drugs - National	2.8%	3.4%	4.8%	N/A	**3.7%**
Specialty Drugs - Texas	10.4%	2.2%	10.0%	13.6%	**9.0%**
Specialty Drugs - National	35.8%	10.1%	6.6%	7.4%	**14.4%**
Aggregate Prescription Drug Trends - Texas	6.2%	2.6%	10.5%	6.0%	**6.3%**
Aggregate Prescription Drug Trends - National	10.2%	5.7%	5.5%	3.7%	**6.2%**

[15] *National benchmark from Express Scripts Annual Drug Trend Reports for Medicaid.*

4.2.11.5. Expenditure Comparison across Other States

In addition to comparing Texas's expenditure data to national benchmarks, Texas's expenditure data was also compared to expenditure data from managed Medicaid programs across other states that were identified as comparable to Texas. To identify these states, other states were reviewed to determine states that had similarities across the dimensions of total Medicaid enrollment, geography and demographics, and managed care evolution. From this analysis, the states selected for comparison purposes were Arizona, Florida, New Mexico, New York, Pennsylvania, and Tennessee.

Expenditure data from CMS 64 summary reports was manipulated to isolate Medicaid Managed Care expenditures and then utilized to calculate expenditure trend rates for Texas and other states identified for comparison. Texas's data from the CMS 64 report only includes data from the STAR, STAR+PLUS, and STAR Health programs. Additionally, Texas's expenditure trends from the report vary from the expenditure trends calculated using information provided by HHSC for the purposes of this analysis due to varying time periods and assumptions made to isolate managed care expenditures from the CMS 64 reports. Texas's data from the report and presented in the following **Figure 22** has not been adjusted to reflect these differences, to ensure all values across states remain on a comparable basis.

Other considerations that impact expenditure trend rates across states include populations covered, benefits/services covered, and administrative requirements. **Appendix Figures 68 and 69** provide a summary of the populations and services, respectively, covered by each state as of August 2014. Based on these exhibits and for purposes of this analysis, it is assumed that all states in the comparison generally cover all the specified populations and services in one or more of their managed care programs.

While some states may have implemented program changes or program expansions over the analysis period or may have higher portions of high expenditure populations, the level of detail needed to make these adjustments to the data is not publicly available and thus has not been considered for this analysis. Note that without these adjustments, there are additional factors impacting the trends for each state, making it difficult to compare trend rates across states. The following figure summarizes per member per year (PMPY) expenditure trends across the comparison states from CMS FY 2013 through CMS FY 2016.

Figure 22. PMPY Expenditure Trends for Comparable States.

State or Territory	CMS FY 2013–2014	CMS FY 2014–2015	CMS FY 2015–2016	CMS FY 2013–2016
Arizona	-1.1%	7.8%	5.1%	3.9%
Florida	5.6%	67.3%	9.5%	24.6%
New Mexico	14.2%	13.7%	2.9%	10.1%
New York	8.1%	5.8%	1.8%	5.2%
Pennsylvania	21.1%	-16.6%	17.1%	5.7%
Tennessee	6.4%	-9.3%	-9.5%	-4.4%
Texas	-3.3%	11.6%	9.6%	5.7%

Texas's annualized trend of 5.7 percent is consistent with the annualized trend rates for New York and Pennsylvania, and slightly higher than the annualized trend rate for Arizona. Florida and New Mexico saw higher expenditure trend rates than Texas. Tennessee was the only comparable state that saw a decrease in PMPY expenditure trends from 2013 to 2016 with an annualized decrease of 4.4 percent.

While Texas's annualized trend rate from SFY2014 to SFY2017 was 5.9 percent, after excluding the impact of the new programs during that period, other service expansions, program changes, administrative expense changes, and population shifting had an additional impact on the trend rate. Through the estimated managed care savings analysis, found in **Section 8** of this report, the impact of these changes was calculated. Removing the impact of these changes results in an annualized trend rate of 2.1 percent from SFY2009 to SFY2017.

4.3. Findings/Conclusions

4.3.1. Texas Enrollment Trends

Total managed care enrollment increased by nearly 600,000 from SFY2014 to SFY2017 with the largest enrollment increase occurring in SFY2015, driven by Medicaid Managed Care expansions and impacts from the ACA. Following SFY2015, enrollment increased slightly, with a total increase of 259,000 members between SFY2015 and SFY2017, driven by managed care expansions and the commencement of the STAR Kids program in SFY2017.

4.3.2. Texas Expenditure and Utilization PMPM Trends

From a PMPM expenditure perspective, there was an annualized increase of approximately 10.1 percent in aggregate PMPMs across all the managed care programs from SFY2014 to SFY2017. The addition of the STAR Kids program in SFY2017 had a large impact on the overall PMPM increase. Removing the STAR Kids population from the PMPM calculation results in approximately 6.5 percent annual PMPM trend rate. The Dual Demonstration program also had an impact on the overall PMPM increase and removing both the STAR Kids population and the Dual Demonstration population results in approximately 5.9 percent annual PMPM trend rate.

When accounting for other service expansions, program changes, administrative expense changes, and population shifting from SFY2009 to SFY2017, the managed care program PMPM cost trended at 2.1 percent, slightly higher than the annualized Medicaid PMPM cost trend rate of 1.8 percent from the CMS NHE Report for Medicaid. Additionally, the estimated managed care PMPM cost trend, when accounting for other service expansions, program changes, administrative changes, and population shifting, is lower than the FY2012 President's Budget Medicaid Baseline trends, ranging from 4.6 percent to 5.8 percent, that were used to project the without-waiver PMPM costs within the Federal approval letter of the 1115 Transformation Waiver.[1]

Program-specific PMPM trend rates remained modest to flat throughout the analysis period for all programs, apart from the STAR+PLUS program. The STAR program expenditure trend rates ranged from an 11 percent decrease in SFY2015, stabilizing to 1 percent and 2 percent increases in the following years. STAR Health trends were negative or flat in all years and CHIP trends did not exceed 5 percent. However, STAR+PLUS expenditure trends surpassed 15 percent in SFY2015 and SFY2016, due to program changes, but moderated in SFY2017.

4.3.3. Texas Expenditure and Utilization PMPM Trends Compared to National Benchmarks

For the STAR program, annualized medical services expenditure trends and prescription drug expenditure trends were lower than the national averages, while hospital services expenditure trends and other services expenditure trends were higher than the national averages. Annualized aggregate expenditures for the STAR program were 0.3 percent higher than annualized national averages over the analysis period of 2014 to 2017. Like the STAR

program, STAR+PLUS hospital service expenditure trend rates were higher than national averages, while professional services and prescription drug expenditure trend rates were lower than national averages. In addition, long-term care expenditure trend rates, representing 50 percent of total expenditures STAR+PLUS expenditures in 2017, were higher than the annualized national expenditure trend rate by 4.8 percent. Annualized aggregate expenditures for the STAR+PLUS program were 2.1 percent higher than annualized national expenditure trend rates.

For prescription drugs, Texas's expenditure trend rates were lower than the national averages across all years for the STAR program. Texas's prescription drug expenditure trend rates were lower than the national averages in 2014 and 2015 for the STAR+PLUS program, but higher in 2016 and 2017.

5. Quality Improvement

Texas HHSC monitors MCOs performance on many health processes and quality outcomes measures. Since 2002, The Institute for Child Health Policy at the University of Florida has worked as Texas Managed Care's EQRO, reviewing Texas managed care quality improvement within each MCO and across the different programs primarily by measuring MCO performance on many HEDIS measures. These measures are commonly used by health plans across the country to analyze their performance.

This section of the report includes analyses of MCO performance on a select set of HEDIS® measures that evaluate the QOC provided to members in Texas's Medicaid Managed Care programs in calendar years 2014, 2015, and 2016. The performance measures are then compared to HHSC High Performance Standards for 2016 when available. According to the *HHSC Uniform Managed Care Manual*, the standards for 2016 were set by calculating the 2014 state mean for each measure and setting the standard as the upper bound of the percentile in which the State mean falls unless the State mean is below the 50th percentile or above the 95th percentile in which that limit is set as the standard. Throughout this section, all years are referring to the calendar year.

Lastly, this section evaluates how Texas HEDIS® performance compares to comparable states and the national 50th percentile for 2016.

5.1. Texas HEDIS® Performance and Trends by Measure/Program

HEDIS® measures included on the Texas MCO Report Cards were the focus of this analysis; however, the actual data used for the analysis was from the THLC Portal. After analysis of both data sets, it was found that the Texas MCO Report Card data was reported at the service delivery area level while the THLC Portal data was reported at the MCO level. For the purposes of this analysis, it was determined that the MCO level data would be utilized. Thus, although the measures discussed in this section were gathered from the Texas MCO Report Cards, the underlying data from the THLC Portal was utilized.

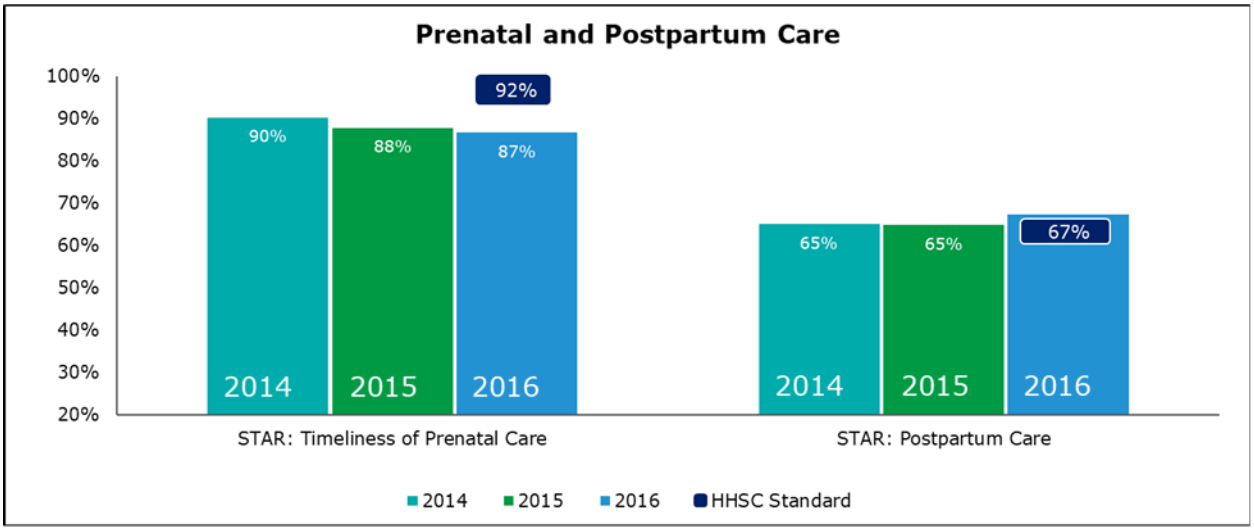
5.1.1. HEDIS® Measures for Adult Population

5.1.1.1. Prenatal and Postpartum Care

The HEDIS® measure for Timeliness of Prenatal Care measures how many pregnant women received a prenatal care visit during the first trimester of pregnancy or within 42 days of the member enrolling in the MCO. The Postpartum Care HEDIS® measure determines whether women receive a checkup within 21 to 56 days after giving birth.

As **Figure 23** below shows, from 2014 to 2016, the STAR Timeliness of Prenatal Care score decreased three percentage points to 87 percent, 5 percent below the high standard set by HHSC. The Postpartum Care measure compliance rate for STAR was in line with the HHSC high standard in 2016 at 67 percent.

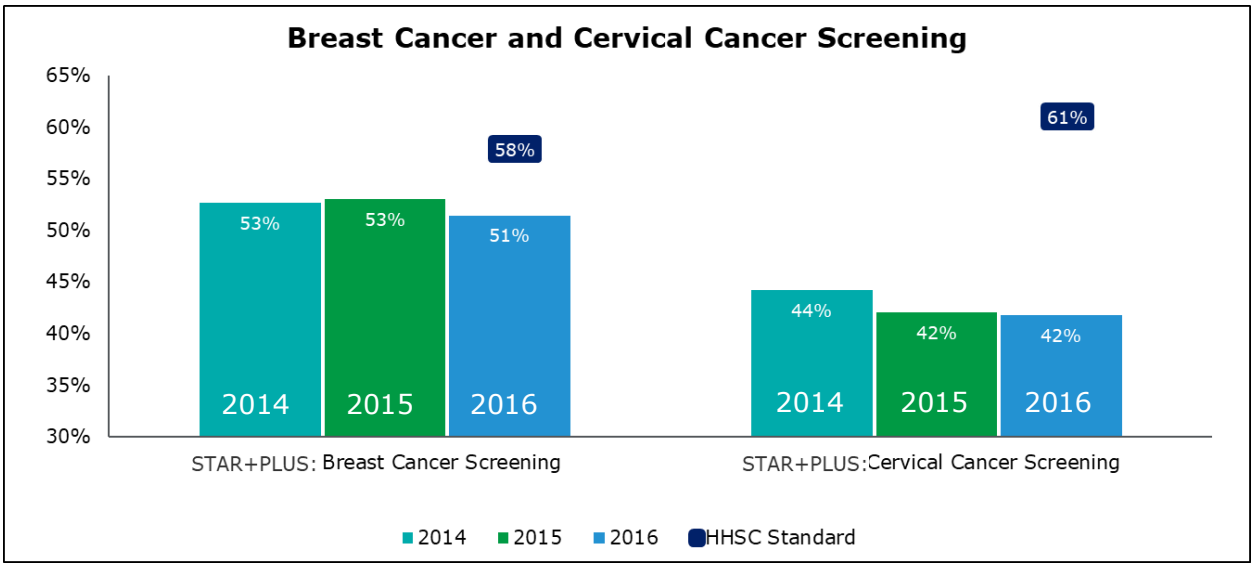
Figure 23. 2014–2016 Prenatal and Postpartum Care HEDIS® Scores.



5.1.1.2. Screening

The Breast Cancer Screening and Cervical Cancer Screening HEDIS® measures assess whether members are getting regular screenings for these types of cancer. The STAR+PLUS Breast Cancer Screening rate decreased slightly across the analysis period reaching 51 percent in 2016, 7 percent below the HHSC high standard of 58 percent. STAR+PLUS Cervical Cancer Screening saw a slight decrease, reaching 42 percent in 2016 and coming in 19 percent below the HHSC high standard of 61 percent.

Figure 24. 2014–2016 Screening HEDIS® Scores.



5.1.1.3. Diabetes

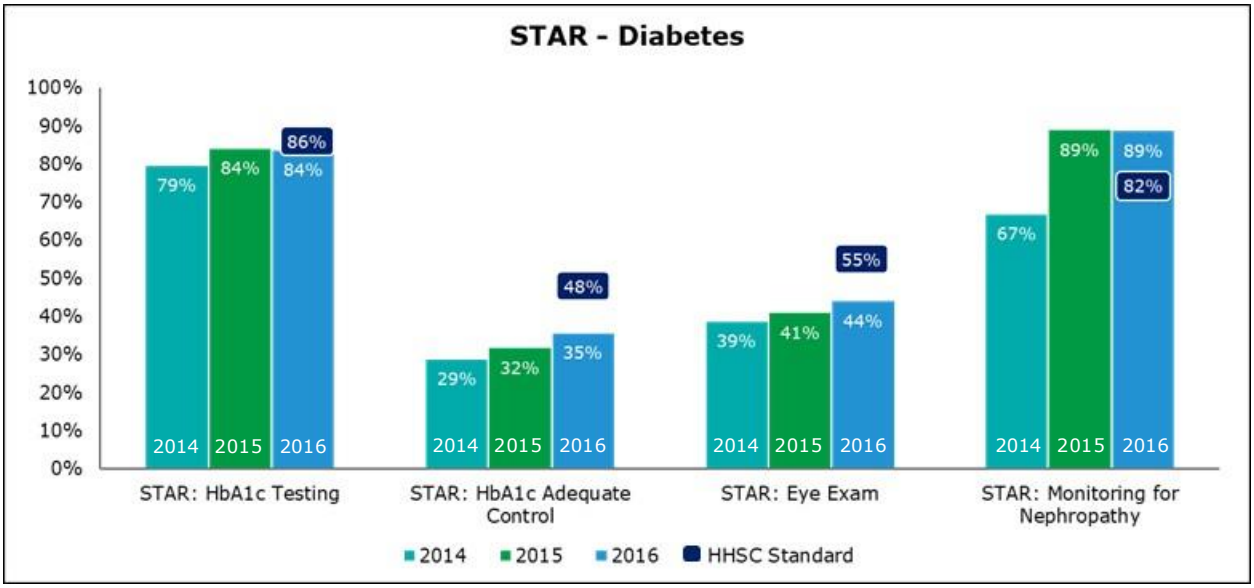
There are four measures that fall under the diabetes category, including Eye Exam, HbA1c Testing, HbA1c Adequate Control, and Monitoring for Nephropathy. The Eye Exam measure evaluates whether diabetic members received an eye screening for retinal disease, the HbA1c Testing measure tracks the number of members who have had the appropriate testing done, the HbA1c Control measure tracks diabetic members who had HbA1c levels less than 8 percent, and the Monitoring for Nephropathy measure assesses whether adequate medical attention was provided to diabetics with nephropathy.

As seen in the **Figure 25** below, in 2015, the score for each diabetes measure increased, with the greatest increase coming in the Monitoring for Nephropathy measure, which increased from 67 percent to 89 percent, surpassing the HHSC high standard of 82 percent. All four of the diabetes measures remained consistent or saw a slight increase in 2016. The rates for the Eye Exam and HbA1c Adequate Control measures were below the HHSC high standards with differences of 11 percent and 13 percent, respectively, while HbA1c Testing was only 2 percent below the HHSC Standard.

The HbA1c Adequate Control measure realized the greatest variation across MCOs with a 37-percentage-point difference between the lowest scoring MCO and the highest scoring MCO with a range of 5 percent to 42 percent.

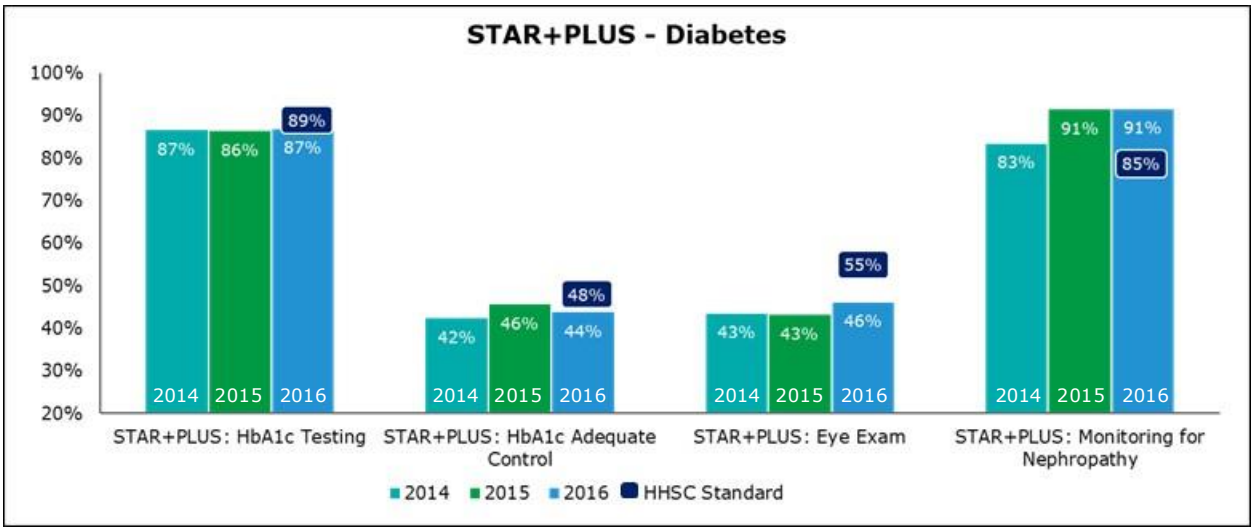
Similarly, the Eye Exam measure realized a 25-percentage-point difference across MCOs ranging from 23 percent to 48 percent.

Figure 25. 2014–2016 STAR: Diabetes HEDIS® Scores.



As the **Figure 26** below shows, STAR+PLUS diabetes measure scores remained relatively constant from 2014 to 2016. The rates for HbA1c Testing and Adequate Control nearly met the HHSC high standards, coming in 2 percent and 4 percent, respectively, below the standards. The Eye Exam measure score increased by a total of 3 percent from 2014 to 2016, but remained below the HHSC high standard by nine percentage points. Monitoring for Nephropathy remained constant at 91 percent from 2015 to 2016, and is 6 percent above the HHSC high standard.

Figure 26. 2014–2016 STAR+PLUS: Diabetes HEDIS® Scores.



5.1.1.4. Chronic Obstructive Pulmonary Disease (COPD)

There are two HEDIS® measures used to evaluate COPD in the STAR+PLUS program. The Use of Spirometry Testing in the Assessment and Diagnosis of COPD measure assesses adults over the age of 40 who have a new diagnosis of COPD or newly active COPD, who received spirometry testing to confirm the diagnosis. The Pharmacotherapy Management of COPD Exacerbation measure monitors appropriate medication treatment for those with a hospital visit related to COPD.

Spirometry Testing remained between 27 percent and 28 percent in all three years and Pharmacotherapy Management remained between 86 percent and 88 percent in all three years. Neither of the COPD Measures had an HHSC standard in 2016.

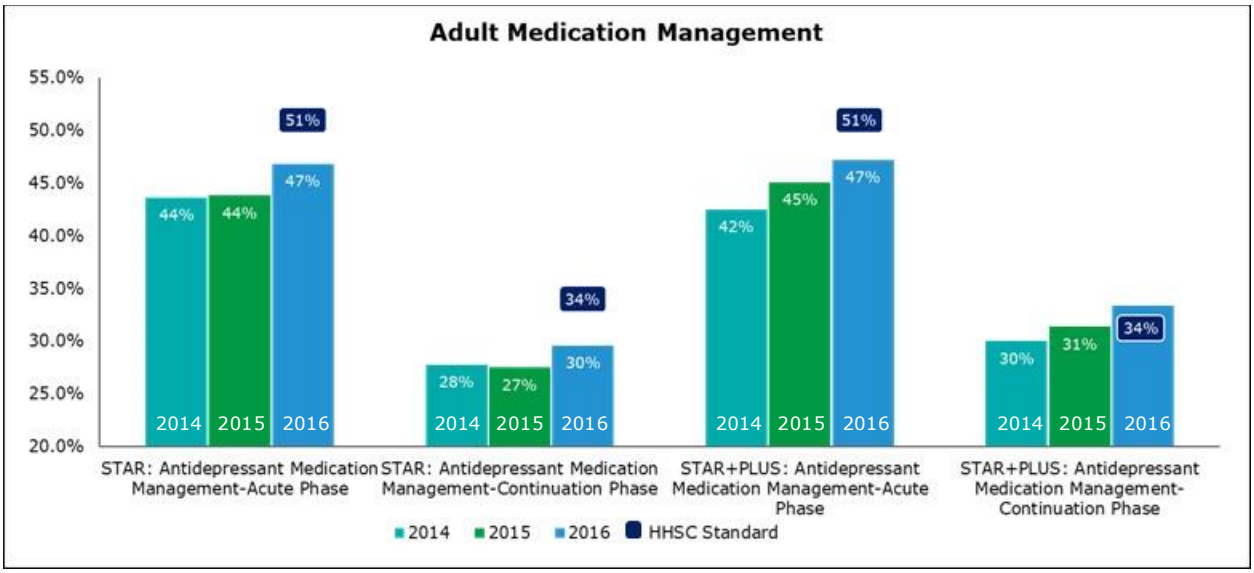
5.1.1.5. Medication Management

HEDIS® measures related to medication management include an Antidepressant Medication Management measure. The Antidepressant Medication Management measure is separated between the Acute Phase, which assesses monitoring of adults on the medication for 12 weeks after a depressive episode, and the Continuation Phase, which assesses monitoring of adults who remained on the medication for at least six months.

All of the medication management measures for STAR and STAR+PLUS showed modest improvements. For STAR+PLUS, the Acute Phase measure rate was 47 percent in 2016 while the Continuation Phase measure rate was

33 percent, 4 percent and 1 percent below the HHSC high standards, respectively. For STAR, the rate for the Acute Phase measure was also 47 percent with the rate for the Continuation Phase measure slightly lower than STAR+PLUS at 30 percent, and both were 4 percent below the HHSC high standards.

Figure 27. 2014–2016 Adults Medication Management HEDIS® Scores.



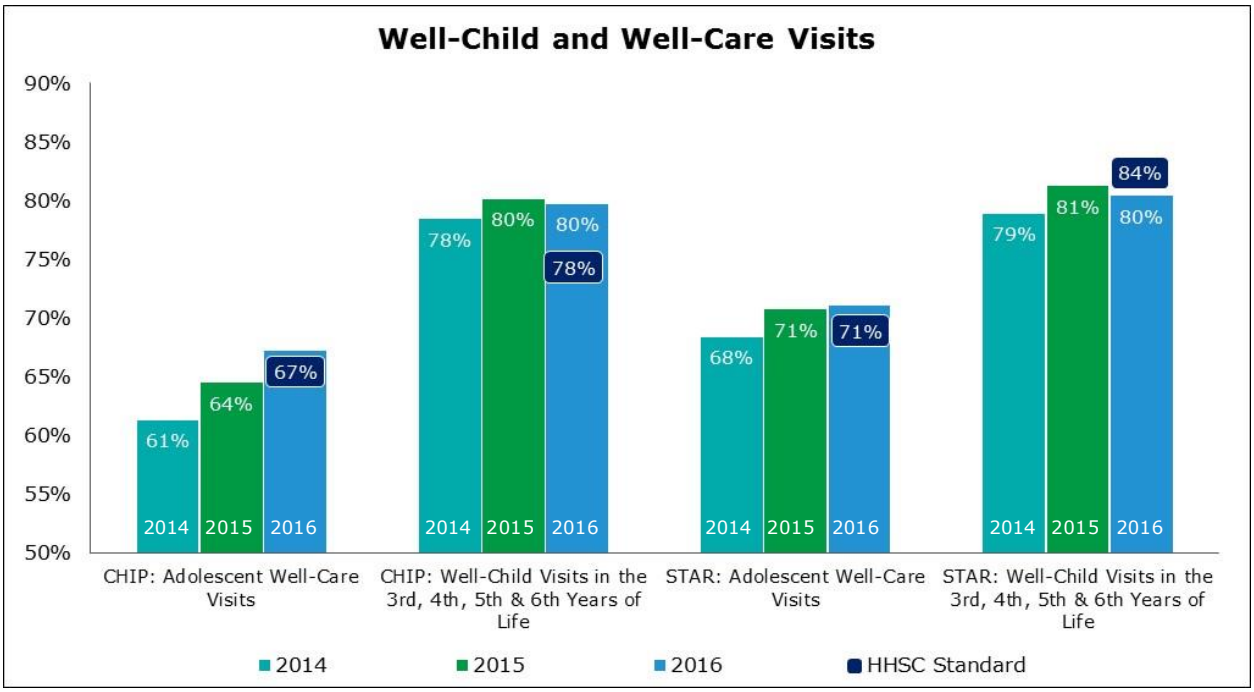
5.1.2. HEDIS® Measures for Child Population

The STAR and CHIP programs reported HEDIS® measures for the child population.

5.1.2.1. Well-Child and Well-Care Visits

The Well-Child Visits measure assesses whether children have received a Primary Care Providers (PCPs) visit in the 3rd, 4th, 5th, and 6th years of life. As the **Figure 28** below shows, both STAR and CHIP members experienced a 2 percent increase from 2014 to 2015 before falling about 1 percent in 2016. Performance on this measure for both STAR and CHIP matched the HHSC high standard. The HEDIS® measure for Adolescent Well-Care Visits measures PCP visits for ages 12 to 21. Adolescent visit rates increased slightly in both STAR and CHIP. Both the STAR measure and CHIP measure were in line with the HHSC high standard.

Figure 28. 2014–2016 Children Well-Child and Well-Care Visit HEDIS® Scores.



5.1.2.2. Immunizations

The HEDIS® measure for Childhood Immunization Status assesses the percentage of two-year old who received a combination of two various vaccines. The STAR program immunization rate was three percentage points below the HHSC high standard of 78 percent in 2016. The CHIP program exceeded the HHSC high standard by 5 percent in 2016.

The HEDIS® measure for Immunizations for Adolescents assesses the percentage of children aged 12 to 21 that received a combination of various vaccines. There is no HHSC standard for this HEDIS® measure. Across the analysis period, Immunizations for Adolescents rates were volatile in both the STAR and CHIP programs, increasing in 2015 and decreasing in 2016.

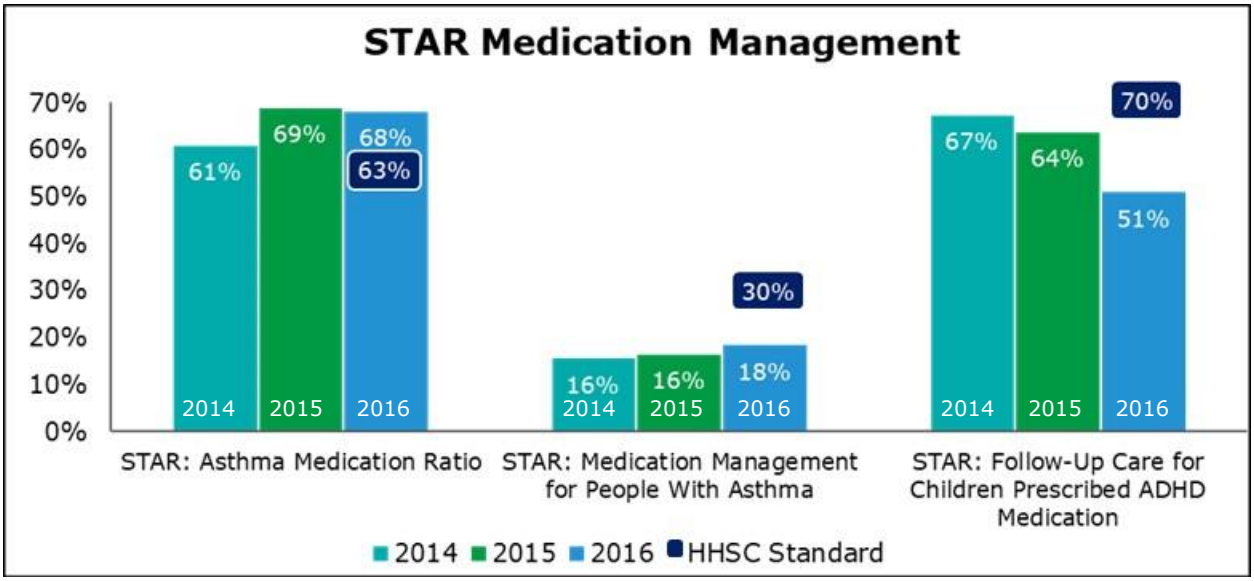
5.1.2.3. Medication Management

The HEDIS® measure for Asthma Medication Ratio assesses the ratio of controller medications to the total number of asthma medications and whether it is 0.5 percent or greater for individuals of ages 5 to 64. The Medication Management for People with Asthma measure assesses whether members of ages 5 to 64 remain on their asthma medication for at least 75 percent of the treatment time. The Follow-Up Care for Children Prescribed

Attention Deficit Hyperactive Disorder (ADHD) Medication, Continuation, and Maintenance Phase measure evaluates the consistency of follow-up visits with a doctor after newly prescribed medication for ADHD.

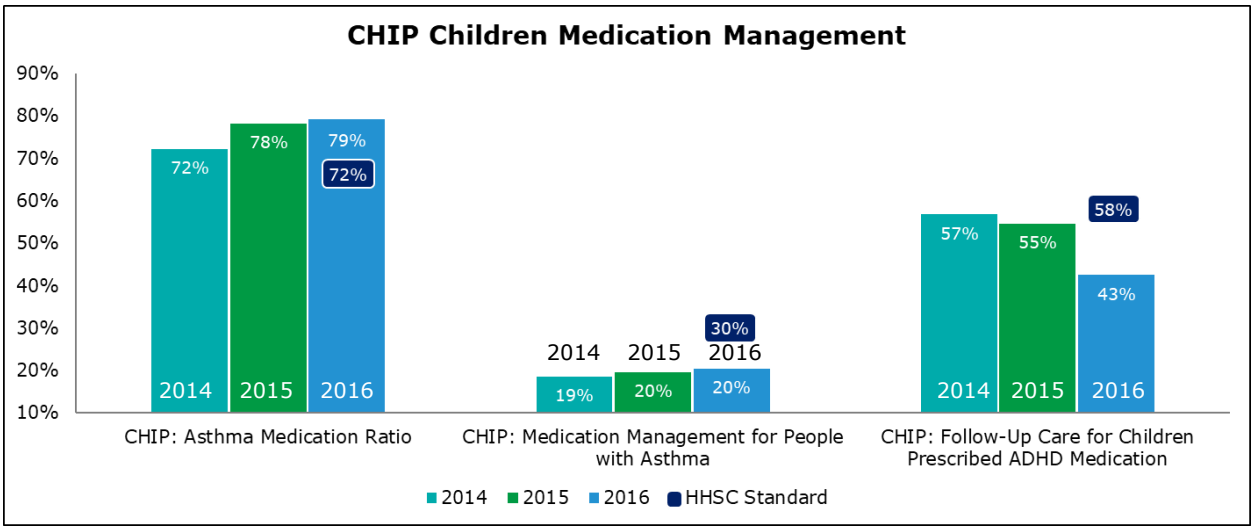
As the **Figure 29** below shows STAR's Asthma Medication rate increased by 7 percent across the analysis period and surpassed the HHSC high standard in 2016 by 5 percent. For the Medication Management for People with Asthma measure, STAR members saw an increase of 2 percent from 2014 to 2016, with the measure scoring lower than the HHSC high standard by 12 percent in 2016. Follow-Up Care for Children Prescribed ADHD Medication scores decreased by a total 16 percent across the analysis period and was 19 percent below the high standard.

Figure 29. 2014–2016 Children Medication Management HEDIS® Scores.



For CHIP, the Asthma Medication Ratio increased by 7 percent from 2014 to 2016, surpassing the HHSC high standard in 2016. Similarly, Medication Management for People with Asthma rate increased by 1 percent but fell short of the HHSC high standard by 10 percent. The Follow-Up Care for Children Prescribed ADHD Medications rate decreased by 14 percent from 2014 to 2016. In 2016, the measure was 15 percent lower than the HHSC high standard.

Figure 30. 2014–2016 Children Medication Management HEDIS® Scores.



5.1.3. Dental

The quality measurement of the managed care dental program utilizes QOC metrics from the THLC Portal. Data on the THLC Portal is submitted to HHSC by Dental Maintenance Care Organizations that provide dental services to Medicaid and CHIP members. HHSC and the State's EQRO review the data to evaluate the dental program. Dental quality data from the QOC metrics was only available through 2015; as a result, data of 2013, 2014, and 2015 were utilized for the analysis. The first eight measures listed in the Dental Medicaid chart are measures from the Dental Quality Association, the measure for "Annual Dental Visit" is a HEDIS® measure, and the last six measures are specific to Texas.

Performance remained flat or realized small increases between 2013 and 2015 across all dental measures. The largest change was an annualized increase of 4 percent in the use of Topical Fluoride for Children measure, followed by an annualized increase of 3 percent in the use of Care Continuity and Sealants for 10- to 14-Year-Old Children at Elevated Caries Risk. No Dental QOC measures experienced a decrease from 2013–2015.

Dental quality measures for the CHIP program realized no changes or small increases across all measures except for the Sealants for 6- to 9-Year-Old Children at Elevated Caries Risk and Treatment Services measures, which each decreased by 1 percent across the analysis period. The largest annualized increase was 13 percent for Topical Fluoride for Children at Elevated Caries Risk.

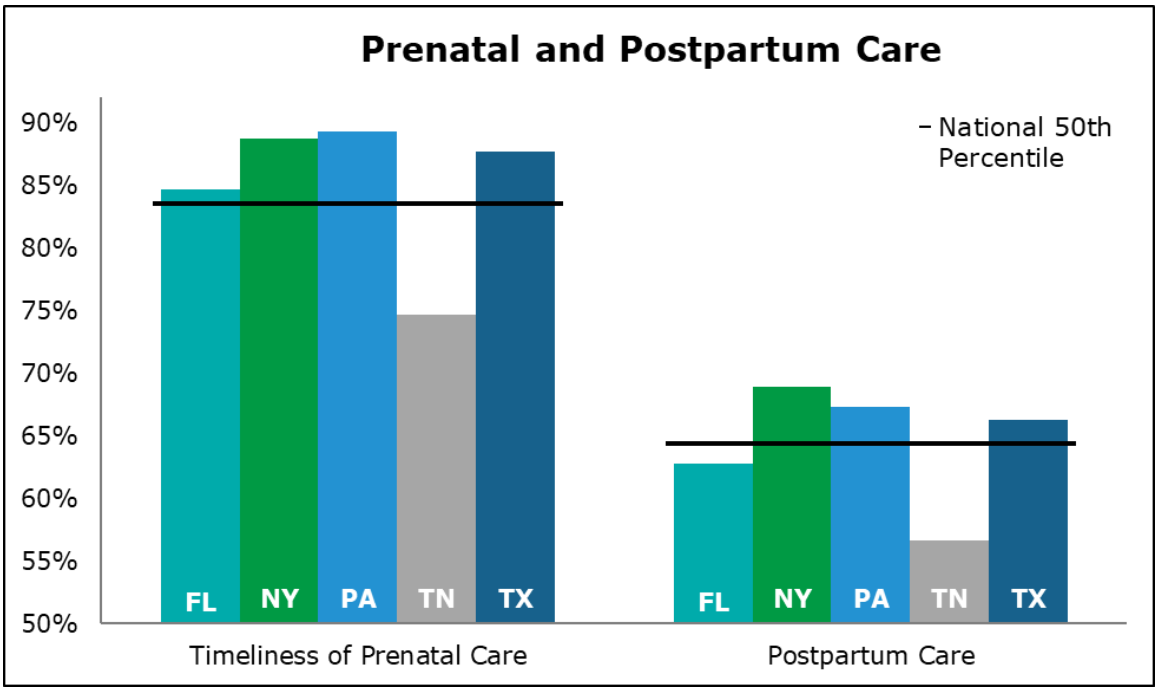
5.2. National HEDIS® Trends and Results

The NCQA collects HEDIS® data across all states. This section compares the same HEDIS® measures that were reviewed in the prior section, across the states that were identified as comparable to Texas and to the national 50th percentile of results for Medicaid MCOs in data year 2016, which is denoted as 2017 in the NCQA database. As previously discussed, these states were chosen based on being similar to Texas in a variety of areas: enrollment, geographic and demographic similarity, and managed care evolution. Two of the states used for comparison throughout the report, Arizona and New Mexico, did not have CAHPS data available on the NCQA Quality Compass® Tool. The NCQA Quality Compass® Tool benchmarks are composed of publicly reported and nonpublicly reported health plan submissions. To maintain confidentiality, there is a five-submission threshold, so if a state does not have five submissions for a certain measure, the measure will not be populated in the NCQA Quality Compass® Tool.

5.2.1. Comparison of Prenatal and Postpartum Care Measures

For the Timeliness of Prenatal Care measure, Texas performed near the top of comparable states in 2016 with the highest state measuring 89.3 percent, Texas at 87.7 percent, and Tennessee being lowest at 74.7 percent. For the Postpartum Care measure, Texas exceeded the 50th percentile and was within the range of results for the comparable states.

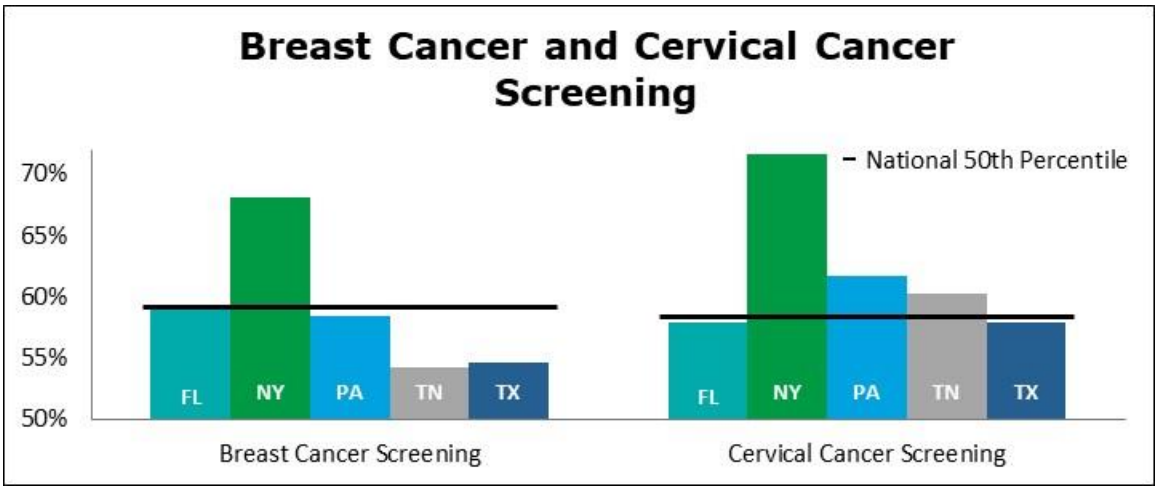
Figure 31. Comparison of 2016 Prenatal and Postpartum Care HEDIS® Measure Results.



5.2.2. Comparison of Screenings Measures

For both the Breast and Cervical Cancer Screenings measures, New York had higher screening rates than the other comparable states. Texas was below the 50th percentile and at the bottom of the range of comparable states for both measures.

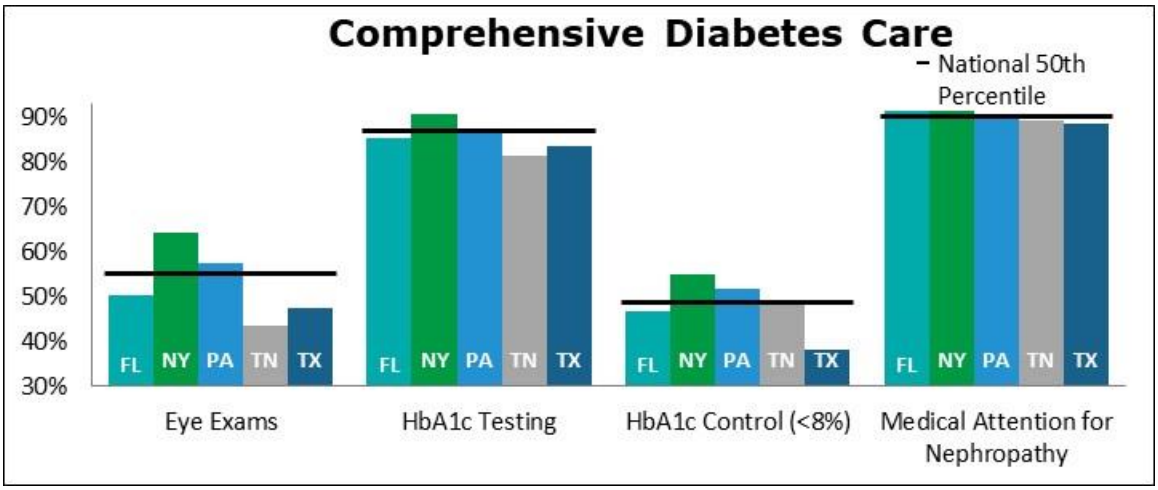
Figure 32. Comparison of 2016 Breast Cancer and Cervical Cancer Screening HEDIS® Measure Results.



5.2.3. Comparison of Diabetes Measures

For all Diabetes-related HEDIS® measures, Texas performed below the national benchmark. Texas had the lowest results of the comparable states for HbA1c Control and Medical Attention for Nephropathy. There was high variation across comparable states for Eye Exams, with Tennessee having the lowest results, followed by Texas, performing approximately 8 percent below the national 50th percentile.

Figure 33. Comparison of 2016 Comprehensive Diabetes Care HEDIS® Measure Results.



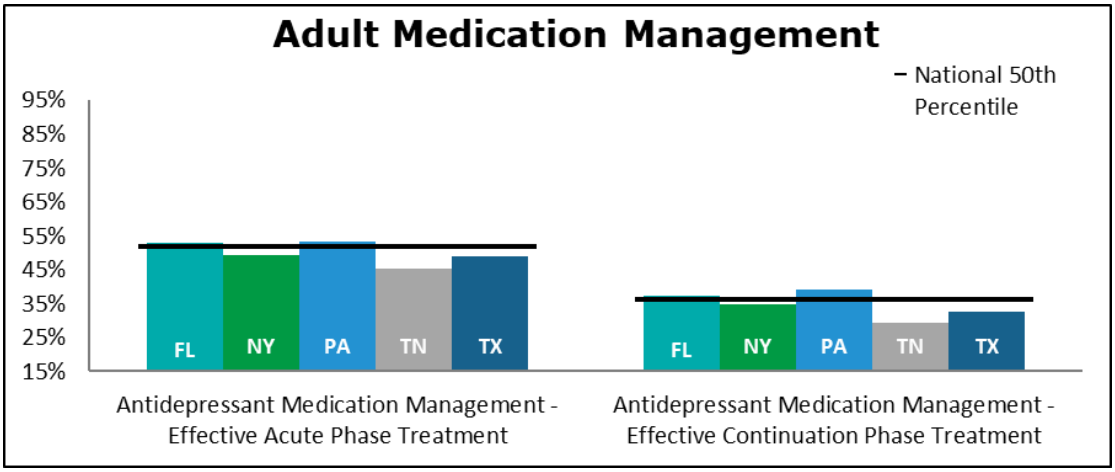
5.2.4. Comparison of COPD Measures

In 2017, the Use of Spirometry Testing measure had a range of results of 21.3 percent across comparable states. Texas's results were approximately 3 percent above the lowest performing state of Florida and 3 percent below the national 50th percentile. For Pharmacotherapy Management of COPD Exacerbation, Texas was the highest performing comparable state with results that were 3 percent above the national 50th percentile.

5.2.5. Comparison of Adult Medication Management Measures

In both the Acute and Continuation Phases for Antidepressant Medication Management, Texas performed below the national 50th percentile, but three percent above the lowest comparable state's results.

Figure 34. Comparison of 2016 Adult Medication Management HEDIS® Measure Results.

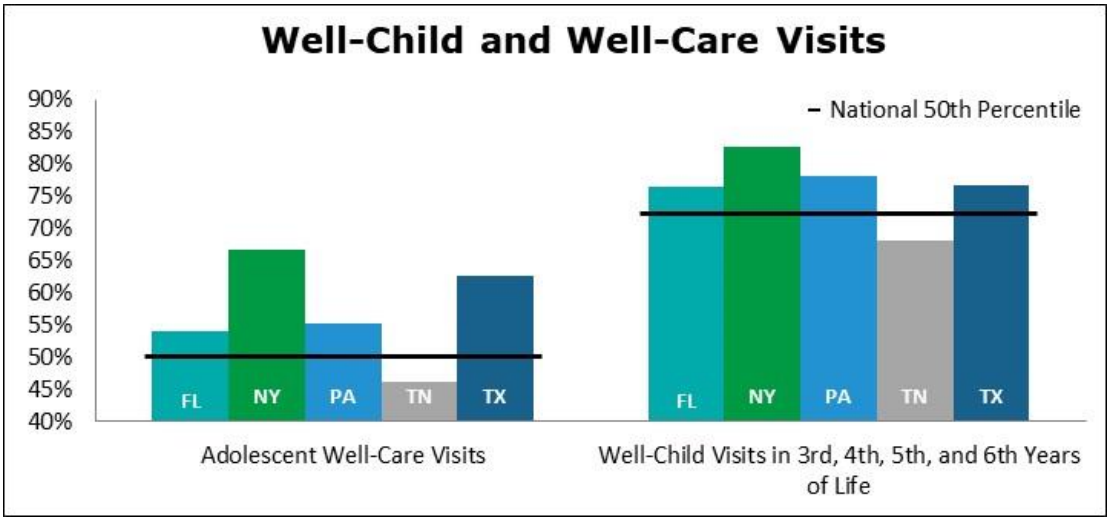


5.2.6. Comparison of Well-Child and Well-Care Visit Measures

Texas's results for Adolescent Well-Care Visits and Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life were both above the national 50th percentiles. Adolescent Well-Care Visits had a range of 20.6 percent across comparable states with Texas's results coming in after New York, the top performer in this measure. While only Tennessee had lower results than Texas in the Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of

Life measure, Texas's results were more than six percent higher than the national 50th percentile.

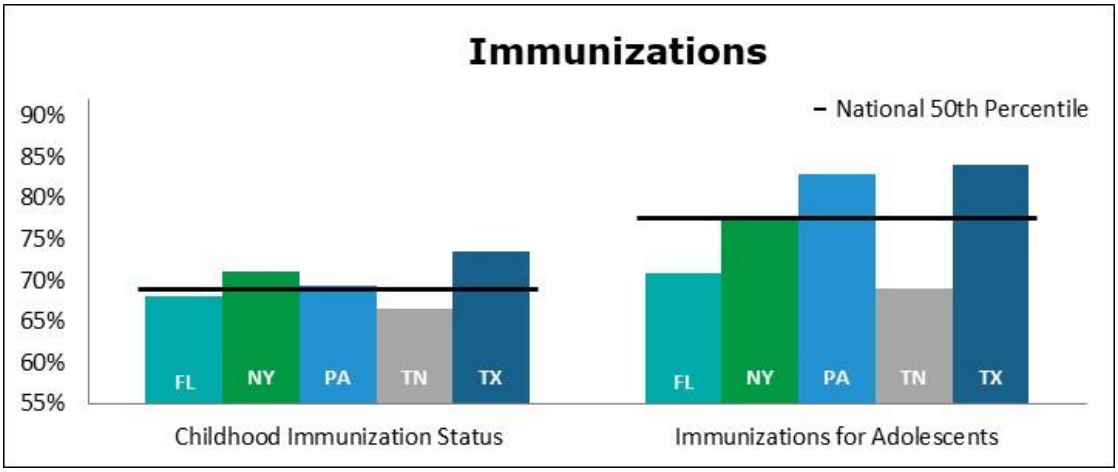
Figure 35. Comparison of 2016 Well-Child and Well-Care Visits HEDIS® Measure Results.



5.2.7. Comparison of Immunization Measures

Texas measured well above the national 50th percentiles and had the highest results across comparable states for both the Childhood Immunization Status measure and the Immunizations for Adolescents measure.

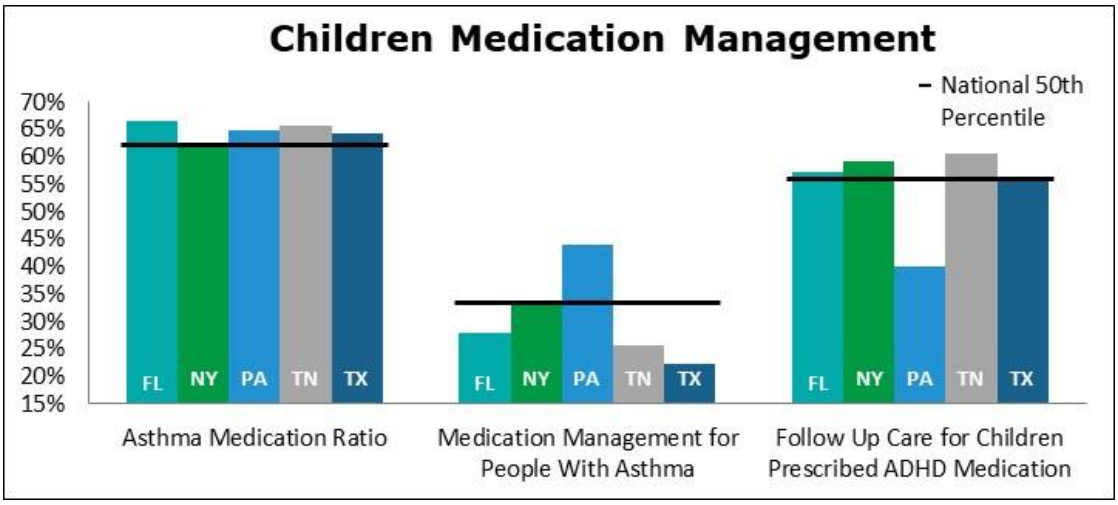
Figure 36. Comparison of 2016 Immunizations HEDIS® Measure Results.



5.2.8. Comparison of Children Medication Management Measures

Results on The Asthma Medication Ratio measure fell into a narrow range across comparable states, with Texas performing approximately two percent above the national 50th percentile and three percent below the highest performing state of Florida. The Medication Management for People with Asthma measure had a range of results across comparable states of nearly 22 percent. Texas's results were the lowest, coming in 11 percent below the national 50th percentile. The measure for Follow-up Care for Children Prescribed ADHD Medication also had a large range of results across comparable states with a range of 21 percent. Texas's results were consistent with the national 50th percentile and approximately four percent below the highest performing state, Tennessee.

Figure 37. Comparison of 2016 Children Medication Management HEDIS® Measure Results.



5.3. Potentially Preventable Measures

For the purpose of this analysis, potentially preventable measure data from calendar years 2014 through 2017 from the THLC Portal was utilized. The four measures on the portal include Potentially Preventable Readmissions (PPRs), Potentially Preventable Admissions (PPAs), Potentially Preventable Emergency Room Visits (PPVs), and Potentially Preventable Complications (PPCs), and the THLC Portal includes data for the STAR, STAR+PLUS, STAR Health, STAR Kids, and CHIP managed care programs. The full calendar year

data for 2017 with one month of lag was utilized for this analysis; the results may change slightly as additional claims are recorded.

5.3.1. Potentially Preventable Readmissions

PPRs indicate a return to hospitalization after a related hospitalization, which could have potentially been prevented by the provider. The Texas EQRO's definition of a PPR is a return to the hospital after a clinically related admission within 30 days; however, not all readmissions are considered potentially preventable. For example, readmissions that were neither a continuation of the initial admission, a chronic problem occurring after the initial admission, or an acute condition that may relate to the care from the initial admission would not be considered PPRs.

Figure 38 below shows PPR rates by program from 2014 to 2017. Across the analysis period, the STAR+PLUS, STAR Health, STAR Kids, and CHIP programs all realized total annualized increases in PPR rates. The STAR program realized a decrease in the annualized PPR of 4 percent over the analysis period; however, there was an increase of 14 percent in the most recent year from 2016 to 2017.

Figure 38. Potentially Preventable Readmissions (per 1,000 at-risk admissions) from 2014 to 2017.

Potentially Preventable Readmissions (per 1,000 at-risk admissions)	CY 2014	CY 2015	CY 2016	CY 2017	Annualized
STAR PPR Rate	22.0	18.0	17.3	19.7	
STAR Trend		-18%	-4%	14%	-4%
STAR Health PPR Rate	151.9	148.0	147.3	161.3	
STAR Health Trend		-3%	0%	10%	2%
STAR+PLUS PPR Rate	235.7	251.5	264.4	278.9	
STAR+PLUS Trend		7%	5%	5%	6%
STAR Kids PPR Rate	-	-	181.0	211.3	
STAR Kids Trend				17%	17%
CHIP PPR Rate	62.1	69.1	70.9	69.1	
CHIP Trend		11%	3%	-3%	4%

5.3.2. Potentially Preventable Admissions

PPAs indicate facility admissions that are due to a lack of coordination of care or poor QOC related to ambulatory services.

As shown in the **Figure 39** below, STAR, STAR Health, and CHIP all experienced decreases in PPA rates from 2014 to 2017. STAR+PLUS's PPA rate realized an annualized increase of 9 percent over the four-year period.

Figure 39. Potentially Preventable Admissions (per 1,000 member months) from 2014 to 2017.

Potentially Preventable Admissions (per 1,000 member months)	CY 2014	CY 2015	CY 2016	CY 2017	Annualized
STAR PPA Rate	0.5	0.3	0.3	0.3	
STAR Trend		-29%	-9%	0%	-14%
STAR Health PPA Rate	3.7	2.7	1.9	1.7	
STAR Health Trend		-29%	-30%	-10%	-23%
STAR+PLUS PPA Rate	7.1	7.9	8.0	9.3	
STAR+PLUS Trend		10%	2%	16%	9%
STAR Kids PPA Rate	-	-	1.8	2.1	
STAR Kids Trend				12%	12%
CHIP PPA Rate	0.2	0.2	0.2	0.2	
CHIP Trend		-17%	-11%	-6%	-11%

5.3.3. Potentially Preventable Emergency Room Visits

PPVs are classified as resulting from a lack of access to care or ambulatory coordination. The figure below shows that PPVs increased in all programs, with the exception of the STAR Kids program which realized a 6% decrease from 2016 to 2017.

Figure 40. Potentially Preventable Emergency Room Visits (per 1,000 member months) from 2014 to 2017.

Potentially Preventable Emergency Room Visits (per 1,000 member months)	CY 2014	CY 2015	CY 2016	CY 2017	Annualized
STAR PPV Rate	8.4	8.5	9.6	8.6	
STAR Trend		2%	12%	-10%	1%
STAR Health PPV Rate	9.0	10.5	11.8	10.9	
STAR Health Trend		16%	13%	-8%	7%
STAR+PLUS PPV Rate	21.5	22.2	26.6	21.5	
STAR+PLUS Trend		3%	20%	-19%	0%
STAR Kids PPV Rate	-	-	10.1	9.5	
STAR Kids Trend				-6%	-6%
CHIP PPV Rate	3.3	3.7	4.1	3.8	
CHIP Trend		11%	11%	-8%	5%

5.3.4. Potentially Preventable Complications

PPCs are classified as conditions that are not present at the time of entry into the hospital, but develop during the patient's stay. These conditions are not in the natural progression of the prior condition and increase health care costs that otherwise would not have been present. The figure below shows that PPCs improved for STAR and STAR+PLUS, but increased across the other programs.

Figure 41. Potentially Preventable Complications (per 1,000 at-risk admissions) from 2014 to 2017.

Potentially Preventable Complications (per 1,000 at-risk admissions)	CY 2014	CY 2015	CY 2016	CY 2017	Annualized
STAR PPC Rate	10.9	8.0	6.8	4.8	
STAR Trend		-27%	-15%	-29%	-24%
STAR Health PPC Rate	1.8	6.1	3.7	3.2	
STAR Health Trend		236%	-39%	-14%	21%
STAR+PLUS PPC Rate	76.1	74.8	71.0	54.7	
STAR+PLUS Trend		-2%	-5%	-23%	-10%
STAR Kids PPC Rate	-	-	8.4	10.3	
STAR Kids Trend				23%	23%
CHIP PPC Rate	2.1	7.2	4.1	3.5	
CHIP Trend		252%	-44%	-15%	19%

5.4. Findings/Conclusions

In general, both the adult population and child population HEDIS® measures saw modest improvement across the analysis period of 2014 through 2016.

5.4.1. Adult Population

For adult quality measures, 14 out of the 18 of the measures across STAR or STAR+PLUS populations saw increases between 2014 and 2016. In addition, for adults in the STAR program, of the 8 measures that were reviewed, performance on two of the measures surpassed the HHSC high standard. For adults in the STAR+PLUS program, of the 10 measures that were reviewed, two did not have an HHSC high standard and performance on two of the measures surpassed the HHSC high standard. In addition, across both the STAR and STAR+PLUS programs, HbA1c Testing was within 2 percent of the HHSC standard and all medication management measures were within 4 percent or less of the HHSC standards.

5.4.2. Children Population

For child quality measures, 11 out of 14 of the measures across STAR or CHIP populations experienced improvement between 2014 and 2016. In addition, the children population results were generally somewhat similar to the adult populations with no consistent patterns of one program performing higher than the other. However, the child-related measures performed slightly better than the adult-related measures when compared to HHSC standards. For children in the STAR program, of the seven measures that were reviewed, one did not have an HHSC high standard and performance on two of the measures surpassed the HHSC high standard. For children in the CHIP program, of the seven measures that were reviewed, one did not have an HHSC high standard and performance on four of the measures surpassed the HHSC high standard. The measures that met or surpassed the standards were Adolescent Well-Care Visits for STAR and CHIP, Childhood Immunizations for CHIP, Asthma Medication Ratio for both STAR and CHIP, and Well-Child Visits for CHIP.

5.4.3. Potentially Preventable Measures

While there were year-over-year variations across all programs, overall PPR rates increased across all programs from 2014 to 2017, apart from the STAR program, which realized an annualized decrease of 4 percent. PPA rates improved across STAR, STAR Health, and CHIP programs, but realized a 9 percent increase in the STAR+PLUS program from 2014 to 2017. PPVs increased in all programs, with the exception of the STAR Kids program which realized a 6% decrease from 2016 to 2017. PPCs improved for STAR and STAR+PLUS, but increased across the other programs.

5.4.4. Comparison to National Benchmarks and Other States

Comparing Texas's HEDIS® results to the national Medicaid 50th percentile and other comparable states' 50th percentile for the same 19 unique measures analyzed, Texas's results were above the national benchmark for nine measures and below the benchmark for 10 measures. Texas scored the highest out of all comparable states in the Pharmacotherapy Management of COPD Exacerbation – Bronchodilator measure and both the Child and Adolescent Immunizations HEDIS® measures. On the contrary, Texas performed the lowest of all comparable states in Medication Management for People with Asthma, HbA1c Control, and Medical Attention for Nephropathy. Lastly, Texas's best performance compared to the national 50th percentile

was for the Adolescent Well-Care Visits measure with Texas exceeding the 50th percentile by 12.7 percentage points.

6. Access

Medicaid MCOs are required to meet certain federal and state access to care standards for their members. The current MCO contract requires that any service provided to MCO members must be offered on a timely basis. In addition, all covered services must be within a reasonable distance to most members. The parameters around the appointment time as well as distance and travel requirements vary based on service and are discussed further throughout the section below.

To provide oversight into participant access to care, the HHSC's EQRO performs an annual statewide Access to Care Study. The Access to Care Study evaluates metrics, such as appointment availability and wait time for appointment scheduling. The required standards for appointment availability vary depending on the members affected and type of service offered.

In addition, HHSC performs ongoing analysis and oversight of MCO provider networks adequacy by comparing network provider and recipient locations to confirm that they are in compliance with HHSC thresholds for acceptable distance and travel time a provider.

The following section highlights Texas's performance on various Access-to-Care standards.

6.1. Texas Access Requirements from MCO contracts

Texas MCO Access-to-Care Standards are established by service. The access-to-care standards in the contracts define appointment availability as the time between initiating a request for an appointment and receiving the care. The current HHSC MCO contract includes specific appointment wait time standards as shown in **Figure 42** below.

Figure 42. Appointment Availability Requirements by Service Type.

Members Affected	Service	Appointment Wait Time Standard
All	Emergency Services	Immediate
All	Urgent Condition	24 hours
All	Primary Routine Care	14 days
All	Specialty Routine Care	21 days
All (excluding CHIP Perinates)	Initial Outpatient Behavioral Health Visits	14 days
All	Community Long-Term Services	7 days
All	Prenatal Care	14 days
All	Prenatal Care Emergency	Immediate
All	Prenatal Care High Risk	5 days
Twenty-one years and older	Preventive Health Services	90 days
Less than six months old	Preventive Health Services	14 days
Six months through 20 years old	Preventive Health Services	60 days
All	PCPs make referrals for specialty care	5 days

Along with these appointment wait-time requirements, referred to as Access to Care, there are also Network Adequacy Standards for how far members must travel from their residence to reach a provider as well as travel time requirements for the same. For example, at least 90 percent of members in a metropolitan area must have access to at least two age-appropriate PCPs within 15 minutes or 10 miles. For the same category in rural areas, the standard is within 40 minutes or 30 miles. These standards change depending on provider type. For OB/GYN, at least 90 percent of members in a metropolitan area must have access to a choice of providers within 45 minutes or 30 miles while rural area is increased to 90 minutes or 75 miles. Psychiatric services also have to be available within 45 minutes or 30 miles for 90 percent of patients in metropolitan areas, while the standard in rural areas is within 75 minutes or 60 miles. A comparison between Texas's standards with comparable states follows in **Section 6.2** and additional travel distance standards for Texas can be found in the Appendix.

6.2. PCP/SCP Access Requirements Across Comparable States

To further evaluate Texas's Medicaid Managed Care access requirements, Texas's performance was compared to other states that are similar to Texas across a variety of areas. States were reviewed to determine which states had similarities across the dimensions of total Medicaid enrollment, geographic and demographic similarity, and managed care evolution, and selected Arizona, Florida, New Mexico, New York, Pennsylvania, and Tennessee for comparison purposes. Note that methods for identifying metro versus rural area types may vary by state; however, this information was not available to include in the analysis.

Access requirements to PCP and Specialty Care Providers (SCP) were available for all the selected states. General Surgery and OB/GYN access requirements were available for a subset of the states. **Figure 43** below compares Texas's requirements with the other states.[16]

For PCPs, Texas required shorter travel distances than most comparable states. For specialty providers, Texas's requirements are comparable to the Pennsylvania requirements, with metro requirements of 30 miles for Texas and Pennsylvania and rural requirements of 75 minutes for Texas and 60 minutes for Pennsylvania.

For General Surgery, Texas has the shortest travel time requirement for metro areas and is in line with Florida and Tennessee for rural areas. For OB/GYN services, Texas's and New Mexico's requirement for metro areas is the same at 30 miles while Florida's travel distance requirement is slightly higher at 35 miles. For rural areas, Texas has the longest distance requirement of 75 miles, while both New Mexico and Florida have requirements of 60 miles.

[16] *2019 requirements for Texas.*

Figure 43. Maximum Allowed Travel Distance by Service for Comparable States (Texas, Arizona, Florida, New Mexico, New York, Pennsylvania, and Tennessee).

Maximum Allowed Travel Distance by Service	Area	Texas	AZ	FL	NM	NY	PA	TN
PCP	**Metro**	10 miles or 15 minutes for 90% of enrollees	5 miles for 95% of enrollees	20 miles or 30 minutes	30 miles	30 minutes	30 minutes	20 miles
PCP	**Rural**	30 miles or 40 minutes for 90% of enrollees	No standard	20 miles or 30 minutes	45 miles	30 miles/ minutes	60 minutes	30 miles
SCP	**Metro**	20 miles or 30 minutes (Cardiology, General Surgery, Ophthalmology, and Orthopedics) or 30 miles or 45 minutes (Psychiatry and Urology) for 90% of enrollees	No standard	60 minutes	No standard	30 miles/ minutes	30 minutes	60 miles for 75% of enrollees, 90 miles rest
SCP	**Rural**	60 miles or 75 minutes for 90% of enrollees	No standard	60 minutes	No standard	30 miles/ minutes	60 minutes	60 miles for 75% of enrollees, 90 miles rest
General Surgery	**Metro**	20 miles or 30 minutes for 90% of enrollees	-	35 miles	-	-	-	60 miles
General Surgery	**Rural**	60 miles or 75 minutes for 90% of enrollees	-	60 miles	-	-	-	60 miles
OB/GYN	**Metro**	30 miles or 45 minutes for 90% of enrollees	-	35 miles	30 miles	-	-	-
OB/GYN	**Rural**	75 miles or 90 minutes for 90% of enrollees	-	60 miles	60 miles	-	-	-

6.3. Texas Appointment Availability Results

In 2015 and 2016, HHSC's EQRO performed an appointment availability study that assessed MCOs' compliance with appointment availability standards. The EQRO used a provider directory provided by MCOs to HHSC to call provider offices. During these calls, the EQRO acted as a "secret shopper" and recorded notes on the compliance of each provider. 'Percent Compliant' refers to the percentage of appointments that were available, for providers they were able to contact, within the set compliance standards.

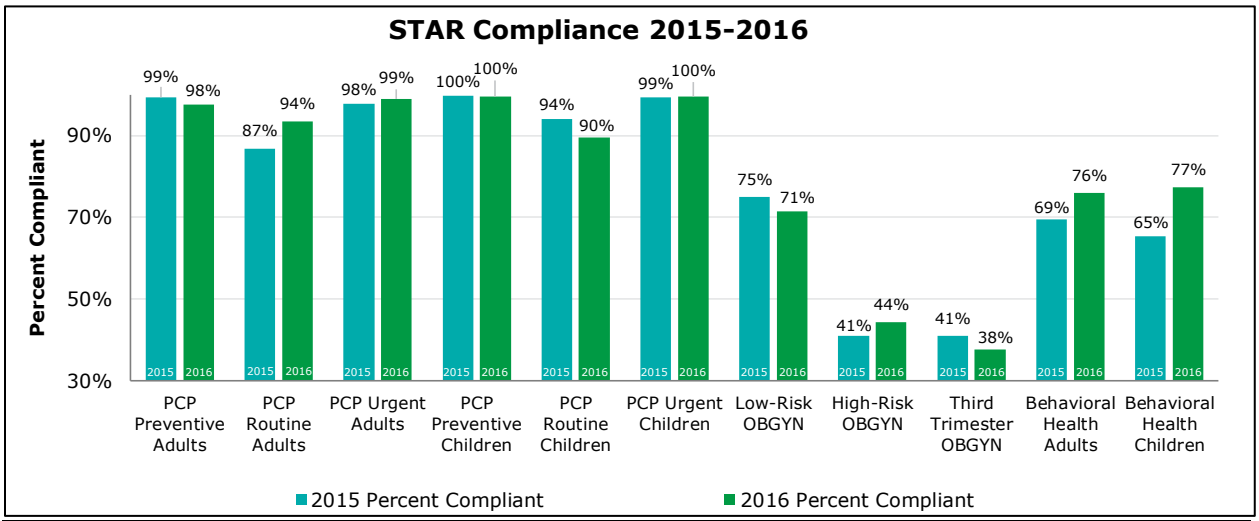
6.3.1. STAR Appointment Availability Results

The HHSC STAR contract outlines compliance standards representing the time in which a provider must be available to a patient requesting an appointment. In general, the compliance standards require an appointment within fewer days for more urgent types of services. For example, PCPs serving an adult who needs urgent care have one day to provide an appointment; however, a PCP serving an adult who needs preventive care has 90 days to provide an appointment. The list of standards can be found in the Appendix.

As shown in the **Figure 44** below, and based on the data set provided by the MCOs and the methodology used, in 2015 and 2016, the STAR program had consistently strong compliance percentages across all PCP categories.

- OB/GYN access in the STAR program was substantially lower than PCP access and both Low-Risk OB/GYN and Third Trimester OB/GYN declined slightly from 2015 to 2016 by four percent and three percent, respectively.
- High-Risk OB/GYN appointment availability increased by three percent over the two-year period.
- MCO compliance rates for High-Risk and Third Trimester appointments were 40 percent while Low-Risk appointment compliance was more than 70 percent.
- Access across Behavioral Health services increased from 2015 to 2016 by seven percent in the adult category and by 12 percent in the children category, both surpassing a 75 percent compliance rate in 2016.

Figure 44. STAR Compliance 2015–2016 by Service Type.

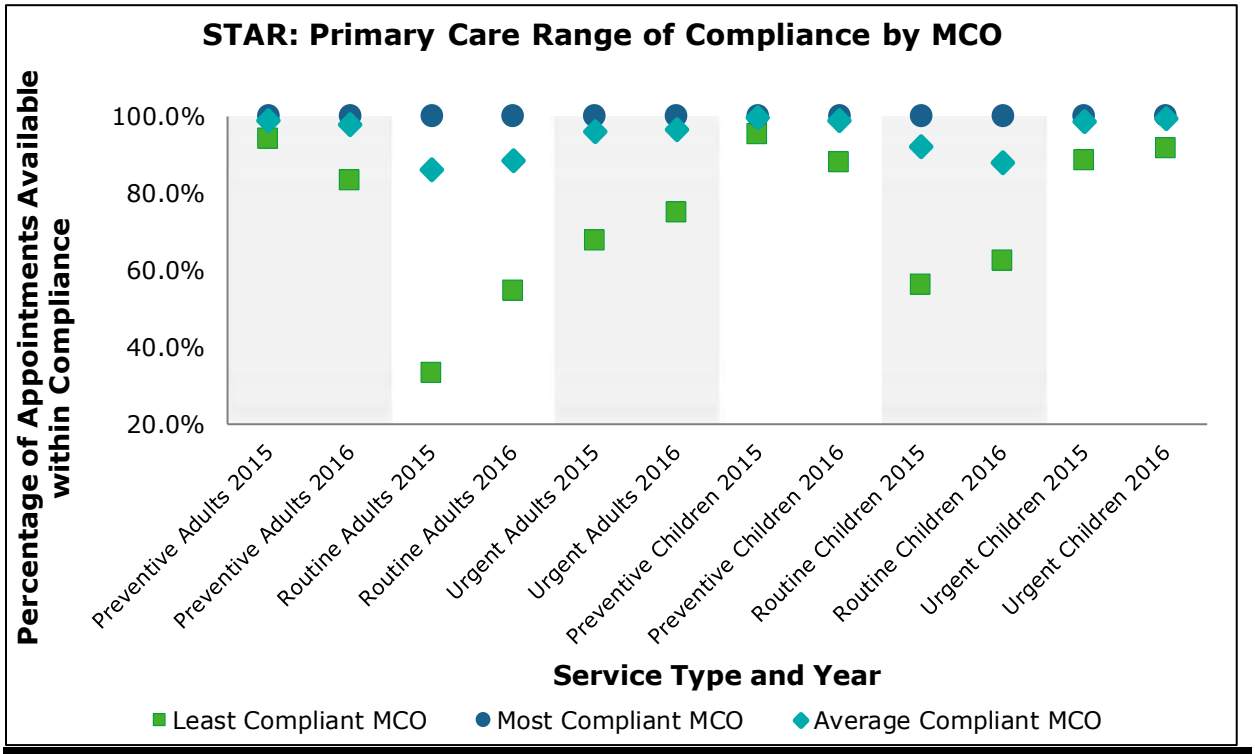


Percent Compliant by Service Type	2015 Percent Compliant	2016 Percent Compliant
PCP Preventive Adults	99%	98%
PCP Routine Adults	87%	94%
PCP Urgent Adults	98%	99%
PCP Preventive Children	100%	100%
PCP Routine Children	94%	90%
PCP Urgent Children	99%	100%
Low-Risk OBGYN	75%	71%
High-Risk OBGYN	41%	44%
Third Trimester OBGYN	41%	38%
Behavioral Health Adults	69%	76%
Behavioral Health Children	65%	77%

Figure 45 below shows the distribution of individual MCO's appointment availability compliance within each service category. Based on the survey methodology, nearly all MCOs achieved 100 percent compliance for child and adult Preventive Services, Urgent Services for children in 2015 and 2016, and Urgent Services for adults in 2016. The service category with the lowest compliance rate was Routine Services for children in 2016 with only four MCOs achieving 100 percent compliance. Routine Services for children in 2015 had two MCOs with compliance lower than 60 percent and the rest of the MCOs achieved compliance above 90 percent. The largest variation

occurred in Routine Adults for 2015 with the lowest MCO achieving only 33 percent compliance and the next lowest achieving 47 percent compliance.

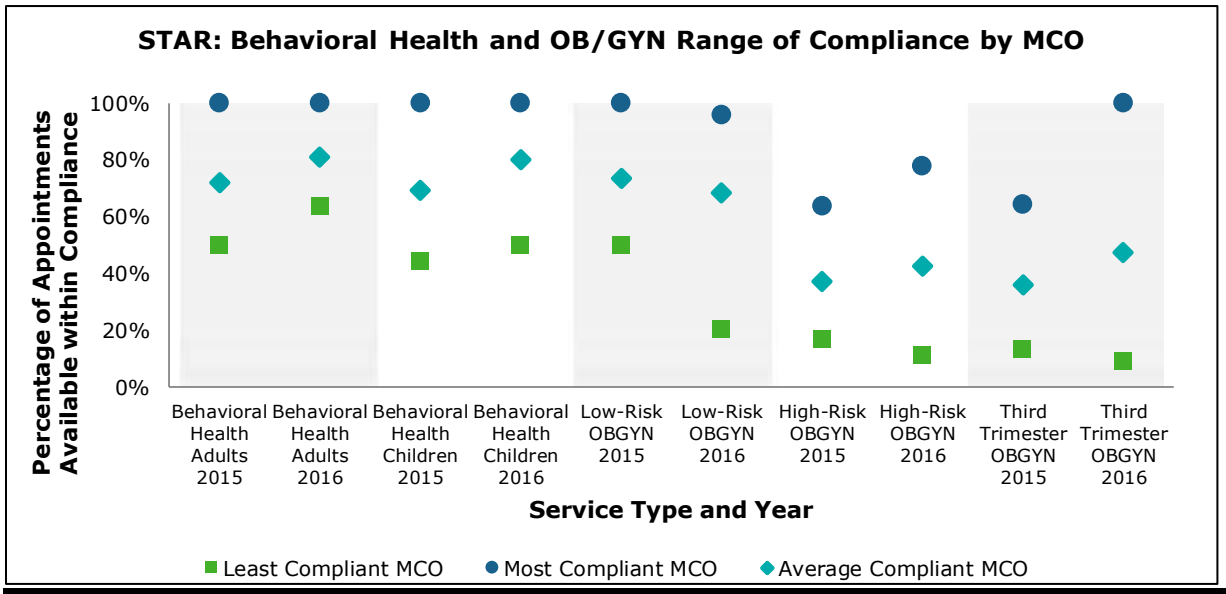
Figure 45. STAR 2015–2016 Primary Care Range of Compliance by MCO.



Percentage of Appointments Available within Compliance by Primary Care Service Type	Year	Least Compliant MCO	Most Compliant MCO	Average Compliant MCO
Preventive Adults	2015	94%	100%	99%
Preventive Adults	2016	83%	100%	98%
Routine Adults	2015	33%	100%	86%
Routine Adults	2016	55%	100%	89%
Urgent Adults	2015	68%	100%	96%
Urgent Adults	2016	75%	100%	97%
Preventive Children	2015	95%	100%	100%
Preventive Children	2016	88%	100%	99%
Routine Children	2015	56%	100%	92%
Routine Children	2016	63%	100%	88%
Urgent Children	2015	88%	100%	99%
Urgent Children	2016	92%	100%	99%

As **Figure 46** below shows, there was MCO variation in the compliance rates for Behavioral health and OB/GYN provider types. In 2016, Third Trimester OB/GYN providers had less than 10 percent compliance in one MCO while another MCO had 100 percent compliance. For each OB/GYN category, the variation across MCOs increased 2015 to 2016. Alternatively, for both behavioral health categories, variation across MCOs decreased from 2015 to 2016.

Figure 46. STAR 2015–2016 Behavioral Health and OB/GYN Range of Compliance by MCO.



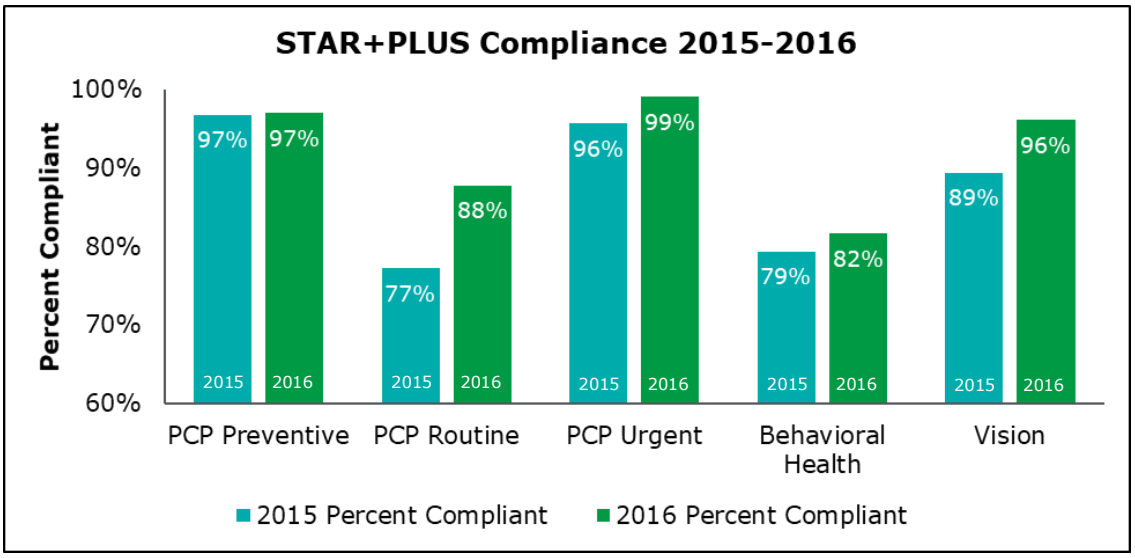
Percentage of Appointments Available within Compliance by Service Type	Year	Least Compliant MCO	Most Compliant MCO	Average Compliant MCO
Behavioral Health Adults	2015	50%	100%	72%
Behavioral Health Adults	2016	64%	100%	81%
Behavioral Health Children	2015	44%	100%	69%
Behavioral Health Children	2016	50%	100%	80%
Low-Risk OBGYN	2015	50%	100%	74%
Low-Risk OBGYN	2016	20%	96%	68%
High-Risk OBGYN	2015	17%	64%	37%
High-Risk OBGYN	2016	11%	78%	43%
Third Trimester OBGYN	2015	13%	64%	36%
Third Trimester OBGYN	2016	9%	100%	47%

6.3.2. STAR+PLUS Appointment Availability Results

The compliance standards for STAR+PLUS are similar to the compliance standards for STAR. The list of standards can be found in the Appendix.

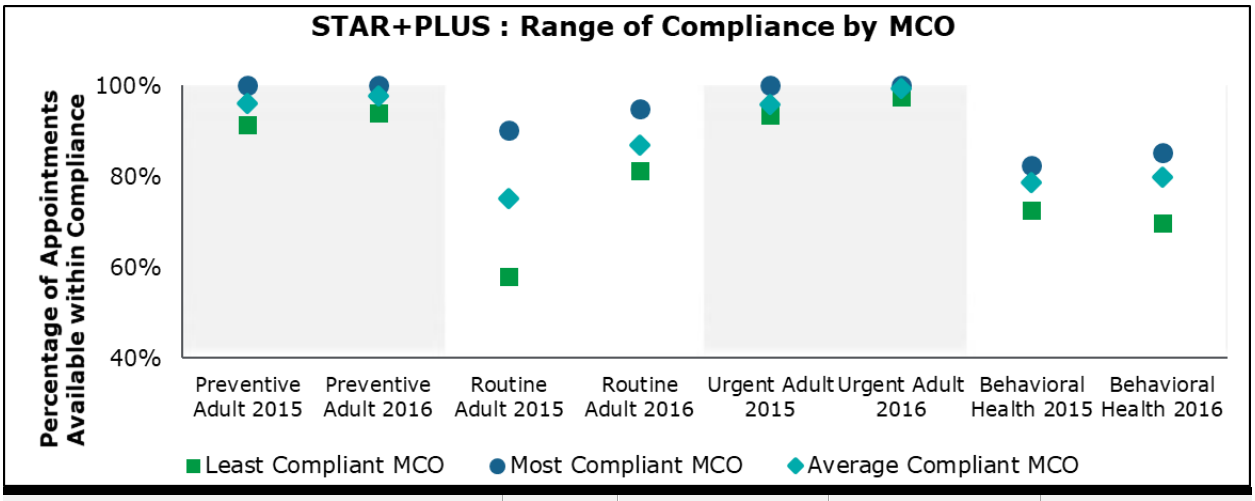
As **Figure 47** below shows, the compliance rate for all visit types improved in 2016. The PCP Routine Care compliance rate improved by 11 percent and the Behavioral Health compliance rate improved slightly to 82 percent.

Figure 47. STAR+PLUS Compliance 2015–2016 by Service Type.



As **Figure 48** below shows, MCO compliance had the most variation for PCP routine care visits and behavioral health visits. In 2016, PCP Urgent Care had the highest compliance and the least variability across MCOs with all MCOs achieving at least 97 percent compliance. In 2015, there were two MCOs with low PCP Routine Care visit rates. However, that performance did not persist in 2016 and the lowest performing MCO increased to 67 percent, which increased average compliance from 75 percent in 2015 to 89 percent in 2016.

Figure 48. STAR+PLUS 2015–2016 Range of Compliance by MCO.



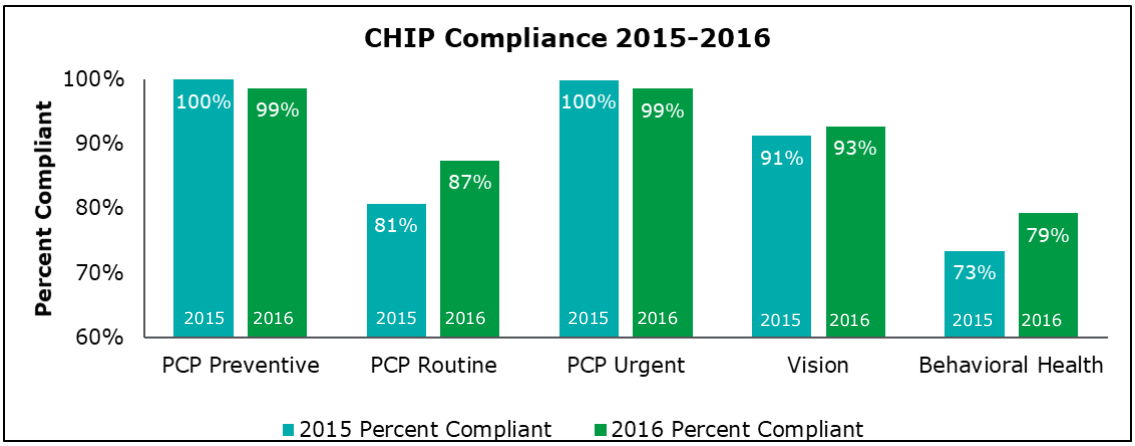
Percentage of Appointments Available within Compliance by Service Type	Year	Least Compliant MCO	Most Compliant MCO	Average Compliant MCO
Preventive Adults	2015	91%	100%	96%
Preventive Adults	2016	94%	100%	98%
Routine Adults	2015	58%	90%	75%
Routine Adults	2016	81%	95%	87%
Urgent Adults	2015	93%	100%	96%
Urgent Adults	2016	97%	100%	99%
Behavioral Health	2015	73%	82%	79%
Behavioral Health	2016	70%	85%	80%

6.3.3. CHIP Appointment Availability Results

The compliance standards for service types in CHIP are identical to the standards for STAR+PLUS and can be found in the Appendix.

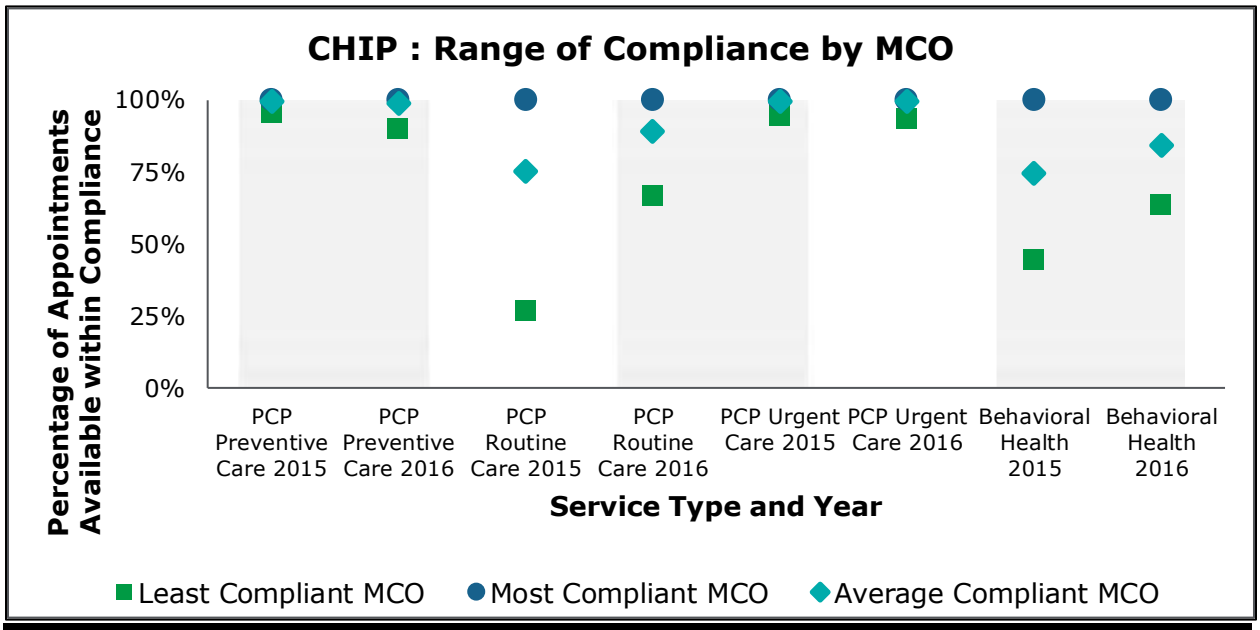
In 2015 and 2016, CHIP had high compliance rates for both PCP Preventive and PCP Urgent appointments with almost 99 percent compliance across all MCOs. The lowest compliance rate was for Behavioral Health appointments with 79 percent compliance in 2016; however, this was 5.8 percent higher than the 2015 compliance rate.

Figure 49. CHIP Compliance 2015–2016 by Service Type.



In 2016, PCP Preventive and PCP Urgent service times had the highest average compliance rate with the lowest variability across MCOs, with the lowest performing MCO having greater than 90 percent compliance. Behavioral Health has the largest variation in the compliance rate ranging from 64 percent for the least compliant MCO to 100 percent for the most compliant MCO, with an average of 85 percent compliance across all MCOs. There was also high variation across Routine Care appointments with compliance ranging from 67 percent to 100 percent and an average compliance rate of 89 percent. While Behavioral Health and Routine care had the highest variation across MCOs in 2016, both saw reduced variation from 2015.

Figure 50. CHIP 2015–2016 Range of Compliance by MCO.



Percentage of Appointments Available within Compliance by Service Type	Year	Least Compliant MCO	Most Compliant MCO	Average Compliant MCO
PCP Preventive Care	2015	96%	100%	100%
PCP Preventive Care	2016	90%	100%	99%
PCP Routine Care	2015	27%	100%	75%
PCP Routine Care	2016	67%	100%	89%
PCP Urgent Care	2015	94%	100%	99%
PCP Urgent Care	2016	93%	100%	99%
Behavioral Health	2015	44%	100%	75%
Behavioral Health	2016	64%	100%	84%

6.3.4. Dental Appointment Availability Results

In 2015, HHSC's EQRO conducted a Dental Caregiver Survey for both STAR and CHIP Programs, utilizing the CAHPS Dental and demographic survey questions. The survey was conducted via 1,204 care providers distributing the survey to members in the population. Additionally, the survey results were weighted by the probability of selection into the survey sample and response bias by members' race/ethnicity. This analysis focuses on six survey questions related to access.

The Dental Appointment Availability measure had the highest results across the measures with 93 percent of STAR members and 91 percent of CHIP members "usually" or "always" able to schedule an appointment as soon as they wanted. Specialty Dental Appointment Availability was the lowest performing measure in the STAR program and second lowest performing measure in the CHIP program. Only 30 percent of STAR members and 43 percent of CHIP members stated that they could "usually" or "always" schedule an appointment with a specialty dentist as soon as they wanted. Additionally, this measure had the highest variation between the STAR and CHIP programs, with 13 percent more CHIP members able to schedule appointments with specialty dentists as soon as they wanted.

Performance on The Dental Appointment Waiting Time and Ease of Access to Dental Care composite measures exceeded 70 percent. The Emergency Dental Appointment Availability measure had less member satisfaction, with only 61 percent of members "definitely" or "sometimes" able to see a dentist for emergency care as soon as they wanted. Dental Appointment Waiting Time Communication also has had a lower satisfaction rate with only 37 percent to 40 percent of members noting that they were informed of a delay and how long that delay would be before an appointment.

6.4. Findings/Conclusions

The analysis of other states' access time and distance requirements indicates that Texas's performance measures are similar to other states that were reviewed.

For appointment availability measures, in general, the STAR, STAR+PLUS, and CHIP programs saw improvement in these measures from 2015 to 2016. One area of low compliance included OB/GYN appointment availability in the STAR program, with compliance rates below 50 percent for third trimester and for High-Risk OB/GYN appointments. Behavioral Health appointment availability had compliance rates ranging between 76 percent and 82 percent across all programs. High MCO variation was present for both OB/GYN and Behavioral Health appointments, while Primary Care appointments typically saw high compliance and low variation across MCOs.

Results from access questions on the Dental Caregiver Survey indicated that members can typically schedule a regular dentist appointment as soon as they want and typically wait for less than 15 minutes at the dentist's office before a visit. However, members did report some difficulty scheduling emergency or specialty dental care.

7. CAHPS

Texas's EQRO oversees a survey of member satisfaction, recognizing that member satisfaction is a key aspect of a member's health care experience. The CAHPS® survey approach is to survey satisfaction through telephone interviews with members of Medicaid and CHIP. The CAHPS® survey measures member satisfaction across five different composite areas: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Personal Doctor Rating, and Health Plan Rating. Each composite area consists of multiple questions from the survey which are collected and weighted according to the NCQA standards. The composite area definitions are outlined below:

- Getting Needed Care: The percentage of members surveyed who "always" had positive experiences getting routine and specialist care.
- Getting Care Quickly: The percentage of members or caregivers surveyed who were "always" able to access routine and urgent care as soon as needed.
- How Well Doctors Communicate: The percentage of members or caregivers surveyed who "always" had positive experiences communicating with their personal doctor.
- Personal Doctor Rating: The percentage of members or caregivers surveyed who rated their personal doctor as a 9 or a 10 on a scale of 0 to 10.
- Health Plan Rating: The percentage of members or caregivers surveyed who rated their health plan 9 or 10 on a 0 to 10 scale.

Member satisfaction surveys conducted by Texas's EQRO at points in time during 2015, 2016, and 2017 were utilized for this analysis. STAR was surveyed separately for the adults in the program (STAR Adults) and children in the program (STAR Children).

This report evaluates the CAHPS® composite measures to understand Texas performance from 2015 through 2017 and to understand how Texas's performance compares to other states and national benchmarks. The analysis reviewed how Texas performed in each CAHPS® composite measure over the three-year period from 2015 through 2017. Each composite measure was also evaluated for its variation across MCOs within Texas during this period. The variation was calculated by taking the rating for each year's highest performing MCO in each program and subtracting it from that year's lowest performing MCO. A large range signifies less consistency throughout the MCOs. This analysis was completed for 17 MCOs

for adults in the STAR program, 18 MCOs for children in the STAR and CHIP programs, and five MCOs in STAR+PLUS.

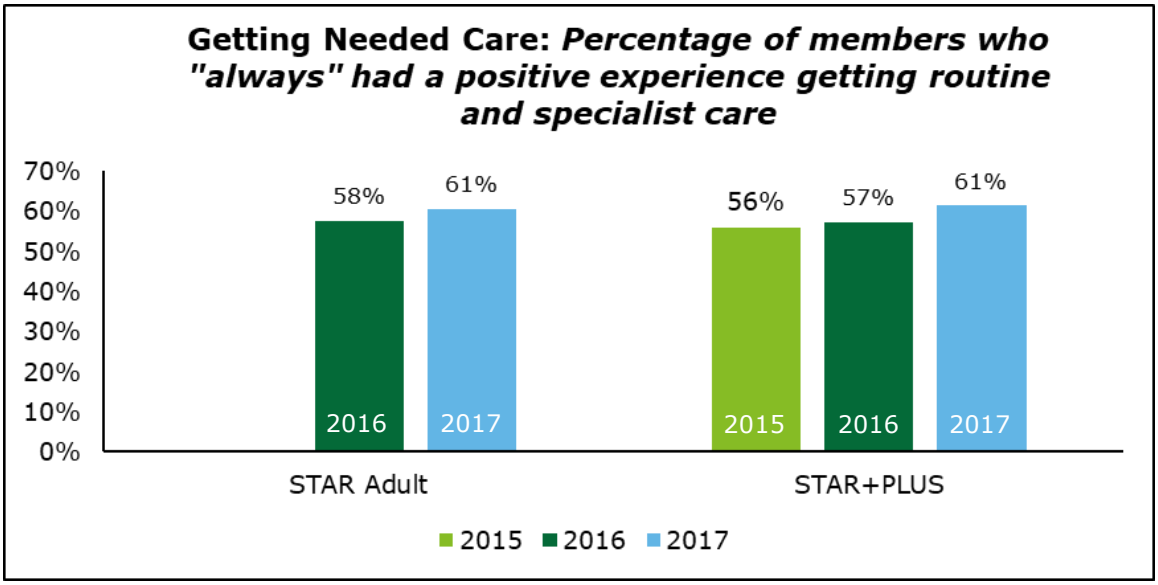
The Texas results for CAHPS® composite measures were also compared to the states identified as comparable to Texas of Arizona, Florida, New Mexico, New York, Pennsylvania, and Tennessee, defined earlier in the report, as well as the national 50th percentile for 2017.

7.1. Texas CAHPS® Results and Trends

7.1.1. Getting Needed Care

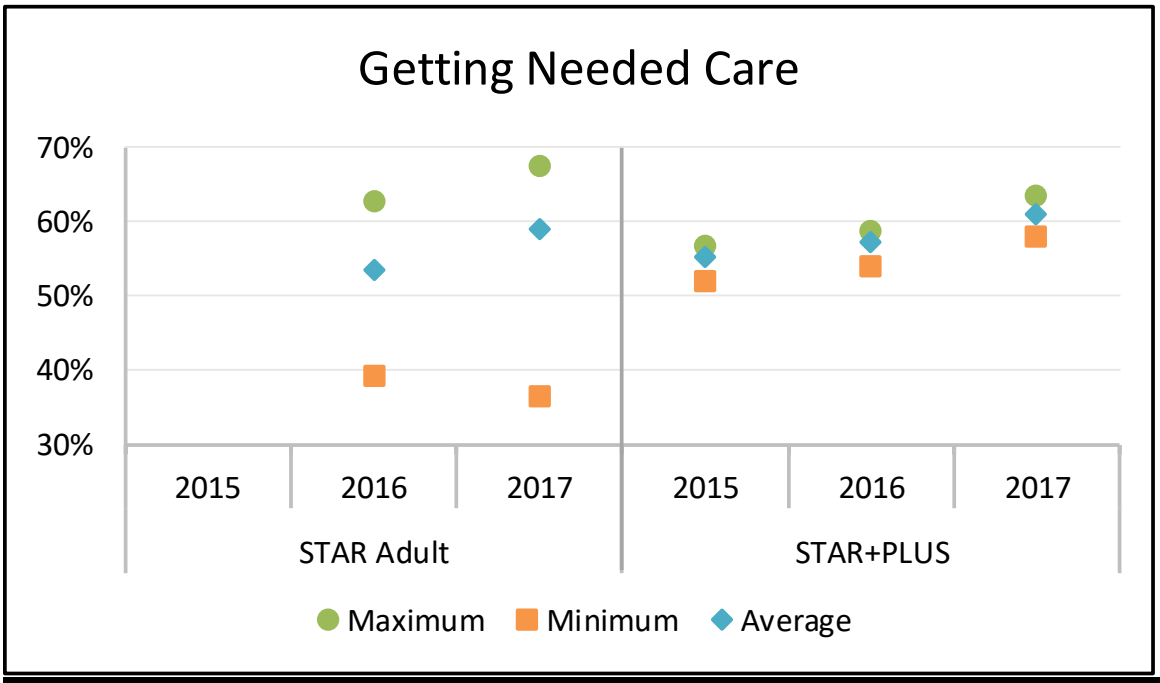
The CAHPS® measure for Getting Needed Care was analyzed across the adults in *the* STAR program and the STAR+PLUS program. In addition, the 2015 Getting Needed Care measure for STAR was excluded in this report as the metric definition changed from 2015 to 2016. In 2017, both programs had a score of 61 percent. Overall, STAR+PLUS saw a steady increase in survey results over the three years; STAR also saw an increase of 3 percent from 2016 to 2017.

Figure 51. 2015–2017 Getting Needed Care for STAR Adults and STAR+PLUS.



The figure below shows the variation in survey results among MCOs for the CAHPS® measure for Getting Needed Care. Similar to the program results above, this measure was analyzed for adults in the STAR program from 2016 to 2017 and for the STAR+PLUS program from 2015 to 2017. For adults in the STAR program, the range of lowest performing MCO to highest performing MCO increased from 23 percentage points in 2016 to 31 points in 2017. The STAR+PLUS program realized less variation across MCOs than the STAR program, averaging a range of approximately five percentage points across MCOs from 2015 to 2017.

Figure 52. 2015–2017 MCO Variation for Getting Needed Care for STAR Adults and STAR+PLUS.

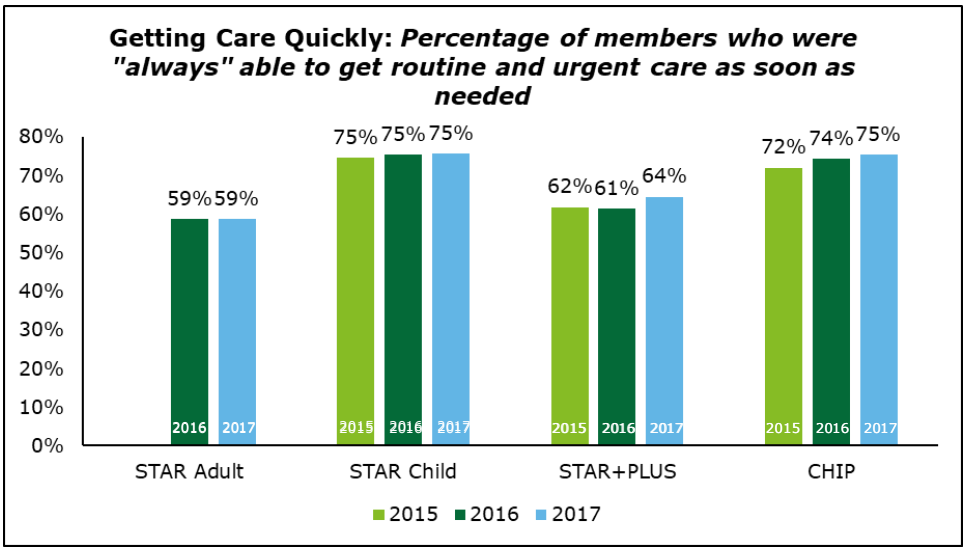


2015–2017 MCO Variation for Getting Needed Care for STAR Adults and STAR+PLUS by Service Type	Year	Maximum	Minimum	Average
STAR Adult	2016	63%	39%	53%
STAR Adult	2017	68%	37%	59%
STAR+PLUS	2015	57%	52%	55%
STAR+PLUS	2016	59%	54%	57%
STAR+PLUS	2017	63%	58%	61%

7.1.2. Getting Care Quickly

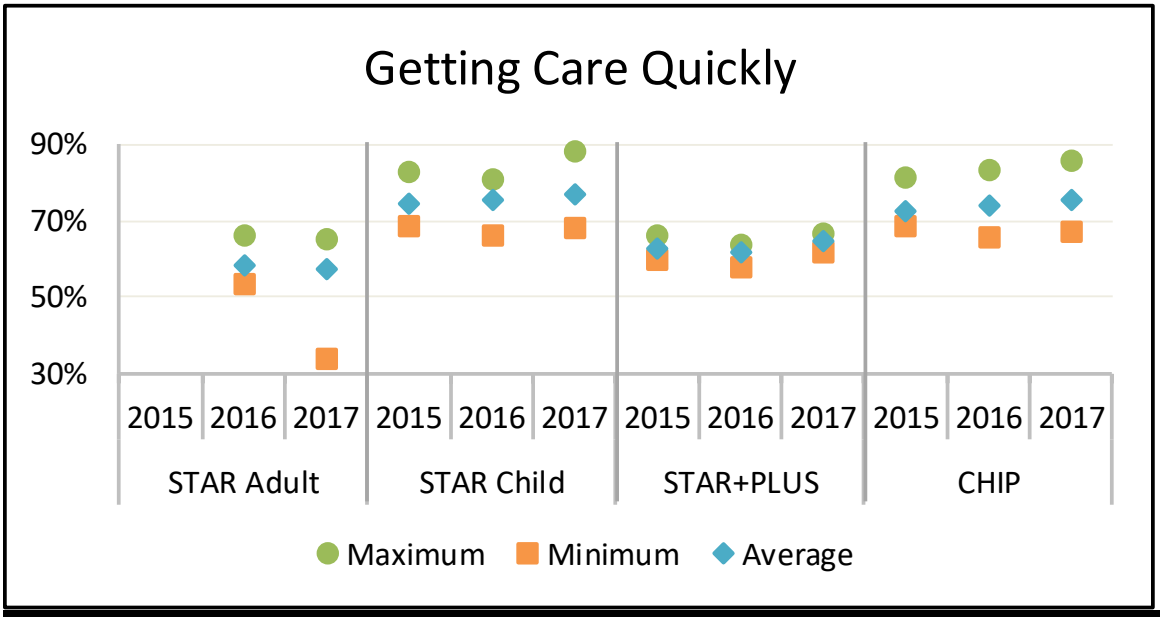
Similar to Getting Needed Care, Getting Care Quickly was not included for adults in the STAR program in 2015, as the measure definition is not comparable across the years. Members across STAR+PLUS and CHIP reported receiving timely care more often across the analysis period of 2015 to 2017. Across programs, the child populations reported receiving timely care more often than the adult populations did. As shown in the **Figure 53** below, two of the four population groups saw an increase in receiving timely care across the analysis period, with adults in the STAR program holding steady at 59 percent from 2016 to 2017 and children in the STAR program holding steady at 75 percent from 2015 to 2017.

Figure 53. 2015–2017 Getting Care Quickly for STAR, STAR+PLUS, and CHIP.



As **Figure 54** below shows, the range for highest and lowest performing MCOs for adults in the STAR program increased from 13 percent in 2016 to 31 percent in 2017. This was due to the lowest MCO rating decreasing from 53 percent to 34 percent when a new MCO was surveyed in 2017. Both the children of STAR and CHIP programs realized increased variation across the analysis period. The STAR+PLUS program realized the lowest variation of the four programs, averaging less than 6 percent variation across MCOs.

Figure 54. 2015–2017 MCO Variation for Getting Care Quickly for STAR, STAR+PLUS, and CHIP.

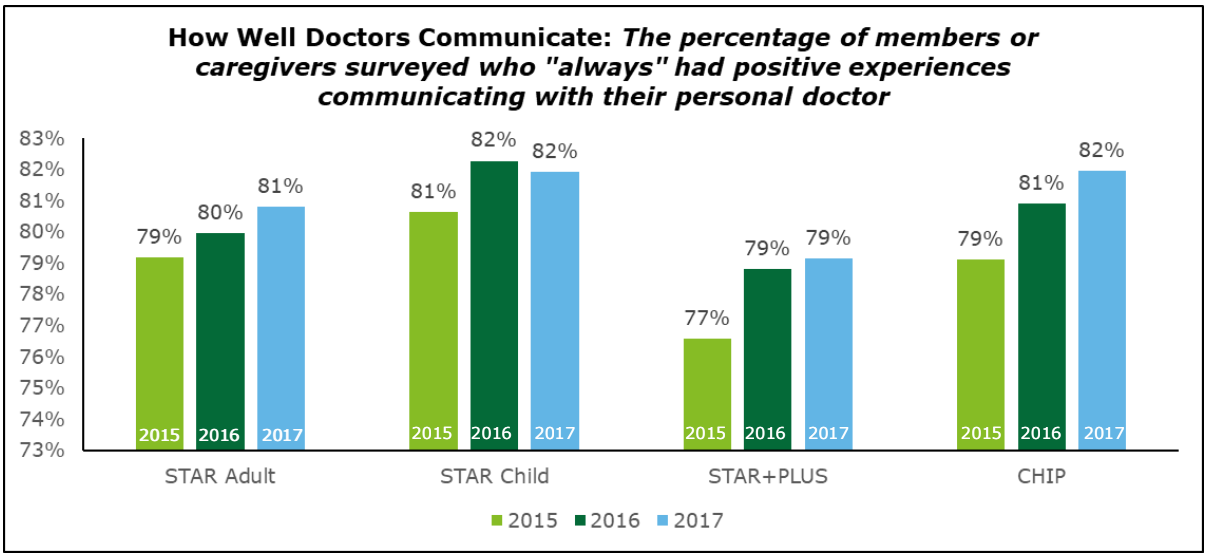


2015–2017 MCO Variation for Getting Care Quickly for STAR, STAR+PLUS, and CHIP by Service Type	Year	Maximum	Minimum	Average
STAR Adult	2016	66%	53%	58%
STAR Adult	2017	6%	34%	57%
STAR Child	2015	83%	68%	75%
STAR Child	2016	81%	66%	76%
STAR Child	2017	88%	68%	77%
STAR+PLUS	2015	66%	60%	62%
STAR+PLUS	2016	64%	58%	62%
STAR+PLUS	2017	67%	62%	64%
CHIP	2015	81%	68%	72%
CHIP	2016	83%	65%	74%
CHIP	2017	86%	67%	75%

7.1.3. How Well Doctors Communicate

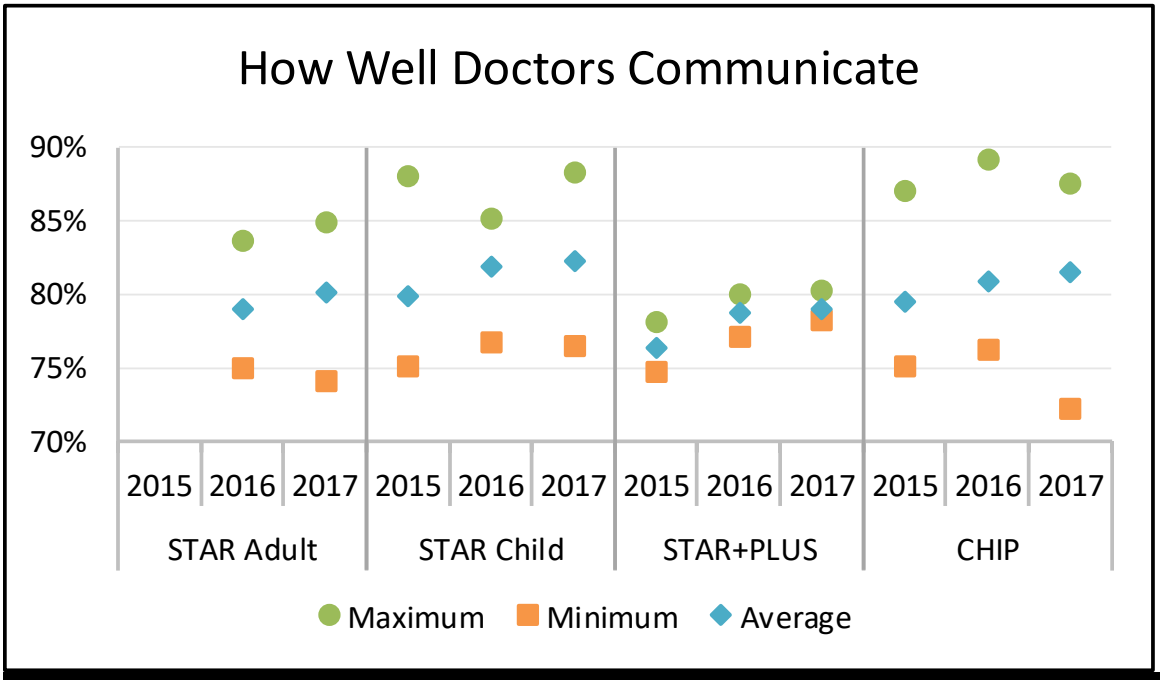
Across all programs, members reported increased positive experiences communicating with their doctors over the analysis period. As **Figure 55** below shows, the CHIP program realized the largest increase in positive experiences communicating with doctors over the analysis period, followed closely by adults in the STAR program and the STAR+PLUS program.

Figure 55. 2015–2017 How Well Doctors Communicate for STAR, STAR+PLUS, and CHIP.



As shown in **Figure 56** below, the STAR+PLUS program realized the lowest variation across MCOs for the measure for How Well Doctors Communicate. MCO variation across adults in the STAR program, children in the STAR program, and CHIP program was approximately 9 to 15 percentage points across the analysis period, while variation for the STAR+PLUS program was between two and three percentage points.

Figure 56. 2015–2017 MCO Variation for How Well Doctors Communicate for STAR Adults, STAR Children, STAR+PLUS, and CHIP.

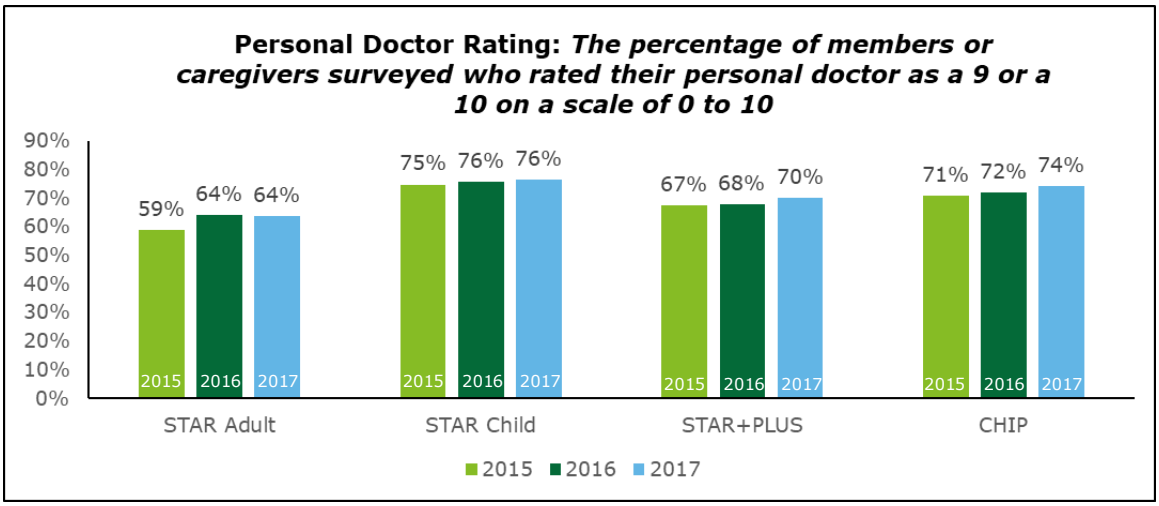


2015–2017 MCO Variation for How Well Doctors Communicate for STAR Adults, STAR Children, STAR+PLUS, and CHIP by Service Type	Year	Maximum	Minimum	Average
STAR Adult	2016	84%	75%	79%
STAR Adult	2017	85%	74%	80%
STAR Child	2015	88%	75%	80%
STAR Child	2016	85%	77%	82%
STAR Child	2017	88%	77%	82%
STAR+PLUS	2015	78%	75%	76%
STAR+PLUS	2016	80%	77%	79%
STAR+PLUS	2017	80%	78%	79%
CHIP	2015	87%	75%	80%
CHIP	2016	89%	76%	81%
CHIP	2017	88%	72%	81%

7.1.4. Personal Doctor Rating

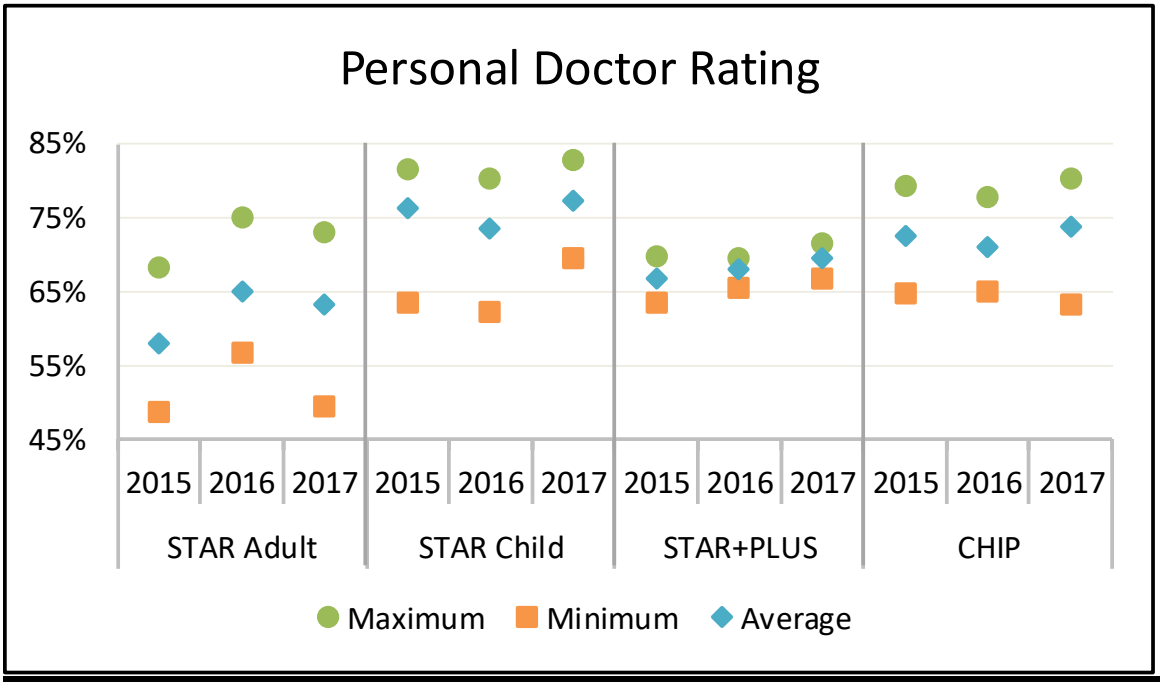
As the **Figure 57** below shows, scores for the Personal Doctor Rating modestly increased over the analysis period, with the child populations having higher scores for their Personal Doctor Ratings than the adult populations. Children in the STAR program assessed their experience with their main doctor with a score of "9" or "10" more often than any other program across each year in the analysis period.

Figure 57. 2015–2017 Personal Doctor Rating STAR, STAR+PLUS, and CHIP.



Adults in the STAR program had the highest variation for Personal Doctor Rating across all three years, while the STAR+PLUS program realized the lowest variation across the analysis period. Both child populations reported similar variation across MCO ranging from approximately 13 percent to 18 percent.

Figure 58. 2015–2017 MCO Variation for Personal Doctor Rating for STAR, STAR+PLUS, and CHIP.

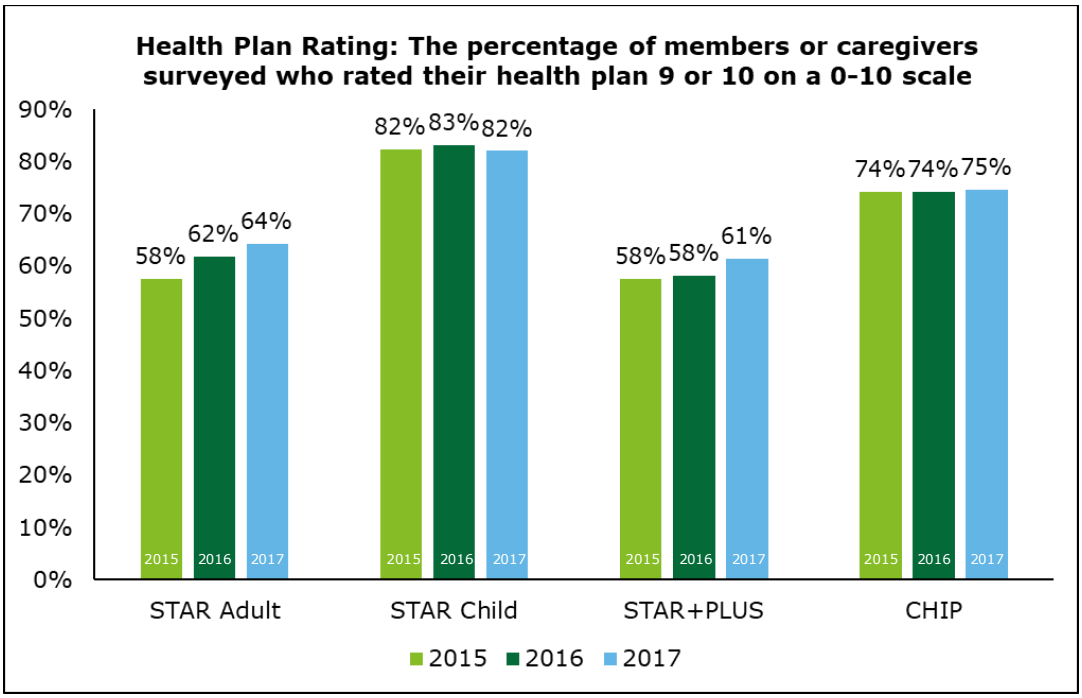


2015–2017 MCO Variation for Personal Doctor Rating for STAR, STAR+PLUS, and CHIP by Service Type	Year	Maximum	Minimum	Average
STAR Adult	2015	68%	49%	58%
STAR Adult	2016	75%	57%	65%
STAR Adult	2017	73%	50%	63%
STAR Child	2015	82%	64%	76%
STAR Child	2016	80%	62%	74%
STAR Child	2017	83%	69%	77%
STAR+PLUS	2015	70%	64%	67%
STAR+PLUS	2016	70%	66%	68%
STAR+PLUS	2017	72%	67%	70%
CHIP	2015	79%	65%	73%
CHIP	2016	78%	65%	71%
CHIP	2017	80%	63%	74%

7.1.5. Health Plan Rating

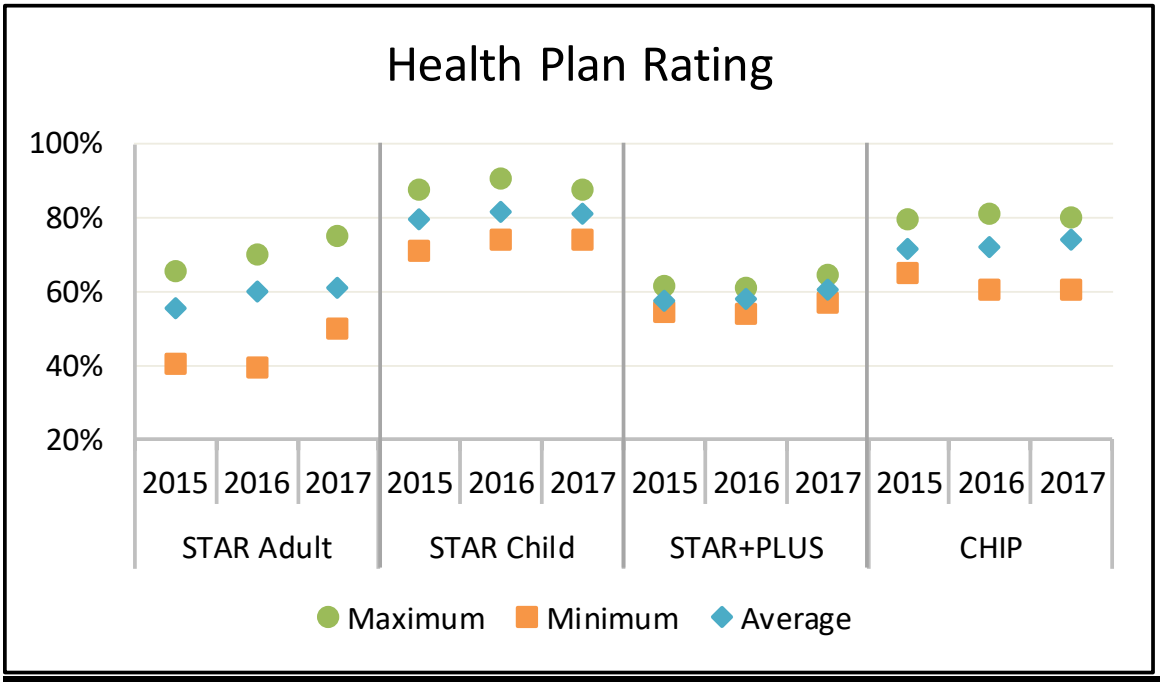
As shown in **Figure 59** below, the child populations received higher health plan ratings than the adult populations. Although this finding was seen across most CAHPS® composite measures, the differences between the child and adult populations were greater across the Health Plan Rating composite measure than any other measure. Children in both the STAR Program and CHIP program gave consistent scores across the analysis period; the 2017 score for children in the STAR program was 82 percent while the score for the CHIP program was 75 percent. Adults in the STAR program began the analysis period with the lowest score, this population also had the most improvement across the period, improving from 58 percent in 2015 to 64 percent in 2017. The STAR+PLUS scores did not improve over the three-year period, remaining around 82 percent.

Figure 59. 2015–2017 Health Plan Rating for STAR, STAR+PLUS, and CHIP.



As shown in **Figure 60** below, the most variation across MCOs occurred for adults in the STAR program. The STAR+PLUS program realized the lowest variation, ranging from 4 percent to 6 percent across the analysis period. The child populations fell between adults in the STAR program and the STAR+PLUS program in terms of variation, with variation ranging from 14 percent to 21 percent across the analysis period.

Figure 60. 2015–2017 MCO Variation for Health Plan Rating for Adults in STAR, Children in STAR, STAR+PLUS, and CHIP.



2015–2017 MCO Variation for Health Plan Rating for Adults in STAR, Children in STAR, STAR+PLUS, and CHIP by Service Type	Year	Maximum	Minimum	Average
STAR Adult	2015	66%	41%	56%
STAR Adult	2016	70%	39%	60%
STAR Adult	2017	75%	50%	61%
STAR Child	2015	88%	71%	80%
STAR Child	2016	91%	74%	82%
STAR Child	2017	88%	74%	81%
STAR+PLUS	2015	62%	55%	58%
STAR+PLUS	2016	61%	54%	58%
STAR+PLUS	2017	65%	57%	61%
CHIP	2015	80%	65%	72%
CHIP	2016	81%	60%	72%
CHIP	2017	80%	61%	74%

7.1.6. Dental CAHPS

The Dental CAHPS® composite measures evaluated are from the SFY2015 Medicaid/CHIP Dental Caregiver Survey conducted across the STAR and CHIP programs by the EQRO.

In the STAR program, the highest satisfaction ratings by members were attributed to the child's dental plan. 99 percent of members said they would "definitely" or "probably" recommend their dental plan to others. However, only 78 percent of individuals rated their child's dentist as a score of "9" or "10" out of a possible 10 points.

In the CHIP program, 98 percent of members reported that their child's dentist treats them with courtesy and respect. 96 percent of the members would recommend their child's dental plan to others but only 69 percent would rate their child's dental care in the last six months with a score of "9" or "10". Additional detail on the Dental CAHPS analysis can be found in **Figure 77** in the Appendix.

7.2. National CAHPS® Trends and Results

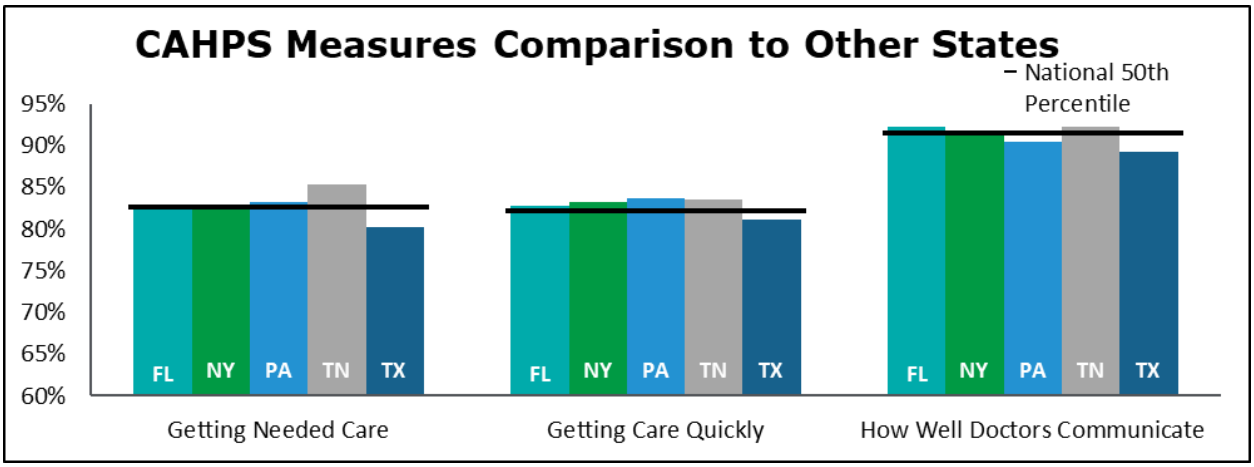
The NCQA sets the standards for the CAHPS® survey for both private and public healthcare plan assessments. Additionally, NCQA collects data across all plans and states to produce national benchmarks and state averages. This section compares the CAHPS® composite measures that were reviewed in the prior section, across the states that were identified as comparable to Texas and to the national 50th percentile of results for Medicaid MCOs in 2017. As previously discussed, these states were chosen based on their similarity to Texas in a variety of areas: enrollment, geographic and demographic similarity, and managed care evolution. Two of the states used for comparison throughout the report, Arizona and New Mexico, did not have CAHPS® data available on the NCQA Quality Compass® Tool. The NCQA benchmarks are composed of publicly reported and nonpublicly reported health plan submissions. To maintain confidentiality, there is a five-submission threshold, meaning if a state does not have five submissions for a certain measure, the measure will not be populated in the NCQA Quality Compass® Tool.

Results of the Getting Needed Care composite measure (the percentage of members surveyed who "always" had positive experiences getting routine and specialist care) across the comparable states had a range of 5 percent. Texas's results were at the bottom of the range, coming in 2.5 percent below the national 50th percentile.

Texas was also below the national average for the Getting Care Quickly composite measure (the percentage of members or caregivers surveyed who were "always" able to access routine and urgent care as soon as needed in 2017). While Texas performed lowest of the comparable states for this measure, Texas's results were only 1 percent below the national 50th percentile.

Texas's results for the How Well Doctors Communicate measure (the percentage of members or caregivers surveyed who "always" had positive experiences communicating with their personal doctor) was 2.3 percent below the national 50th percentile and the lowest across the comparable states.

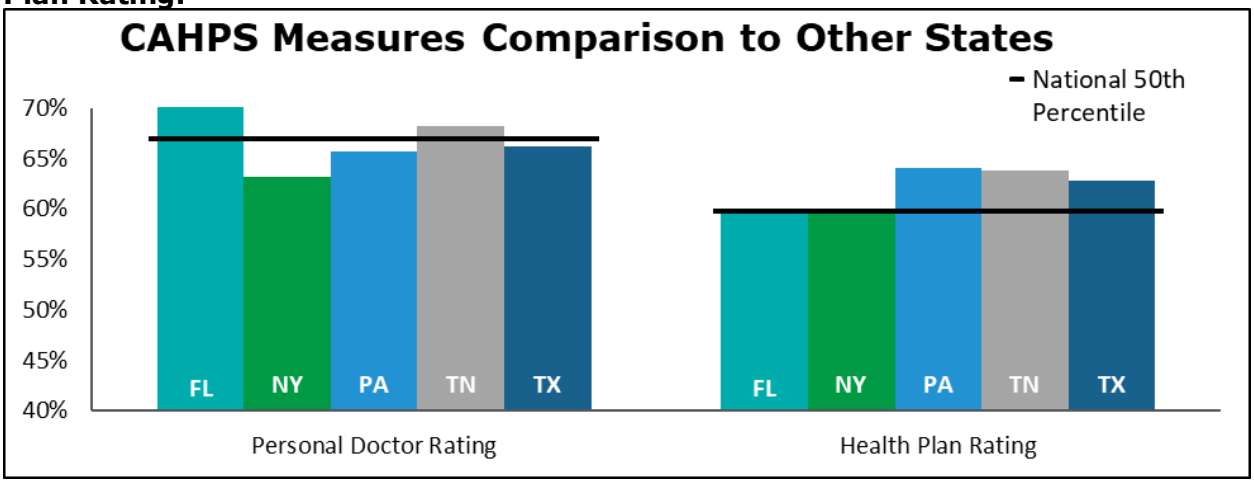
Figure 61. 2017 CAHPS® NCQA Comparison for Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate.



For the Personal Doctor Rating composite measure (the percentage of members or caregivers surveyed who rated their personal doctor as a 9 or a 10 on a scale of 0 to 10), Texas measured below the national 50th percentile by less than one percent. Across comparable states, Texas fell in the middle with results approximately three percent above the lowest comparable state and approximately four percent below the highest comparable state.

For the Health Plan Rating composite measure (the percentage of members or caregivers surveyed who rated their health plan 9 or 10 on a scale of 0 to 10), Texas's results were more than three percent higher than the national 50th percentile. Across comparable states, Texas performed approximately one percent below the highest comparable state.

Figure 62. 2017 CAHPS® NCQA Comparison for Personal Doctor Rating and Health Plan Rating.



7.3. Findings/Conclusions

From 2015 to 2017, Texas experienced modest improvements in the most member satisfaction scores for every program. Across the measures, the child populations typically had higher member satisfaction scores than the adult populations.

Disregarding any outliers in data, MCO variation remained steady from 2015 to 2017 although the variation size itself is different depending on the CAHPS® measure. Specifically, the STAR+PLUS program consistently showed variation of less than 7 percentage points although it should be noted that there were much fewer MCOs in the STAR+PLUS analysis than all other programs.

Comparing Texas's CAHPS® results to national benchmarks in 2017, Texas performed lower than the national 50th percentile for four out of the five CAHPS® composite measures that were reviewed. Only results for the Health Plan Rating measure were above the national 50th percentile. Reviewing Texas's results with other comparable states, Texas's results were the lowest of the comparable states for three of the five CAHPS® composite measures that were reviewed. Texas had the third highest score of five for both the Personal Doctor Rating and Health Plan Rating composite measures.

8. Estimated Managed Care Program Savings

An important component in assessing the current Medicaid and CHIP managed care delivery system and managed care performance is understanding the financial impact. In order to understand the financial impact or expenditure savings, an estimate is needed of the Medicaid and CHIP expenditures if HHSC had kept Medicaid enrollees in the FFS program and if the CHIP program had operated under a fee-for-service model. Expenditure trends are driven by a large number of factors, including program and service expansions, changes in administrative expenses, changes in the number and mix of enrolled populations, and health care cost and utilization trends. In order to evaluate savings across the Medicaid Managed Care program, a retrospective evaluation was conducted to derive estimated savings associated with managed care from the period SFY2009 to SFY2017.

This analysis estimates the financial impact that the managed care program has had by comparing the actual historical managed care program payments to hypothetical expenditures under a FFS arrangement. The analysis does not take into account federal and supplemental drug rebates, thus does not represent the net cost to the state. To estimate the hypothetical expenditures under a FFS arrangement, an assumption was made that the base year of SFY2009 managed care payments was the starting point for FFS expenditures PMPM. While this assumption does not incorporate any managed care cost savings from SFY2009 and prior, it allows for assessment of program trends from SFY2009 to SFY2017 and how that compares to an estimated FFS trend during that time period.

Note that HHSC built managed care savings assumptions into the managed care capitation rates during the initial years of managed care and during program expansions. For acute services and prescription drug benefits, the State noted that during these transition years or managed care expansion years the assumed managed care savings in shifting from FFS to managed care built into the premium was at least budget neutral, if not greater than, to any additional costs associated only under a managed care program. However, for some carve-ins such as LTSS and the STAR Kids expansion, savings assumptions were much lower. Additionally, managed care savings assumptions have varied depending on the program, service delivery area, and population. Thus, while it is difficult to generalize managed care savings assumptions, for the purposes of this analysis, it was assumed that in the managed care capitation rate, the managed care savings would more than

offset administrative costs, risk margins, and other expenses built into the rates.

The hypothetical FFS expenditures use the SFY2009 base year, an estimated FFS trend rate, and adjusts for Medicaid program changes such as benefit changes and population additions that occurred to the managed care program to develop a representative FFS annual expenditure for each year from SFY2010 to SFY2017. This FFS year-over-year expenditure is then compared to the historical, actual managed care payments during the same time period.

The managed care savings were then estimated by comparing the hypothetical FFS PMPM to the historical managed care PMPM payments. Cost savings were reviewed by program, risk group, and by medical and pharmacy costs.

8.1. Methodology

Medicaid and CHIP expenditures under a FFS arrangement were estimated and analyzed separately for the managed care programs, including STAR, STAR+PLUS, the Dual-Eligible Demonstration Project (the "Dual Demonstration"), STAR Health, STAR Kids, CHIP, and CHIP Perinatal. Expenditures were also separated by the risk groups within each program and by medical and pharmacy service categories. While the CHIP program never utilized a FFS reimbursement arrangement, the analysis estimated savings for CHIP program by utilizing the methodology described below. The analysis included all members that were enrolled in a MCO throughout the analysis period, including new members from any service delivery area expansions or covered service expansions that occurred throughout the analysis period. Dental costs were not included in the analysis. Further information regarding how the pharmacy carve-in in 2012 was modeled can be found in the methodology summary below.

8.1.1. Step 1: Summarize and analyze expenditures PMPM

The first step of the analysis was to calculate the Medicaid and CHIP expenditures PMPM for the FFS and managed care populations by program and risk group from SFY2009 to SFY2017. Expenditures were separated by program, risk group, and medical and pharmacy service categories. The FFS PMPMs were used to analyze the historical FFS trend rate across each of the programs, risk groups, and service categories. This data was then used, along with national benchmarks, to set the estimated trend rates for the

hypothetical FFS expenditure calculation. The historical managed care expenditures were then compared to the hypothetical FFS expenditures in the cost savings calculation, after adjustments are applied.

8.1.2. Step 2: Calculate adjustments that were made to the Managed Care Program

To calculate hypothetical FFS expenditures that are comparable to historical managed care expenditures, any adjustments that were made to the managed care program during the analysis period that would have theoretically affected the FFS program were calculated and applied to the hypothetical FFS expenditures.

8.1.2.1. Managed Care Program Expansions

Managed care program expansions that occurred resulting in various impacts to the historical managed care PMPMs were also considered in the hypothetical FFS expenditures. The key managed care expansions that were adjusted for in the analysis included carving prescription drugs into managed care in SFY2012, carving inpatient services into managed care for STAR+PLUS in SFY2012, and carving acute and pharmacy IDD services for the nondual populations and nursing facility services into STAR+PLUS in SFY2015. For each of the service carve-ins that occurred during the analysis period, the estimated PMPM impact was added to the hypothetical FFS PMPM in the appropriate year of the carve-in. If the carve-in occurred midway through the state fiscal year, the adjusted PMPM was included in the initial, partial year of the carve-in and the full PMPM cost was included in the following year.

8.1.2.2. Managed Care Program Changes

In addition to managed care program expansions, there were multiple program changes that occurred in managed care throughout the analysis period. These program changes were most commonly related to provider reimbursement adjustments, such as therapy rate reductions, ambulance reimbursement reductions, or general provider reimbursement reductions. The annual actuarial rate setting certifications performed by HHSC's external actuaries include detailed exhibits of all program changes that occurred each year. These changes were summarized by program, risk group, and year. These program changes were analyzed to determine which program changes would have also been applicable to a FFS program. Program changes that would not be applicable to a FFS program, such as efficiency adjustments or

related-party adjustments, were not included in the program change adjustments.

8.1.2.3. Administrative Expense Changes

While the initial assumption to set the base year for the hypothetical FFS PMPM equal to the managed care PMPM in SFY2009 accounted for administrative expense differences at the time, an additional adjustment was made to the hypothetical FFS PMPM amounts to account for any year-over-year administrative expense changes in the subsequent years of the analysis. Year-over-year administrative expense changes were calculated utilizing the actual administrative expenses from SFY2009 to SFY2010 by program from the annual actuarial rate setting certifications. These year-over-year administrative expense change percentages were then applied to the hypothetical FFS cost amount, so the hypothetical FFS PMPMs account for any administrative expense changes that were seen in the managed care program.

8.1.2.4. Population Mix Changes

Population mix changes, such as members shifting from one program to another, or one risk group to another, also need to be accounted for in the analysis. This adjustment was accounted for when calculating the aggregate PMPM across all programs and risk groups. In each year, for the hypothetical FFS expenditures, the aggregate PMPM was calculated utilizing actual membership across all programs and risk groups, as well as the projected total hypothetical FFS costs, after trending and adjustments have been made.

8.1.3. Step 3: Calculate Savings Estimates

To calculate savings estimates, the hypothetical FFS PMPM across the analysis period of SFY2009 through SFY2017 was calculated. Note that the analysis does not consider federal and supplemental drug rebates, thus does not represent the net cost to the state. First, an assumption was made that in the base year of the analysis, SFY2009, FFS expenditures PMPM were equal to the managed care capitated rates PMPM.

The next step in calculating the hypothetical FFS PMPMs was trending the base year PMPM forward through SFY2017. To determine a reasonable trend rate for the hypothetical FFS costs, historical FFS trend rates for Texas were reviewed. Based on the multiple benchmark sources, as well as the historical Texas FFS trend rates, a medical trend range of 4 percent to 6 percent was established for all programs, apart from STAR+PLUS that had a medical

trend range of 5 percent to 7 percent. In addition, a pharmacy trend of 2.5 percent was established. Additional detail on the development of the trend rate ranges can be found in **Section 8.2 Data and Assumptions**. These trend rates were then applied to the appropriate programs and services across the analysis period.

Next, the managed care expansion adjustments, program change adjustments, and administrative cost adjustments, summarized above, were made to the hypothetical FFS PMPMs.

After all adjustments to the hypothetical FFS PMPMs are calculated, the difference between the hypothetical FFS PMPMs and the historical managed care PMPMs are estimated to be the financial savings realized by the managed care program.

8.2. Data and Assumptions

To calculate the adjustments and changes discussed above, several data sources were utilized.

8.2.1. Cost and Enrollment Data

Detailed cost and enrollment data from SFY2009 to SFY2017 by program, risk group, medical versus pharmacy, and FFS versus managed care was provided by HHSC. This information was utilized to calculate the historical FFS and managed care PMPMs. The annual membership by program and risk group was also used in the aggregate population mix adjustment.

8.2.2. Actuarial Rate Setting Certifications

The actuarial rate setting certifications were utilized to estimate the PMPMs for managed care program expansions and service carve-ins. Regarding service delivery area expansions, new members from service delivery area expansions were assumed to have the same PMPM cost as previously enrolled members. Based on this assumption, the PMPMs were not adjusted when service delivery area carve-ins occurred. However, these new members were adjusted for in the aggregate PMPM when the population mix adjustment is applied.

The actuarial rate setting certifications were utilized to understand annual program changes. The detailed program change exhibits from the actuarial rate setting certifications were utilized to calculate annual program changes by program and risk group. The certifications were also used to calculate the year-over-year administrative cost changes from SFY2009 to SFY2017.

8.2.3. Data Sources for Trend Development

Several data sources were utilized to determine a reasonable trend rate range for the hypothetical FFS costs across medical and prescription drug service categories. The key data sources included historical Texas FFS trend rates and the CMS Health Expenditure report. The CMS NHE trends were reviewed for both the Medicaid and Commercial populations. Additionally, these trend rates were provided by medical service category, which allowed for them each to be reviewed utilizing the medical service category mix for Texas's two largest Medicaid Managed Care programs, STAR, and STAR+PLUS.

Figure 63 below summarizes the key trend benchmark sources, annualized trend rates from these sources, and the notes on how the trend rates were considered when establishing the trend rate range for the analysis.

Figure 63. Trend Development Sources and Benchmarks.

Source	Trend Rate	Date Range	Annualized Trend	Comments
Historical Texas Medicaid FFS Trend Rates	Medicaid FFS	SFY2009-SFY2017	6.5%	See Comment 1 below
Historical Texas Medicaid FFS Trend Rates	Medicaid FFS	SFY2007-SFY2010	7.3%	See Comment 1 below
Historical Texas Medicaid FFS Trend Rates	Medicaid FFS	SFY2008-SFY2010	3.9%	See Comment 1 below
CMS NHE Report: Medicaid Trend Rates	Aggregate National Expenditure Trend Rate	SFY2009-SFY2017	1.2%	See Comment 2 below
CMS NHE Report: Medicaid Trend Rates	Aggregated Medical Trend Rate based on STAR service category mix	SFY2009-SFY2017	1.9%	See Comment 2 below
CMS NHE Report: Medicaid Trend Rates	Aggregated Medical Trend Rate based on STAR+PLUS service category mix	SFY2009-SFY2017	0.3%	See Comment 2 below

Source	Trend Rate	Date Range	Annualized Trend	Comments
CMS NHE Report: Medicaid Trend Rates	Aggregate Prescription Drug Trend Rate	SFY2009-SFY2017	2.9%	See Comment 2 below
CMS NHE Report: Commercial Trend Rates	Aggregate National Expenditure Trend Rate	SFY2009-SFY2017	5.5%	See Comment 3 below
CMS NHE Report: Commercial Trend Rates	Aggregated Medical Trend Rate based on STAR service category mix	SFY2009-SFY2017	5.8%	See Comment 3 below
CMS NHE Report: Commercial Trend Rates	Aggregated Medical Trend Rate based on STAR+PLUS service category mix	SFY2009-SFY2017	4.6%	See Comment 3 below
CMS NHE Report: Commercial Trend Rates	Aggregate Prescription Drug Trend Rate	SFY2009-SFY2017	2.5%	See Comment 3 below
Prescription Drug Trend Rates	CMS NHE Report: Medicaid	SFY2009-SFY2017	2.9%	See Comment 4 below
Prescription Drug Trend Rates	CMS NHE Report: Commercial	SFY2009-SFY2017	2.5%	See Comment 4 below
Prescription Drug Trend Rates	Express Scripts Annual Trend Report	SFY2010-SFY2017	5.5%	See Comment 4 below
Prescription Drug Trend Rates	Historical Texas Medicaid FFS Prescription Drug Trend Rates	SFY2007-SFY2012	4.8%	See Comment 4 below

Comment 1: *Due to large managed care expansion over these years, the trend varies depending on period being reviewed.*
Comment 2: *The CMS Medicaid Trend Rates have a large portion of managed care costs included which may not be reasonable to estimate a FFS trend rate.*
Comment 3: *While the CMS Commercial Trend Rates are not Medicaid expenditures, they do exclude managed care which may be a more reasonable source to determine FFS trends.*
Comment 4: *Historical Texas FFS trend rates are higher than the CMS NHE trend rates, but in line with the trend rates from the Express Scripts Annual Trend Reports.*

While prescription drug trend benchmarks were considered when establishing the prescription drug trend rate for the hypothetical FFS costs, the final prescription drug trend rate was assumed to follow the managed care trend rate over the analysis period. Consistent with information gathered for the Rider 60 report, it is understood that HHSC currently applies limitations and restrictions on how MCOs can administer prescription drug benefits to their members. Given the restrictions, for this analysis it was assumed that pharmacy utilization and cost trends would follow a similar pattern under a FFS arrangement as realized in the managed care program. Note that while pharmacy under a FFS arrangement may have higher or lower costs, as noted in the Rider 60 report, for this analysis a trend is applied to a baseline SFY2009 managed care costs to develop the hypothetical FFS cost estimate. Therefore, the analysis is only applying the trend rather than repricing under the different program structures.

Based on historical Texas FFS trend rates, as well as CMS NHE trend rates, along with actuarial judgement, it was deemed reasonable to establish the following trend ranges:[17]

Figure 64. Estimated FFS Trend Rate Range

	STAR+PLUS	All Other Programs	Prescription Drugs
Trend Rate Range	3% - 5%	3.5% - 5.5%	2.5%

The trend during SFY2014 through SFY2017 was 5.9 percent, after excluding the impact of the new programs during that period. However, when accounting for other service expansions, program changes, administrative expense changes, and population shifting from SFY2009 to SFY2017, the managed care program trended at 2.1 percent. Additionally, the estimated managed care PMPM cost trend, when accounting for other service expansions, program changes, administrative changes, and population shifting, is lower than the SFY2012 President's Budget Medicaid Baseline trends, ranging from 4.6 percent to 5.8 percent, that were used to project the without-waiver PMPM costs within the federal approval letter of the 1115 Transformation Waiver.[18]

[17] *Annualized managed care prescription drug trend from SFY2012 through SFY2017 calculated from forecasting files provided by HHSC (Prem_201411_MFC.xlsx and Prem201801.xlsx).*

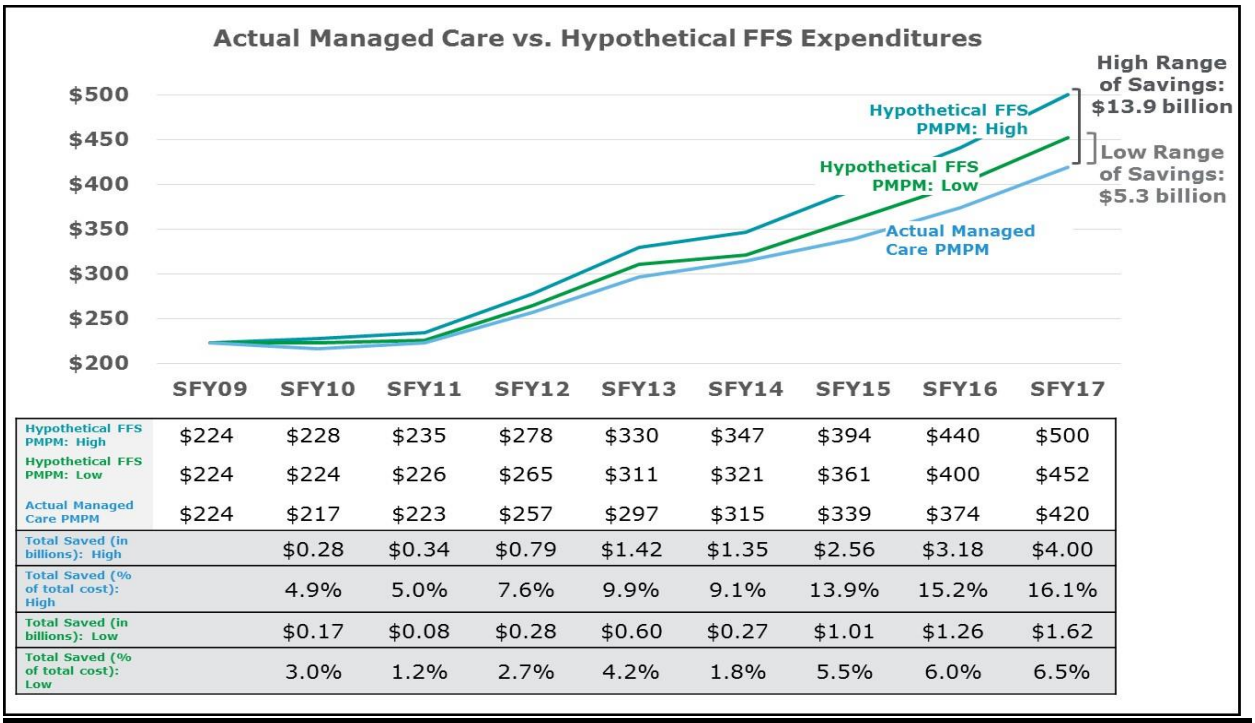
[18] *Center for Medicare and Medicaid Services, "Texas Healthcare Transformation and Quality Improvement Program," https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8393.*

8.3. Cost Impact Estimates

Based on the analysis described in the previous sections, it is estimated that the Texas Medicaid and CHIP managed care programs have generated a cost savings in the range of 4.7 percent to 11.5 percent or $5.3 billion to $13.9 billion from SFY2009 to SFY2017 when compared to hypothetical expenditures in a FFS structure. This range applies to the cost impact study population, which covered the STAR, STAR+PLUS, STAR Health, STAR Kids, Dual Demonstration, and CHIP programs representing approximately $107.5 billion in Texas Managed Care spending for this period.

The following **Figure 65** represents the savings achieved by the managed care program, compared to hypothetical expenditures under a FFS structure from the time period of SFY2009 through SFY2017. As with any study of this type and magnitude, the estimated savings in dollars are highly dependent on the assumptions being used, thus high- and low-end estimates of hypothetical FFS expenditures have been established and are represented in **Figure 65**. The estimated range of cost savings was calculated by comparing the actual managed care expenditures over the period to the high and low ends of hypothetical FFS expenditures.

Figure 65. 2009–2017 Managed Care Cost Savings Results.



	SFY09	SFY10	SFY11	SFY12	SFY13	SFY14	SFY15	SFY16	SFY17
Hypothetical FFS PMPM: High	$224	$228	$235	$278	$330	$347	$394	$440	$500
Hypothetical FFS PMPM: Low	$224	$224	$226	$265	$311	$321	$361	$400	$452
Actual Managed Care PMPM	$224	$217	$223	$257	$297	$315	$339	$374	$420
Total Saved (in billions): High		$0.28	$0.34	$0.79	$1.42	$1.35	$2.56	$3.18	$4.00
Total Saved (% of total cost): High		4.9%	5.0%	7.6%	9.9%	9.1%	13.9%	15.2%	16.1%
Total Saved (in billions): Low		$0.17	$0.08	$0.28	$0.60	$0.27	$1.01	$1.26	$1.62
Total Saved (% of total cost): Low		3.0%	1.2%	2.7%	4.2%	1.8%	5.5%	6.0%	6.5%

	SFY 09	SFY 10	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17
Hypothetical FFS PMPM: High	$224	$228	$235	$278	$330	$347	$394	$440	$500
Hypothetical FFS PMPM: Low	$224	$224	$226	$265	$311	$321	$361	$400	$452
Actual Managed Care PMPM	$224	$217	$223	$257	$297	$315	$339	$374	$420
Total Saved (in Billions): High		$0.28	$0.34	$0.79	$1.42	$1.35	$2.56	$3.18	$4.00
Total Saved (Percent of total cost): High		4.9%	5.0%	7.6%	9.9%	9.1%	13.9%	15.2%	16.1%
Total Saved (in Billions): Low		$0.17	$0.08	$0.28	$0.60	$0.27	$1.01	$1.26	$1.62
Total Saved (Percent of total cost): Low		3.0%	1.2%	2.7%	4.2%	1.8%	5.5%	6.0%	6.5%

Overall, this analysis suggests that the expanding managed care in the Texas Medicaid and CHIP programs between SFY2009 and SFY2017 has resulted in cost savings ranging from $5.3 billion to $13.9 billion, or 4.7 percent to 11.5 percent, compared to the previous FFS model. Note that this

analysis does not assess the reimbursement level of MCOs to providers or make assumptions on the impact of difference between the level of care, access to care, or QOC between FFS and managed care programs. The analysis compares the actual Texas managed care trends to industry FFS trends to estimate the savings between SFY2009 and SFY2017.

When accounting for other service expansions, program changes, administrative expense changes, and population shifting from SFY2009 to SFY2017, the managed care program PMPM cost trended at 2.1 percent across the analysis period of SFY2009 through SFY2017. The realized trend rate is lower than the FY2012 President's Budget Medicaid Baseline trends, ranging from 4.6 percent to 5.8 percent, that were used to project the without-waiver PMPM costs within the federal approval letter of the 1115 Transformation Waiver.[19]

The analysis was also performed individually by Medicaid Managed Care program. Across programs, the STAR program produced the largest estimated savings and CHIP produced estimated savings in both the high and low ends of the range. The other programs realized estimated losses under for the low range scenario.

Figure 66. Total Managed Care Cost Savings Results by Program.

Managed Care Cost Savings	STAR	STAR+ PLUS	CHIP	Other Programs
Total Saved (In billions): High	$13.4	-$0.3	$0.7	$0.1
Total Saved (Percentage of program cost): High	*19.9%*	*-0.7%*	*8.5%*	*1.4%*
Total Saved (In billions): Low	$8.1	-$2.9	$0.2	-$0.1
Total Saved (Percentage of program cost): Low	*13.1%*	*-8.0%*	*2.3%*	*-1.8%*

[19] *Center for Medicare and Medicaid Services, "Texas Healthcare Transformation and Quality Improvement Program," https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8393.*

8.3.1. ACA Health Insurance Provider's Fee and Premium Taxes

The cost savings analysis focused on savings associated with the total managed care costs across the analysis period. During this period, there were costs associated with the ACA Health Insurance Provider's Fee (HIF) and revenue collected via premium taxes, which the managed care expenditures were not adjusted for.

The HIF was an annual fee on health insurance premiums required by the ACA. This fee was built into the managed care capitation rates from 2014 through 2017, but was not included in the managed care expenditures received from HHSC for purposes of this analysis. However, if the fee was reflected in the managed care expenditures, the estimated managed care savings would decrease by the total HIF from 2014 through 2017 of approximately $310 million. HHSC provided the following data on the Health Insurer Fee from 2014 through 2017.

Figure 67. 2014–2017 Health Insurer Fees.

Year	Health Insurance Provider's Fee
2014	$210,050,899
2015	$274,792,219
2017	$275,182,941

Texas assesses a tax on health insurance premiums in the amount of 1.75 percent. Provision for this tax is included in the Medicaid and CHIP capitation rates paid by the agency to the MCOs. The State comptroller collects this portion of the revenues from the MCOs. The state agency is entitled to federal matching funds for the full capitation rate paid, including the portion of the capitation rate attributable to the 1.75 percent premium tax.

The Federal Medical Assistance Percentages are the percentage rates used to determine the matching fund rate allocated to the Medicaid Managed Care program. Thus, under a FFS arrangement the federal share of the premium tax amounts would be lost federal funding. Since the hypothetical FFS expenditures are not adjusted for the lost federal funding the analysis accounting for the lost federal funding would increase the managed care savings estimates. HHSC provided the following data on the premium tax amounts from CY2011 through CY2017.

Figure 68. 2011–2017 Premium Taxes.

Year	Federal Medical Assistance Percentages (FMAP) A	Total Estimated Premium Tax B	Federal Funding Generated (C = A x B)
2011	62.9%	$105,302,833	$66,256,543
2012	58.5%	$160,316,703	$93,769,240
2013	59.2%	$175,428,644	$103,766,043
2014	58.5%	$257,901,177	$150,949,559
2015	57.8%	$318,761,502	$184,307,900
2017	56.9%	$346,935,719	$197,371,730

9. Opportunities for Additional Cost Containment Initiatives, Delivery System Reforms, and Operational Efficiencies

Overall, Texas Medicaid and CHIP managed care cost trends appear to be in line with national Medicaid cost trends. The STAR program annualized trend rate was approximately 0.3 percent higher than annualized national averages over the analysis period of 2014 to 2017 and the STAR+PLUS annualized trend rate was approximately 2.1 percent higher than annualized national averages of the same analysis period. Additionally, aggregate program trends after adjusting for the impacts of service expansions, program changes, administrative expense changes, and population shifting were 2.1 percent from SFY2009 to SFY2017.

However, there is continuous pressure on the Texas Medicaid program to further control the cost growth of Medicaid and improve the value that provides to the Medicaid enrollees and the taxpayers. Below is a description of the ongoing and potential improvement opportunities that could further contain costs, improve the delivery system, and improve operational efficiencies.

9.1. Texas's Current Cost Containment Initiatives

As of April 2018, HHSC has identified and begun implementing cost containment initiatives that are estimated to generate approximately $411 million in general revenue savings.

A substantial portion of the savings is related to the managed care program. Approximately $101 million in general revenue savings was identified as a result of expansion of the STAR and STAR+PLUS program and the full implementation of the managed care model statewide. An additional $74 million was attributed to changes to the Medicaid MCO risk margin in the rate setting process.

Increasing the scope of hospital utilization reviews in managed care and recovering provider overpayments is estimated to total approximately $15 million in savings in the HHSC cost containment plan. HHSC plans to continue strengthening and expanding its prior authorization and utilization

reviews, resulting in additional identification and collection of overbilling or under billing during its hospital reviews.

Another initiative in the cost containment plan was reinstating previous hospital designation criteria for Rural Referral Centers, Sole Community Hospitals, and Critical Access Hospitals; HHSC expects to avoid approximately $90 million in costs due to the updated criteria.

9.2. Additional Cost Containment Opportunities

9.2.1. Opportunity for more aggressive efficiency adjustments in the rate setting process

As discussed in the Rider 61(c) report, Texas currently incorporates incentive arrangements, efficiency adjustments, and quality adjustments in a similar manner as other states that were reviewed. Efficiency adjustments are commonly used to adjust for attainable levels of cost containment. As managed care programs continue to mature, states have been increasing the use of efficiency adjustments to drive changes in the program from the shift to value-based purchasing to reducing PPRs. States have also introduced additional incentive and withhold arrangements to continuously drive their MCOs to manage medical cost trends and improve member outcomes.

From analysis of Texas's PPR rates, an increase in rates was seen across all programs from 2014 to 2017, apart from the STAR program, which realized an annualized decrease of 3 percent. Texas could further target reductions in PPR rates through capitation withhold arrangements with their MCOs to achieve additional managed care savings.

9.2.2. Potential strengthening of the experience rebates for those MCOs deemed to have excessive administrative expenses or profits above the profit-sharing thresholds

As discussed in the Rider 61(d) report, the experience rebate contractual provision in Texas' Medicaid managed care program can provide greater incentive for MCOs to moderate total program expenditures, including administrative expenses, than a potential penalty for not meeting an 85

percent Medical Loss Ratio requirement.[20] If the State seeks to provide an increased incentive to moderate administrative expense growth over time, consider revisiting the various profit-sharing thresholds within the experience rebate calculation. For instance, the State currently has a claw-back of 20 percent on profits between 3 percent and 5 percent. Increasing that percentage or getting to 100 percent at a lower level of net income (currently in excess of 12 percent) could provide an increased incentive for MCOs to moderate expenditures.

Adjustments to the profit-sharing thresholds within the experience rebate calculation should consider the impact the experience rebate contractual provision has on MCO medical expenditures. The experience rebate allows MCOs to retain some profits, some of which may currently be reinvested within the Texas Medicaid and CHIP programs. Texas MCO investments around value-based purchasing, quality improvement programs, or other innovative quality and efficiency reforms may result in a reduction in overall program expenditures and improved member access and quality of services. Therefore, the potential short-term impact of an adjustment to the experience rebate thresholds needs to be considered against the potential longer-term impacts the profit-sharing mechanism has on the Texas Medicaid and CHIP programs.

9.2.3. Additional detail regarding outsourced services to compare administrative costs by FSR cost category in a more consistent manner across the MCOs

As discussed in the Rider 61(d) report, MCOs must report on outsourced payments to third-party vendors to manage certain aspects of the managed care business within the Texas Medicaid and CHIP programs. Outsourced services generally are for typical MCO functions, such as non-capitated payments for claims management and capitated payments for behavioral health or dental benefits.

The FSRs require MCOs to disclose the vendors receiving funds for outsourced services and the total aggregate payments for those services, but there is little disclosure required on the types of services provided or spending by FSR cost category. Asking MCOs for additional details regarding the types of services provided by third-party vendors could allow for a more

[20] *Evaluation of the 1115(a) Texas Demonstration Waiver - Healthcare Transformation and Quality Improvement: Final Evaluation Report, May 30, 2017.*

comprehensive and consistent analysis of expenditures by cost category within the FSR for each MCO, encompassing both services performed in-house and those outsourced.

For example, the survey proved inconclusive on whether outsourcing services to third-party vendors correlated with lower overall administrative expenses (some MCOs with outsourced services had lower PMPM administrative expenses, while others did not). Collecting additional information to compare MCOs by FSR cost category in a more consistent manner may allow Texas to further assess which FSR cost categories are driving variances by MCO.

9.2.4. Revisions to the quality incentive program

As discussed in the Rider 61(c) report, HHSC has recently revised its MCO Pay-for-Quality program that creates both incentives and penalties based on MCO performance on certain quality measures. Up to 3 percent of the managed care premium is at risk in this program, and the program was designed so that all recouped dollars are redistributed to the high performing MCOs. Thus, there is a net zero impact at the program level. HHSC should continue to monitor the results as the program continues to mature and emerging experience becomes available.

9.2.5. Savings from implementing changes to the current method of administering prescription drug benefits

Rider 60 was commissioned to study the potential savings from implementing certain changes to HHSC's current method of administering prescription drug benefits for Medicaid and CHIP. Based on the results of this study, there is a range of cost or savings inherent in carving the pharmacy benefit out of managed care. Note that any savings scenarios should be assessed against the risks and other considerations posed herein.

9.3. Delivery System Reform Opportunities

State Medicaid programs, as well as other health care payers have increasingly focused their cost containment and outcome improvement strategies on shifting from a system that pays providers based on the volume of the services that they provide to a system that pays providers based on the outcomes achieved through the delivery of those services. State Medicaid programs with a significant portion of their Medicaid beneficiaries enrolled in a managed care program are turning to their MCOs

to act as change agents with their provider networks to achieve this shift from volume-based reimbursement to value-based reimbursement.

Beyond the current MCO contractual requirement, HHSC could, as other states have done, also further incent the MCOs to develop more value-based payment models by implementing a performance incentive/withhold program with the MCOs based on achievement of the targets for value-based payment contracts with providers. Additionally, HHSC could consider having the MCO's focus their provider value-based payment arrangements on improving select QOC and outcome measures that are part of the MCO Pay-For-Quality Program to further align the MCOs and providers to drive improvement on those measures.

10. Appendices

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10.2. State Comparison Populations Covered

Figure 69. State Comparison Populations Covered.

State	Program	Aged	Disabled Children and Adults	Children	Low-Income Adults	Medicare-Medicaid Eligible	Foster Care Children	American Indians / Alaska Natives
AZ	Arizona Health Care Cost Containment System (MCO)	√	√	√	√	√	√	
AZ	Arizona Health Care Cost Containment System (MH/SUD PIHP)	√	√	√	√	√	√	
AZ	Arizona Long-Term Care System (MCO)	√ (NF level of care)	√ (NF level of care)			√ (NF level of care)		
FL	Medical Managed Assistance Program	√	√	√	√	√	√	√
FL	Long-Term Care Managed Care Program	√	√ (NF level of care)			√		
FL	Program for the All-Inclusive Care for the Elderly (PACE)	√	√ (age 55+)			√ (age 55+)		
FL	FL Coordinated Nonemergency Transportation	√	√	√	√		√	√
NM	Program for the All-inclusive Care for the Elderly (PACE)	√	√ (age 55+)			√ (age 55+)		
NM	Salud! Behavioral Health	√	√	√	√		√	

State	Program	Aged	Disabled Children and Adults	Children	Low-Income Adults	Medicare-Medicaid Eligible	Foster Care Children	American Indians / Alaska Natives
NM	State Coverage Initiative (SCI)				√ (childless adults only)			
NM	Centennial Care	√	√	√		√	√	√
NY	Medicaid Managed Care (Partnership Plan)			√	√		√	
NY	Managed Long-Term Care Program		√			√ (excludes partial duals)		
NY	Family Health Plus (Partnership Plan)				√			
NY	Program for the All-inclusive Care for the Elderly (PACE)	√	√ (age 55+)			√ (age 55+)		
NY	Medicaid Advantage Plus (MAP)		√			√ (excludes partial duals)		
PA	Health Choices	√	√	√	√	√ (except partial duals age 21+)	√	
PA	Living Independence for the Elderly (LIFE)	√	√ (age 55+)			√		
PA	Medical Assistance Transportation	√	√	√	√	√	√	√
TN	TennCare II MCO	√	√	√	√	√ (excludes partial duals)	√	
TN	TennCare II PIHP		√ (NF level of care)	√		√ (excludes partial duals)	√	
TN	TennCare II Pharmacy PAHP	√	√	√	√	√ (full benefits duals age 21+)	√	

State	Program	Aged	Disabled Children and Adults	Children	Low-Income Adults	Medicare-Medicaid Eligible	Foster Care Children	American Indians / Alaska Natives
TN	TennCare II Dental PAHP		√ (age <21 only)	√		√ (full benefits duals age 21+)		
TN	Program for the All-Inclusive Care for the Elderly (PACE)	√	√ (age 55+)			√		
TX	STAR		√	√	√			
TX	STAR+ Plus	√	√	√		√ (excludes partial duals)		
TX	STAR Health		√	√			√	

10.3. Comparison States Services Covered

Figure 70. Comparison States Services Covered.

State	Program	IP	PCP and OP	Pharmacy	LTC	Personal Care/ HCBS	IP Behav. Serv.	OP Behav. Serv.	Dental	Trans-portation
AZ	Arizona Health Care Cost Containment System (MCO)	√	√	√		√	√	√	√	√
AZ	Arizona Health Care Cost Containment System (MH/SUD PIHP)		√	√	√		√	√		√
AZ	Arizona Long-Term Care System (MCO)	√	√	√	√	√	√	√	√	√
FL	Medical Managed Assistance Program	√	√	√				√	√	√
FL	Long-Term Care Managed Care Program	√	√	√		√			√	√
FL	Program for the All-Inclusive Care for the Elderly (PACE)	√	√	√	√	√	√	√	√	√
FL	FL Coordinated Nonemergency Transportation									√
NM	Program for the All-Inclusive Care for the Elderly (PACE)	√	√	√	√	√	√	√	√	√
NM	Salud! Behavioral Health			√			√	√		
NM	State Coverage Initiative (SCI)	√	√	√			√	√		
NM	Centennial Care	√	√	√	√	√			√	

State	Program	IP	PCP and OP	Pharmacy	LTC	Personal Care/ HCBS	IP Behav. Serv.	OP Behav. Serv.	Dental	Trans-portation
NY	Medicaid Managed Care* (Partnership Plan)	√	√			√	√	√	√	√
NY	Managed Long-Term Care Program		√		√	√			√	√
NY	Family Health Plus (Partnership Plan)	√	√	√		√	√	√	√	√
NY	Program for the All-Inclusive Care for the Elderly (PACE)	√	√	√	√	√	√	√	√	√
NY	Medicaid Advantage Plus (MAP)	√	√	√	√	√			√	√
PA	HealthChoices	√	√	√		√	√	√	√	√
PA	Living Independence for the Elderly (LIFE)	√	√	√	√	√	√	√	√	√
PA	Medical Assistance Transportation									√
TN	TennCare II MCO	√	√		√	√	√	√		√
TN	TennCare II PIHP	√	√		√	√	√	√		√
TN	TennCare II Pharmacy PAHP			√						
TN	TennCare II Dental PAHP								√	
TN	Program for the All-Inclusive Care for the Elderly (PACE)	√	√	√	√	√	√	√	√	√
TX	STAR	√	√	√			√	√	√	√
TX	STAR+ Plus	√	√		√	√	√	√	√	√
TX	STAR Health	√	√	√	√	√	√	√	√	√

For transportation, Texas's STAR program excludes non-emergency transfer.

10.4. Time and Distance Standards

Additional discussion of MCS distance and time standards for network adequacy can be found in the **Rider 61(b) Report Section**.

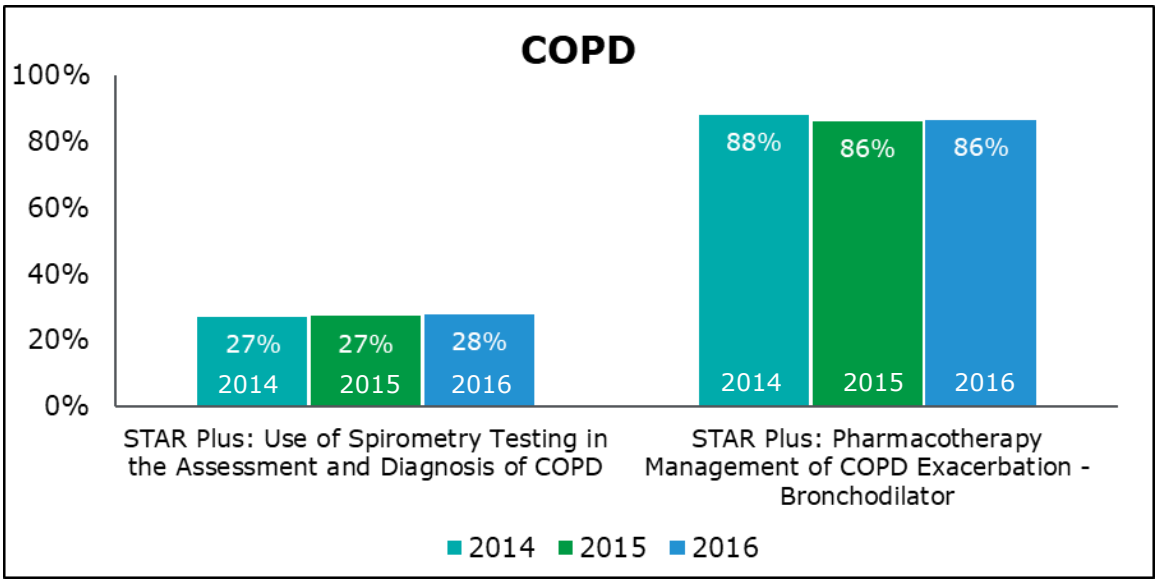
Figure 71. Network Adequacy Distance and Time Standards.

Standards by Provider Type for Distance in Miles and Travel Time in Minutes	Distance for Metro	Distance for Micro	Distance for Rural	Travel Time for Metro	Travel Time for Micro	Travel Time for Rural
Behavioral Health – Outpatient	30	30	75	45	45	90
Hospital – Acute Care	30	30	30	45	45	45
Prenatal	10	20	30	15	30	40
Primary Care Provider (PCP)	10	20	30	15	30	40
Specialty Care Provider - Cardiovascular Disease	20	35	60	30	50	75
Specialty Care Provider - ENT (Otolaryngology)	30	60	75	45	80	90
Specialty Care Provider - General Surgeon	20	35	60	30	50	75
Specialty Care Provider - OB/GYN (Non-primary Care Physician)	30	60	75	45	80	90
Specialty Care Provider - Ophthalmologist	20	35	60	30	50	75
Specialty Care Provider - Orthopedist	20	35	60	30	50	75
Specialty Care Provider - Pediatrician (Non-primary Care Physician)	20	35	60	30	50	75
Specialty Care Provider - Psychiatrist	30	45	60	45	60	75
Specialty Care Provider - Urologist	30	45	60	45	60	75

Standards by Provider Type for Distance in Miles and Travel Time in Minutes	Distance for Metro	Distance for Micro	Distance for Rural	Travel Time for Metro	Travel Time for Micro	Travel Time for Rural
Specialty Care Provider - Other Physician Specialties	30	60	75	45	80	90
Occupational, Physical, or Speech Therapy	30	60	60	45	80	75
Nursing Facility	75	75	75	N/A	N/A	N/A
Main Dentist (General or Pediatric)	30	30	75	45	45	90
Dental Specialists - Pediatric Dental	30	30	75	45	45	90
Dental Specialists - Endodontist, Periodontist, or Prosthodontist	75	75	75	90	90	90
Dental Specialists - Orthodontist	75	75	75	90	90	90
Dental Specialists - Oral Surgeons	75	75	75	90	90	90

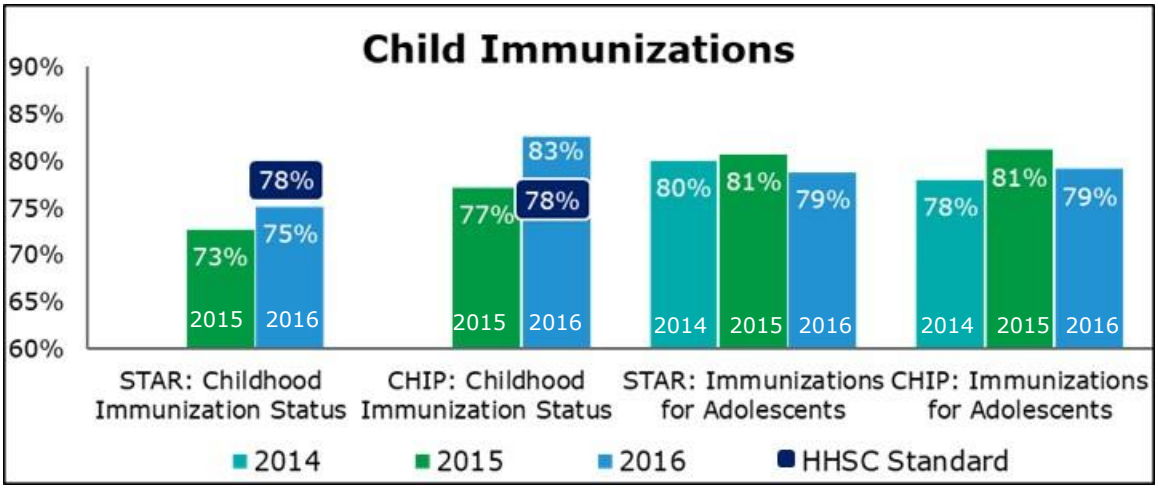
10.5. 2014–2016 STAR+PLUS COPD HEDIS® Scores

Figure 72. 2014–2017 STAR+PLUS COPD HEDIS® Scores.



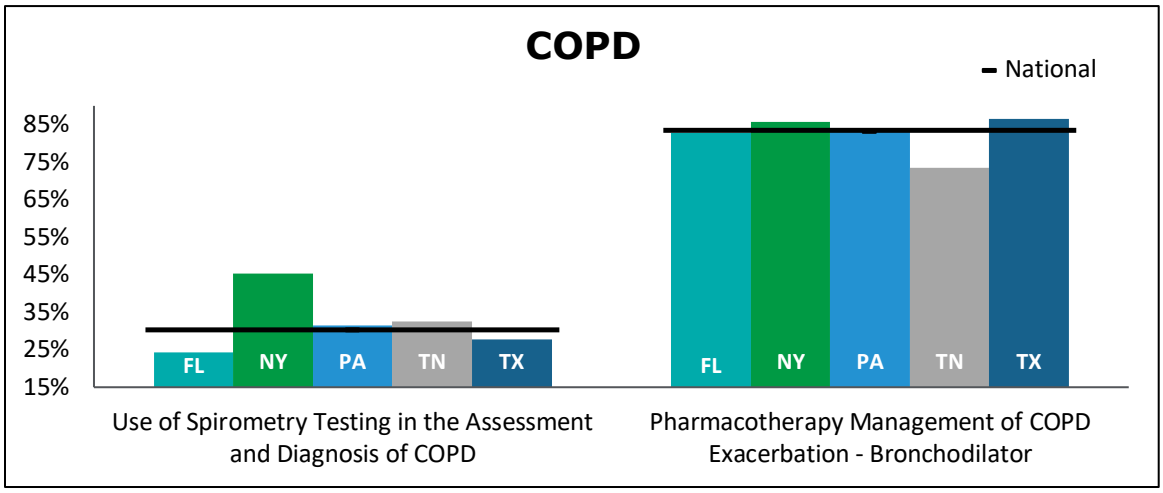
10.6. 2014–2016 Children Immunization HEDIS® Scores

Figure 73. 2014–2017 Children Immunization HEDIS® Scores.



10.7. Comparison of 2017 COPD HEDIS® Measure Results

Figure 74. Comparison of 2017 COPD HEDIS® Measure Results.



10.8. 2013–2015 Dental Medicaid Quality Measures

Figure 75. 2013–2015 Dental Medicaid HEDIS® Measures.

Dental Quality Measures for Dental Medicaid	2013	2014	2015	Annualized Trend (2013–2015)
Care Continuity	56%	60%	60%	3%
Oral Evaluation	68%	67%	69%	1%
PMPM Cost of Clinical Services	$29	$30	$30	1%
Sealants for 6–9-Year-Old Children at Elevated Caries Risk	24%	25%	25%	1%
Sealants for 10-14-Year-Old Children at Elevated Caries Risk	16%	17%	17%	3%
Topical Fluoride for Children at Elevated Caries Risk	39%	40%	42%	4%
Treatment Services	32%	32%	32%	0%
Utilization of Services	70%	70%	71%	1%
Annual Dental Visit	77%	76%	78%	1%
Use of Dental Sealants on 1st Permanent Molar Teeth	27%	27%	27%	1%
Use of Dental Sealants on 2nd Permanent Molar Teeth	15%	16%	16%	2%
Use of Preventive Dental Services	74%	74%	76%	1%
First Dental Home Initiative	67%	67%	68%	1%
Texas Health Steps Dental Checkup Within 90 Days of Enrollment	27%	26%	27%	0%
Texas Health Steps Dental Checkups	37%	37%	38%	1%

10.9. 2013–2015 Dental CHIP Quality Measures

Figure 76. 2013–2015 Dental CHIP HEDIS® Measures.

Dental Quality Measures for Dental CHIP	2013	2014	2015	Annualized Trend (2013 - 2015)
Care Continuity	48%	50%	54%	7%
Oral Evaluation	59%	59%	63%	4%
PMPM Cost of Clinical Services	$18	$19	$20	5%
Sealants for 6– to 9-Year-Old Children at Elevated Caries Risk	21%	20%	20%	-1%
Sealants for 10- to 14-Year-Old Children at Elevated Caries Risk	12%	13%	13%	2%
Topical Fluoride For Children at Elevated Caries Risk	29%	33%	38%	13%
Treatment Services	27%	26%	26%	-2%
Utilization of Services	61%	62%	66%	4%
Annual Dental Visit (ADV)	69%	70%	74%	4%
Use of Dental Sealants on 1st Permanent Molar Teeth	21%	21%	21%	0%
Use of Dental Sealants on 2nd Permanent Molar Teeth	11%	12%	12%	2%
Use of Preventive Dental Services	67%	68%	73%	4%

10.10. Compliance Standards for STAR Program

Figure 77. Compliance Standards for STAR Program.

Service Type	Compliance Standard
PCP Preventive Adults	90 Days
PCP Routine Adults	14 days
PCP Urgent Adults	1 day
PCP Preventive Children	90 days
PCP Routine Children	14 days
PCP Urgent Children	1 day
Low-Risk OBGYN	14 days
High-Risk OBGYN	5 days
Third Trimester OBGYN	5 days
Behavioral Health Adults	14 days
Behavioral Health Children	14 days

10.11. Compliance Standards for STAR+PLUS Program

Figure 78. Compliance Standards for STAR+PLUS Program.

Service Type	Compliance Standard
PCP Preventive	90 days
PCP Routine	14 days
PCP Urgent	1 day
Vision	No Referral Needed
Behavioral Health	14 days

10.12. Compliance Standards for CHIP Program

Figure 79. Compliance Standards for CHIP Program.

Service Type	Compliance Standard
PCP Preventive	90 days
PCP Routine	14 days
PCP Urgent	1 day
Vision	No Referral Needed
Behavioral Health	14 Days

10.13. Access Results for Dental Program

Figure 80. Access Results for Dental Program.

Question from 2015 STAR and CHIP Dental Access Results	Criteria	STAR %	CHIP %
Dental Appointment Availability: In the last six months, how often were your child's dental appointments as soon as you wanted?	Usually or Always	92.6%	91.0%
Emergency Dental Appointment Availability: If your child needed to see a dentist right away because of a dental emergency in the last six months, did he or she get to see a dentist as soon as you wanted?	Definitely Yes or Sometimes Yes	61.3%	60.3%
Specialty Dental Appointment Availability: If you tried to get an appointment for your child with a dentist who specializes in a particular type of dental care in the last six months, how often did you get an appointment for your child as soon as you wanted?	Usually or Always	70.4%	56.3%
Dental Appointment Waiting Time: In the last six months, how often did your child have to spend more than 15 minutes in the waiting room before he or she saw someone for an appointment?	Never or Sometimes	74.6%	74.3%
Dental Appointment Waiting Time Communication: If your child had to spend more than 15 minutes in the waiting room before he or she saw someone for an appointment, how often did someone tell you why there was a delay or how long the delay would be?	Usually or Always	37.0%	39.6%
Ease of Access to Dental Care: Using any number from 0 to 10, where 0 is extremely difficult and 10 is extremely easy, what number would you use to rate how easy it was for you to find a dentist for your child?	Score of 9 or 10	76.0%	70.0%

10.14. 2015 STAR and CHIP Dental CAHPS® Results

Figure 81. 2015 STAR and CHIP Dental CAHPS® Results.

Measure No.	Question from 2015 STAR and CHIP Dental CAHPS® Results	Criteria	STAR Percent	CHIP Percent
6	In the last six months, how often did your child's regular dentist explain things in a way that was easy to understand?	Usually or Always	93%	93%
7	In the last six months, how often did your child's regular dentist listen carefully to you?	Usually or Always	93%	94%
8	In the last six months, how often did your child's regular dentist treat you with courtesy and respect?	Usually or Always	97%	98%
9	In the last six months, how often did your child's regular dentist spend enough time with your child?	Usually or Always	93%	90%
10	Using any number from 0 to 10, where 0 is the worst regular dentist possible and 10 is the best regular dentist possible, what number would you use to rate your child's regular dentist?	Score of 9 or 10	78%	72%
11	In the last six months, how often did the dentists or dental staff do everything they could to help your child feel as comfortable as possible during your child's dental work?	Usually or Always	95%	96%
12	In the last six months, how often did the dentists or dental staff explain what they were doing while treating your child?	Usually or Always	96%	95%
18	Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate all of the dental care your child received in the last six months?	Score of 9 or 10	79%	70%
28	In the last six months, how often did the customer service staff at your child's dental plan treat you with courtesy and respect?	Usually or Always	97%	95%

Measure No.	Question from 2015 STAR and CHIP Dental CAHPS® Results	Criteria	STAR Percent	CHIP Percent
29	Using any number from 0 to 10, where 0 is the worst dental plan possible and 10 is the best dental plan possible, what number would you use to rate your child's dental plan?	Score of 9 or 10	82%	69%
31	Would you recommend your child's dental plan to people who want to join?	Definitely Yes or Probably Yes	99%	96%

10.15. Estimated Managed Care Cost Savings Analysis Sources

Figure 82. Estimated Managed Care Cost Savings Analysis Data Sources.

Category	Adjustment Made	Data Sources
Program Changes	Changes to the program benefits for each year and each risk group	SFY2009-SFY2017 Rate Certifications: https://rad.hhs.texas.gov/managed-care-services
Other Program Adjustments	SFY2010 PAS Cost Increases SFY2011 and SFY2012 STAR+PLUS Service Delivery Area Carve-Ins SFY2012 STAR+PLUS Inpatient Carve-In SFY2013 STAR Risk Group Change Adjustment SFY2015 STAR+PLUS Nursing Facility and IDD Carve-Ins	SFY2009-SFY2017 Rate Certifications: https://rad.hhs.texas.gov/managed-care-services and SFY2009-SFY2017 Enrollment and Expenditure Data for Texas provided by HHSC: (Prem201801.xlsx, Prem_201411.xlsx)
Administrative Changes	Year-over-year changes to administrative costs	SFY2009-SFY2017 Rate Certifications: https://rad.hhs.texas.gov/managed-care-services

Rider 61(b): Evaluation of Medicaid and CHIP Managed Care – Review of Managed Care Contract Review and Oversight Function

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1. Rider 61(b) Executive Summary

The 85th Legislature of the State of Texas required the Texas Health and Human Services Commission (HHSC) to conduct a review of the agency's contract management and oversight function for Medicaid and Children's Health Insurance Program (CHIP) managed care contracts.

Two frameworks were used to conduct the assessment: 1) the Medicaid and CHIP Managed Care Final Rule issued by the Centers for Medicare & Medicaid Services (CMS) in May 2016 and 2) Contract Management Maturity Model (CMMM)[21], introduced by the National Contract Management Association in 2005 to help organizations measure the maturity of their contract management processes.

The assessment was based on nine interviews, 16 sessions with leaders and staff from HHSC sections and offices, the review of over 300 documents, and the use of relevant benchmarks from other states. The assessment was conducted between February 21, 2018, and June 1, 2018.

The assessment reviewed requirements across nine functional areas, eight of which align with the Medicaid and CHIP Managed Care Final Rule and are described in **Section 2.1.1 CMS Medicaid and CHIP Managed Care Final Rule**.

1. State Monitoring Standards
2. Quality of Care
3. Network Adequacy and Access to Care
4. Program Integrity
5. Grievances and Appeals
6. Marketing and Communication Activities
7. Enrollments and Disenrollments
8. Rate Development Standards

In addition, a ninth area, Contract Amendment and Procurements[22], was defined in Rider 61 as a functional area to review.

[21] G.A. Garrett and R.G. Rendon, Contract Management Organizational Assessment Tools (McLean, VA: NCMA, 2005).

[22] "The vendor will also conduct a review of the processes used for managing contract amendments and new procurements." - General Appropriations Act for the 2018-19 Biennium, Senate Bill No. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, Rider 61, Subsection (b)).

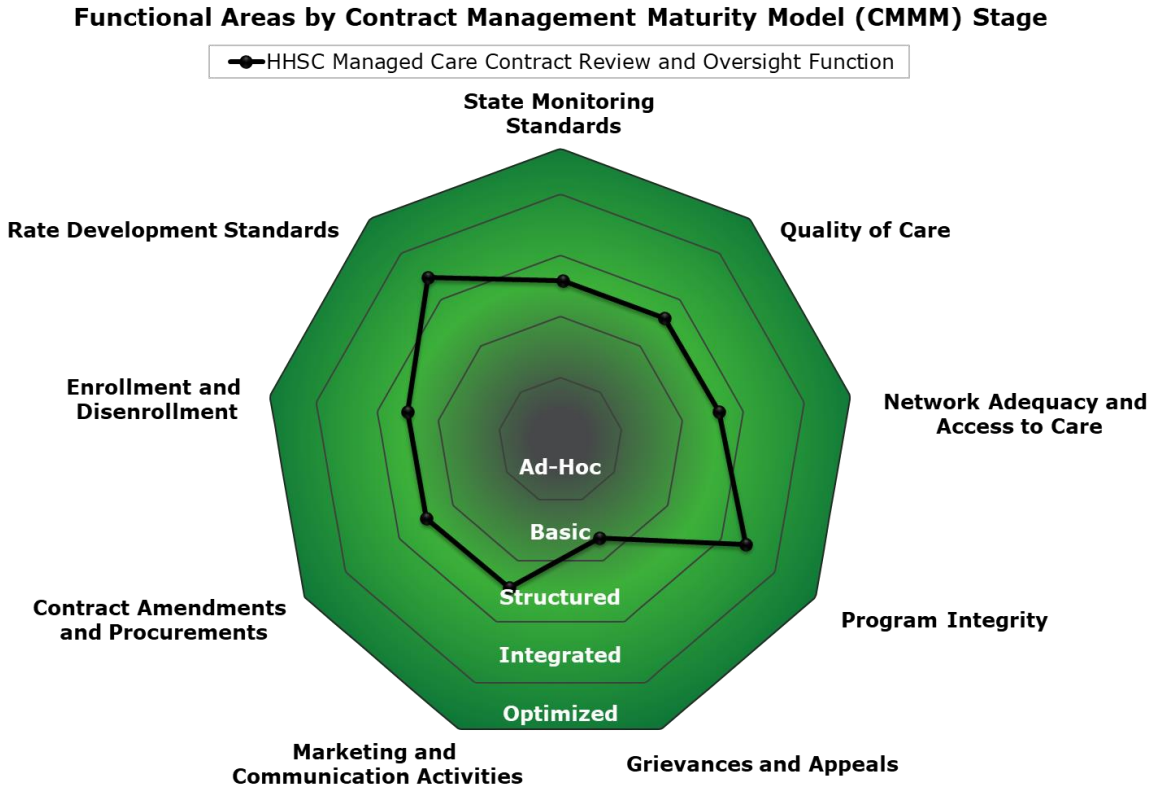
For the purposes of this assessment, the nine functional areas served as a framework for applying the CMMM. The CMMM measures five levels of maturity:

- **Ad-Hoc** – some processes are established and exist, but are ad-hoc
- **Basic** – disciplined process capability
- **Structured** – fully established and institutionalized process capability
- **Integrated** – processes are integrated with other enterprise processes
- **Optimized** – all processes are optimized, focused on continuous improvement and adoption of lessons learned and best practices

These levels are further described in **Section 2.1.2 CMMM Framework**.

The review of HHSC's Medicaid and CHIP Managed Care contract review and oversight function indicates that the CMMM level for each of the functional areas assessed includes Basic, Structured, and Integrated **(Figure 1).** In **Sections 5.1 to 5.9** of the report, the rationale for these levels is provided for each functional area.

Figure 1. CMMM Stages of HHSC's Medicaid and CHIP Managed Care Contract Review and Oversight Functional Areas.



1.1. Summary of Findings

Findings for each functional area were developed for HHSC to further evolve its managed care contract review and oversight capabilities. Each finding was broadly characterized as either 1) "Continue," which means that the activity is well aligned to the oversight function and should be maintained and/or enhanced; or 2) "Opportunity," which means that HHSC could introduce new activities to improve the oversight function. Details of these findings, along with information to support the findings, can be found in **Sections 5.1 to 5.9**.

1.1.1. Findings: Activities for HHSC to Continue

The findings relative to the activities that HHSC should continue to execute, indicate that HHSC has built a strong foundation for its oversight of Medicaid and CHIP managed care programs **(Figure 2)**. The findings fall into four broad categories that emphasize some of the key accomplishments of HHSC's Medicaid and CHIP managed care oversight efforts:

1. **Adherence to standard processes**: HHSC has developed and documented processes for its core managed care contract management and oversight functions. Staff are aware of these processes and follow them.
2. **Collaboration within and outside of HHSC**: HHSC works across divisions and with other entities in executing a wide range of contract management and oversight functions.
3. **Validation of information utilized for oversight**: HHSC has established processes to validate and audit much of the data provided to them for oversight purposes.
4. **Provision of guidance**: HHSC has developed written guidance for Managed Care Organizations (MCOs) for many of the elements of the various Medicaid programs.

Figure 2. Findings to Continue Activities Well-Aligned to the Managed Care Oversight Function.

Adherence to standardized processes

***Continue:* Activities well-aligned to the managed care oversight function**	**Functional Area Reference**
Continue Accountability through the Strengthened Graduated Remediation Process and Liquidated Damages (LDs)	5.1. State Monitoring Standards
Continue to Improve Grievances and Appeals Data Aggregation and Identification of Trends	5.5. Grievances and Appeals
Continue Recovery Activities	5.4. Program Integrity

Collaboration within and outside of HHSC

***Continue:* Activities well-aligned to the managed care oversight function**	**Functional Area Reference**
Continue to Enhance Coordination of Audits and Reviews	5.1. State Monitoring Standards
Continue with Integrated Managed Care Compliance and Operations (MCCO) Teams	5.1. State Monitoring Standards
Continue to Strengthen Integration of Managed Care Oversight Across Divisions	5.1. State Monitoring Standards

***Continue:* Activities well-aligned to the managed care oversight function**	**Functional Area Reference**
Continue Elevation of the Medicaid and CHIP Services (MCS) Major Procurement Office	5.7. Contract Amendments and Procurements
Continue the Texas Fraud Prevention Partnership	5.4. Program Integrity

Validation of information utilized for oversight

***Continue:* Activities well-aligned to the managed care oversight function**	**Functional Area Reference**
Continue the MCO Risk Assessment Instrument	5.1. State Monitoring Standards
Continue to Enhance Validation of Encounter Data	5.2. Quality of Care
Continue Use of the External Quality Review Organization (EQRO)	5.2. Quality of Care
Continue to Enhance the Texas Healthcare Learning Collaborative (THLC) Portal	5.2. Quality of Care
Continue Efforts to Automate Deliverable Submissions	5.1. State Monitoring Standards

Provision of guidance

***Continue:* Activities well-aligned to the managed care oversight function**	**Functional Area Reference**
Continue Ongoing Effort to Streamline MCO Deliverables	5.1. State Monitoring Standards
Continue the Newly Redesigned Pay-for-Quality (P4Q) Program	5.2. Quality of Care
Continue to Improve Guidance on Utilization Management and Medical Necessity Determinations	5.2. Quality of Care
Continue the Consumer (Member) Information Toolkit	5.6. Marketing and Communication Activities
Continue to Provide Financial Reporting Transparency	5.9. Rate Development Standards

1.1.2. Findings: Opportunities for HHSC to Consider

Opportunities include new activities that HHSC may wish to implement to improve the oversight function **(Figure 3)**. These opportunities fall into five broad categories:

1. **Increase efficiency and automation of processes:** There are number of opportunities to take existing processes and make them less time and/or labor-consuming.
2. **Share information across organizational units:** HHSC has opportunities to enhance sharing of information gathered for one oversight function to another oversight function to strengthen oversight efforts using information that already exists.
3. **Improve data integration:** Merging existing data sources or pulling in additional data sources could offer HHSC more insights on addressing certain oversight functions.
4. **Improve the effectiveness of priority functions:** HHSC has opportunities to strengthen some key oversight efforts.
5. **Increase transparency of relevant information:** While HHSC makes a significant amount of information available to the public, there are additional opportunities to provide more information to policy makers and consumers.

Figure 3. Findings for Opportunities to Enhance the Managed Care Oversight Function.

Increase efficiency and automation of processes

***Opportunity:* Findings to enhance the managed care oversight function**	**Functional Area Reference**
Opportunity to Introduce a Summary Compliance Framework	5.1. State Monitoring Standards
Opportunity for Process Automation	5.3. Network Adequacy and Access to Care
Opportunity to Align Entry Points for Grievances	5.5. Grievances and Appeals
Opportunity to Streamline Planning and Development Procurement Phase	5.7. Contract Amendments and Procurements
Opportunity to Improve the Manual Contracting Process	5.7. Contract Amendments and Procurements
Opportunity to Improve Contract Amendment Guidance	5.7. Contract Amendments and Procurements

Share information across organizational units

***Opportunity:* Findings to enhance the managed care oversight function**	**Functional Area Reference**
Opportunity to Align Network Adequacy and Access to Care Efforts	5.3. Network Adequacy and Access to Care
Opportunity to Introduce Additional Factors into the Default Enrollment Methodology	5.8. Enrollments and Disenrollments

Improve data integration

***Opportunity:* Findings to enhance the managed care oversight function**	**Functional Area Reference**
Opportunity for Network Adequacy Standards for Long Term Services and Supports (LTSS) provider types	5.3. Network Adequacy and Access to Care
Opportunity to Introduce Additional Factors in Network Adequacy Analysis	5.3. Network Adequacy and Access to Care
Opportunity to Leverage Performance Metrics to Make Data-Driven Decisions	5.9. Rate Development Standards

Improve the effectiveness of priority functions

***Opportunity:* Findings to enhance the managed care oversight function**	**Functional Area Reference**
Opportunity to Increase Utilization Review Resources	5.2. Quality of Care
Opportunity to Update the Methodology for Measuring Program Integrity	5.4. Program Integrity
Opportunity to Enhance Education on the Issue Resolution Process	5.5. Grievances and Appeals
Opportunity to Validate New Member Onboarding	5.6. Marketing and Communication Activities
Opportunity to Enhance Data Validation with Financial Subject Matter Expertise	5.9. Rate Development Standards

Increase transparency of relevant information

Opportunity: **Findings to enhance the managed care oversight function**	**Functional Area Reference**
Opportunity to Enhance the HHSC website	5.6. Marketing and Communication Activities
Opportunity to Enhance Managed Care Report Cards	5.8. Enrollments and Disenrollments

2. Introduction and Purpose

According to the General Appropriations Act for the 2018-19 Biennium, Senate Bill No. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, **Rider 61, Subsection (b)**:

"Out of funds appropriated above in L.1.1, Health and Human Services (HHS) System Supports, Texas Health and Human Services Commission (HHSC) shall conduct a review of the agency's contract management and oversight function for Medicaid and Children's Health Insurance Program (CHIP) managed care contracts. The review should consider the effectiveness and frequency of audits; the data necessary to evaluate existing contract requirements and enforcement, including penalties; and the need for additional training and resources for effective contract management."

2.1. Approach and Frameworks

Two frameworks were applied to assess Texas's Medicaid and CHIP managed care contract review and oversight function. The first is the regulatory framework established by the Centers for Medicare & Medicaid Services (CMS) in April 2016 through the Medicaid and CHIP Managed Care Final Rule[23], which includes several requirements for state oversight of Medicaid and CHIP managed care programs.

The second framework utilized for this assessment is the Contract Management Maturity Model (CMMM)[24], introduced by the National Contract Management Association in 2005 to help organizations measure the maturity of their contract management processes.

2.1.1. CMS Medicaid and CHIP Managed Care Final Rule

The CMS Medicaid and CHIP Managed Care Final Rule aligns key requirements with those of other health insurance coverage programs, modernizes how states purchase managed care for individuals, and

[23] *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third-Party Liability; Final Rule, 81 Fed. Reg. 88 (May 6, 2016). Federal Register: The Daily Journal of the United States. Web. 6 May 2016.*

[24] *G.A. Garrett and R.G. Rendon, Contract Management Organizational Assessment Tools (McLean, VA: NCMA, 2005).*

strengthens the consumer experience and key consumer protections. It includes the following goals:

- To support state efforts of advancing delivery system reform and improve the quality of care
- To strengthen the individual's experience of care and key beneficiary protections
- To strengthen program integrity by improving accountability and transparency
- To align key Medicaid and CHIP managed care requirements with other health coverage programs

Eight functional areas from the CMS Medicaid and CHIP Managed Care Final Rule align with the scope of review required in Rider 61b. The table below outlines those functional areas and supporting requirements, as well as those requirements from Rider 61b that align with these functional areas (**Figure 4**). In addition, a ninth functional area, Contract Amendment and Procurements[25], is defined in Rider 61 as an additional functional area to review.

Figure 4. Functional Area Requirements.

Functional Area	Requirement Category	Requirements
State Monitoring Standards	State Monitoring Requirements	States must have a monitoring system to address all aspects of the managed care program, including performance of each Managed Care Organization (MCO). [42 CFR 438.66]
State Monitoring Standards	Data Collected by HHSC to Evaluate Existing Contract Requirements	The review should consider the data necessary to evaluate existing contract requirements. This includes Quarterly Performance Reports (QPRs), deliverables, and Agreed-Upon Procedures (AUPs). [Rider 61b]
State Monitoring Standards	Reviews/Audits Conducted by HHSC	The review should consider the effectiveness and frequency of audits. [Rider 61b]
State Monitoring Standards	Contract Enforcement and Penalties	The review should consider the data necessary to evaluate contract enforcement, including penalties. [Rider 61b]

[25] *"The vendor will also conduct a review of the processes used for managing contract amendments and new procurements." - General Appropriations Act for the 2018-19 Biennium, Senate Bill No. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, Rider 61, Subsection (b)).*

Functional Area	Requirement Category	Requirements
Quality of Care	Managed Care Quality Strategy	Each State contracting with an MCO must draft and implement a quality strategy for assessing and improving the quality of health care and services furnished by the MCO entity. [42 CFR 438.340]
Quality of Care	Quality Assessment and Performance Improvement (QAPI) Program	States must require MCOs, through contracts, to establish and implement an ongoing comprehensive QAPI program for services it furnishes to enrollees. [42 CFR 438.330 / 42 CFR 457.1240]
Quality of Care	External Quality Review	Each MCO must be reviewed by an External Quality Review Organization (EQRO) at least annually. [42 CFR 438.350 / 42 CFR 457.1250]
Quality of Care	Encounter Data	States must validate that encounter data for accuracy and completeness as required under 438.242 before submitting data to CMS. [42 CFR 438.818]
Quality of Care	Health Information Systems	Each MCO must maintain a system that collects, analyzes, integrates, and reports data. Systems must provide data on utilization, claims, grievances/appeals, and disenrollments for reasons other than loss of Medicaid eligibility. [42 CFR 438.242]
Network Adequacy and Access to Care	Network Adequacy Standards	States that contract with MCOs must develop and enforce network adequacy standards. At minimum, time and distance standards must be established for: primary care, OB/GYN, behavioral health, specialists, hospitals, pharmacies, pediatric dental, and other provider types when it promotes the objectives of the Medicaid program. States that cover Long Term Services and Supports (LTSS) must develop network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services. [42 CFR 438.68]
Program Integrity	Program Integrity Requirements	The State, through its contract with MCOs, must require that the MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. [42 CFR 438.608]

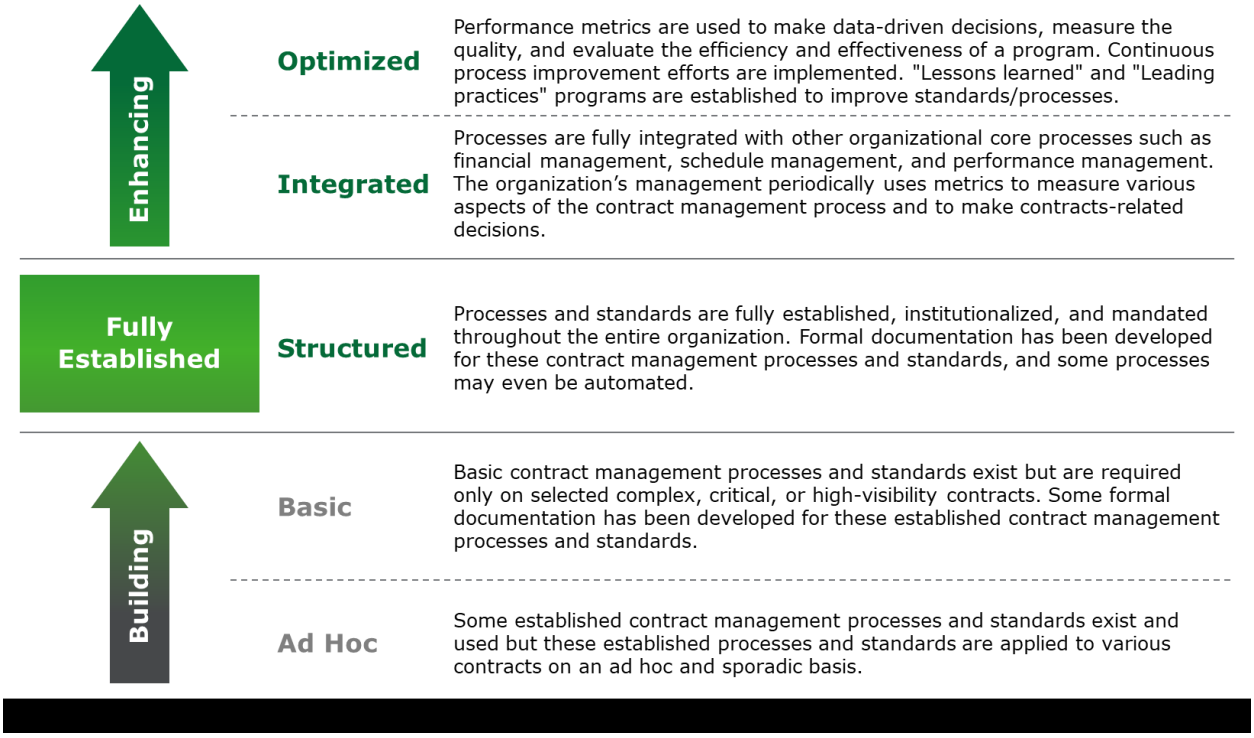
Functional Area	Requirement Category	Requirements
Grievances and Appeals	Grievances and Appeals System	Each MCO must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system. [42 CFR 438.402 / 42 CFR 457.1260]
Marketing Activities	Marketing Activities	Specify the methods by which the entity ensures the State agency that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the beneficiaries or the State agency. [42 CFR 438.104]
Contract Amendments and Procurements	Contract Amendments and Procurements	The vendor will also conduct a review of the processes used for managing contract amendments and new procurements. [Rider 61b]
Enrollments/ Disenrollments	Member Enrollments	For mandatory programs, states may use an active enrollment process where the enrollee chooses a plan or, if not, is assigned to a plan using the State's default enrollment process; or they may use a passive enrollment process where the person either maintains enrollment in the assigned plan or selects a different plan. In the passive enrollment process, if the enrollee does not make a selection during the time allowed by the State, the plan selected by the passive enrollment remains in effect. [42 CFR 438.54]
Enrollments/ Disenrollments	Member Disenrollments	All MCO contracts must specify the reasons MCOs may request disenrollment of an enrollee and prohibit the MCO from requesting disenrollment of an enrollee due to an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs. [42 CFR 438.56]
Rate Development Standards	Rate Development Standards	States must provide all validated encounter data, fee-for-service (FFS) data, and audited financial reports for the populations served by MCOs to the actuary developing capitation rates for three prior years. [42 CFR 438.5]

2.1.2. Contract Management Maturity Model

The CMMM measures five levels of maturity shown in **Figure 5** ranging from an "Ad-Hoc" level to a level in which all processes are "Optimized," focused on continuous improvement and adoption of lessons learned and best practices.

According to the National Contract Management Association, more than 200 companies from 12 different industries have successfully applied the tools to measure the maturity of their contract management processes.[26] The typical CMMM assessment covers six contract management key processes: procurement planning, solicitation planning, solicitation, source selection, contract administration, and contract closeout. However, since this is a review of managed care contract review and oversight function, the tool was adapted to cover the functional areas described in **Section 2.1.1 CMS Medicaid and CHIP Managed Care Final Rule**.

Figure 5. The CMMM.



[redacted]

[26] *National Contract Management Association (NCMA), Contract Management Process Maturity: The Key for Organizational Survival, https://www.ncmahq.org/stay-informed/contract-management-magazine/contract-management-magazine---article-detail/improving-the-u.s.-federal-acquisition-workforce-part-2-of-3-contract-management-process-maturity-the-key-for-organizational-survival.*

2.1.3. Approach

The approach employed to meet the Rider 61b's requirements includes:

- **Goals and Objectives** – Nine interviews were conducted with MCS leaders to understand the goals, objectives, and vision for the managed care contract review and oversight function.
- **Operating Model and Functional areas** – Sixteen sessions were facilitated with HHSC staff to assess the maturity stages for the nine managed care contract review and oversight functional areas, as well as to clarify questions and results from the document review and analysis. The list of sessions conducted is in **Appendix 3.2**. The scope of these sessions and this assessment included reviewing HHSC's oversight functions and processes, and less so on the effectiveness of those processes and the performance of the managed care programs.
- **Benchmarks** – The review included leading practices and benchmarks, where relevant, from other state Medicaid programs such as:
  - **Published Managed Care Quality Data** – Texas Healthcare Collaborative Learning (THLC) Portal, a tool supporting Texas's Managed Care Quality strategy, and other published quality data was compared to other states' published quality data on their Medicaid Managed Care programs, including those in California, Louisiana, New York, Minnesota, and Tennessee. See **Section 5.2 Quality of Care**, for the comparison.
  - **Program Integrity** – Data[27] reported by State Medicaid Fraud Control Units (MFCUs) to the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services was used to compare percentage of recoveries[28] against total Medicaid expenditures for the top ten states with the highest Medicaid spending, including California, Florida, Illinois, Massachusetts, Michigan, New York, New Jersey, Ohio, Pennsylvania, and Texas. The details of this analysis can be found in **Section 5.4 Program Integrity**.

[27] U.S. Department of Health and Human Services - Office of Inspector General, Medicaid Fraud Control Units – MFCUs, https://www.oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

[28] Recoveries are defined as the amount of money that defendants are required to pay as a result of a settlement, judgment, or prefilling settlement in criminal and civil cases and may not reflect actual collections. Recoveries may involve cases that include participation by other Federal and State agencies.

- **State Medicaid Agency Websites** – Other state Medicaid agencies' websites were reviewed in comparison to HHSC's website, including those for the Arizona Health Care Cost Containment System, Ohio Department of Medicaid, New York Department of Health, and Wisconsin Department of Health Services. See **Section 5.6 Marketing and Communication Activities** for more information.
- **Contract amendment and procurement processes** – States were surveyed about their contract amendment and procurement processes. This exercise provided benchmarks by which to compare Texas processes and identify potential leading practices. The states surveyed included Arizona, California, Florida, New York, Ohio, Pennsylvania, and Wisconsin. More details on the findings from the survey can be found in **Section 5.7 Contract Amendments and Procurements**.

- **Texas's Medicaid and CHIP Managed Care Context** – A sampling of multiple documents provided or referenced by HHSC staff were reviewed to gain an understanding of Texas's Medicaid and CHIP managed care environment, including Standard Operating Procedures for various areas, including contract compliance; policy and program management; appointment availability studies; quality strategies; Value-Based Purchasing (VBP) road map; Pay-for-Quality (P4Q) programs and other quality programs; organizational charts; individual sections' and offices' overview presentations; QPRs; network adequacy reports; risk assessment instrument; training manuals; Managed Care Report Cards; managed care contracts and manuals; member handbooks; External Quality Review Organization (EQRO) summary reports; Joint Interface Plan (JIP); Provider procedures manuals; Medicaid and CHIP state plans; legislative hearing presentations; Performance Improvement Project (PIP) plans; and audit reports and studies. The list of information reviewed is in **Appendix 3.3**.

3. Overview of Texas Medicaid and CHIP Managed Care Contract Review and Oversight Environment

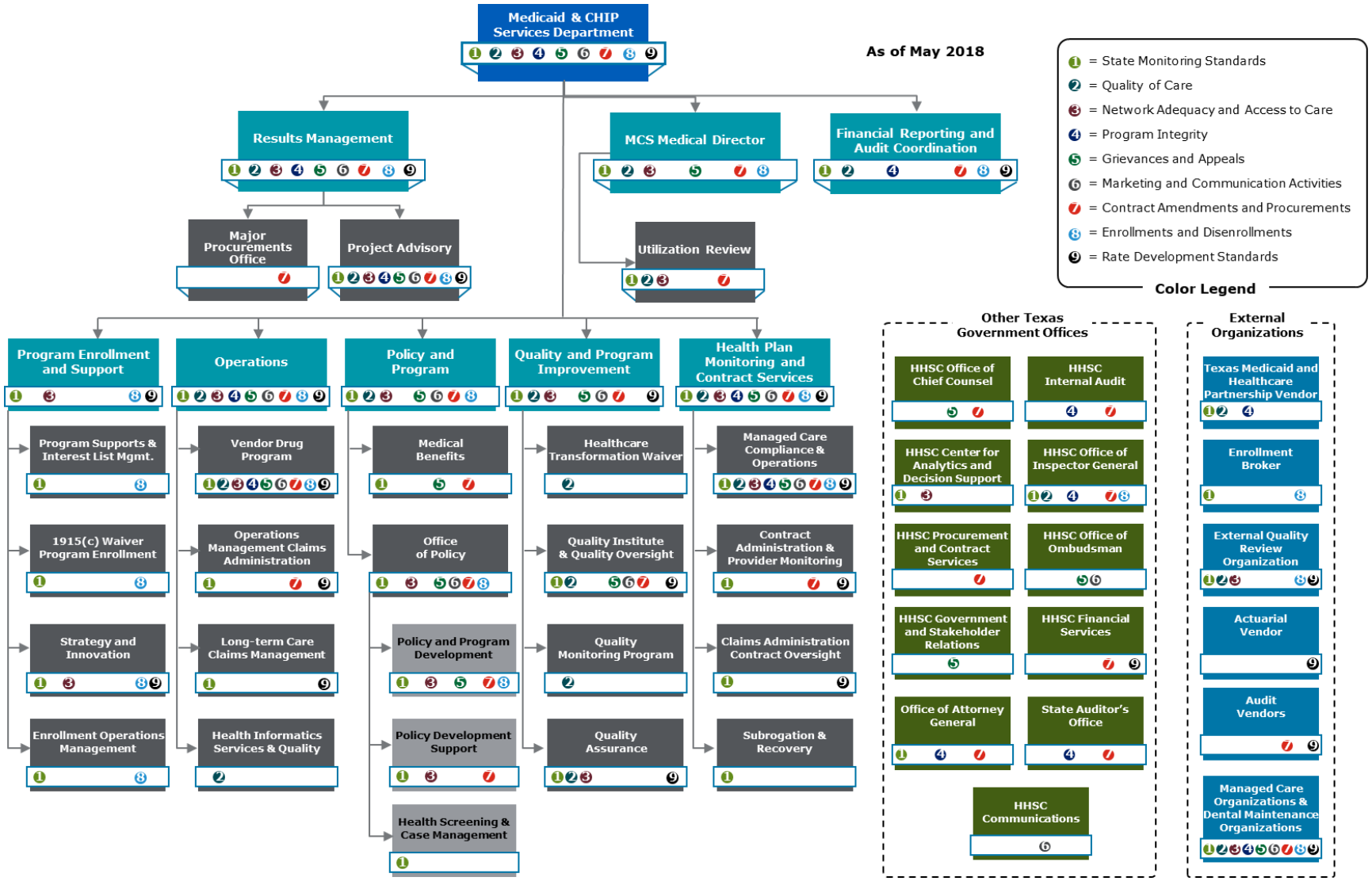
Texas provides health care services through two service delivery models: Medicaid Fee-for-Service (FFS), and Medicaid and Children's Health Insurance Program (CHIP) managed care.[29] Texas Medicaid has shifted gradually over the course of more than 20 years from a fully FFS model to an almost exclusively managed care model. Texas implemented CHIP as a managed care model in 2000. In fiscal year 2018, it is projected that 92 percent of Medicaid enrollees in Texas will receive care through a managed care model.[30] The Medicaid Managed Care model is delivered through programs with differing membership and services: CHIP, STAR, STAR+PLUS, STAR Kids, STAR Health, Dual Eligible Integrated Care Demonstration Project (known as the Dual Demonstration), and a statewide dental program. See **Appendix 3.1** for descriptions of the programs and a list of Managed Care Organizations (MCOs) by program.

Texas Health and Human Services Commission's (HHSC) managed care contract review and oversight function is a shared effort among sections and offices in HHSC's Medicaid and CHIP Services (MCS) Department with support provided by other HHSC departments, as well as contract vendors. With 92 percent of Medicaid members served in the managed care delivery system, most of the sections and offices of the MCS Department – as well as sections and offices in many other Texas government entities – are involved in the oversight and management of the Medicaid and CHIP managed care contracts. **Figure 6** depicts the sections, units, and other agencies involved in managed care oversight functions. Each managed care oversight function is represented by a color that aligns with the nine functional areas.

[29] *In Texas, all CHIP services are delivered through a managed care model.*

[30] *HHSC System Forecasting, March 2017.*

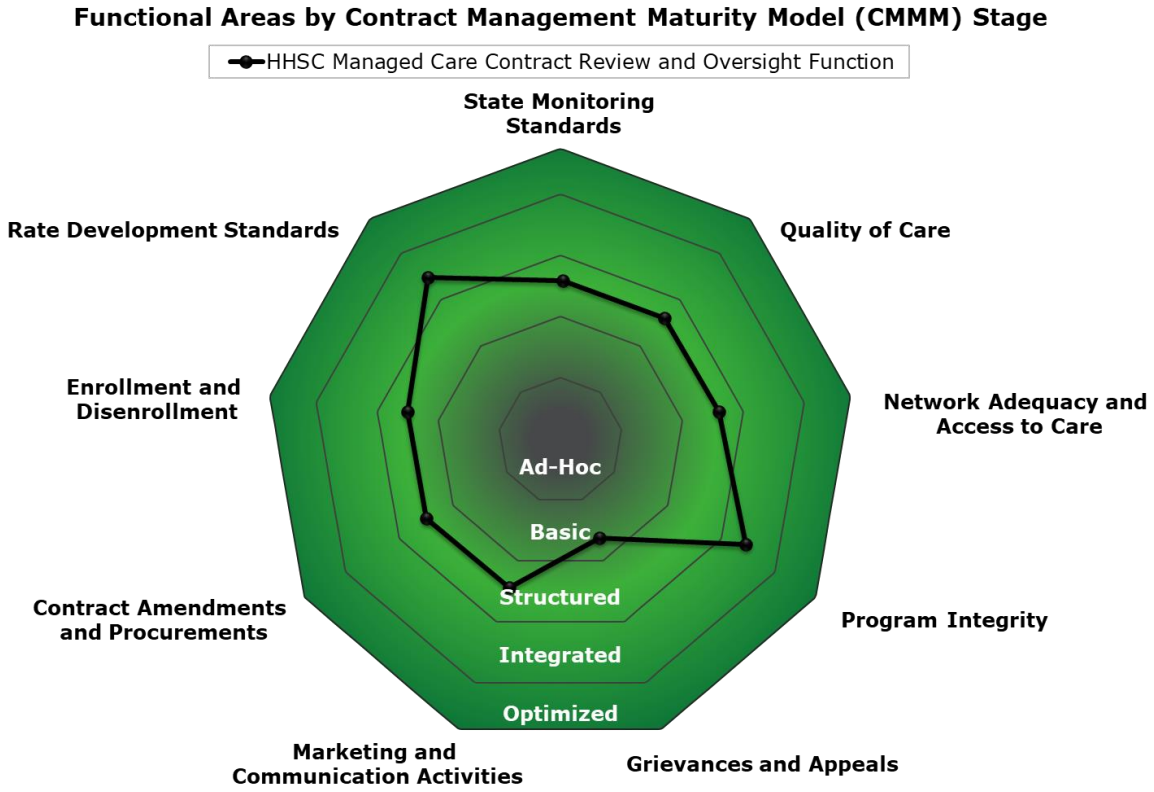
Figure 6. Managed Care Contract Review and Oversight Environment for MCS.



4. HHSC Medicaid and CHIP Managed Care Contract Review and Oversight Function Maturity Model

The review of Texas Health and Human Services Commission's (HHSC) Medicaid and Children's Health Insurance Program (CHIP) Managed Care contract review and oversight function indicates that the maturity level for each of the functional areas assessed includes Basic, Structured, and Integrated **(Figure 7).**

Figure 7. CMMM Stages of HHSC's Medicaid and CHIP Managed Care Contract Review and Oversight Functional Areas.



The National Contract Management Association indicates that, based on their industry analysis of 200 companies across 12 industries, 72 percent of the companies were operating at a maturity level of between "Basic" and "Structured". None of the companies surveyed and evaluated were operating

at a contract management maturity above Integrated.[31] It is important to note that this model should not be interpreted as a comparison to other states. Instead, alignment with the CMMM is a useful tool for understanding the current state of maturity, and identifying goals for continuous improvement. Additionally, this model considers the maturity of the contract management processes of an organization and not the program outcomes achieved by that organization.

In the following **Sections 5.1 to 5.9** of the report, information is provided for each functional area, including the rationale for the maturity level and examples of what HHSC can do to further develop and evolve its processes.

Recent efforts, such as the creation of a Results Management Office, will support HHSC's plan to mature and optimize its contract management functions. In accordance with recommendations from Health and Human Services (HHS) Sunset Review and Transformation via the Senate Bill (S.B.) 200, HHSC undertook a phased approach to consolidating and restructuring the HHS system starting in 2016. Since the second phase of the planned system-wide transformation took place in September 2017, MCS has continued to refine its operations and improve newly formed operating relationships among its sections and offices.

[31] *National Contract Management Association (NCMA), Contract Management Process Maturity: The Key for Organizational Survival, https://www.ncmahq.org/stay-informed/contract-management-magazine/contract-management-magazine---article-detail/improving-the-u.s.-federal-acquisition-workforce-part-2-of-3-contract-management-process-maturity-the-key-for-organizational-survival.*

5. Functional Area Findings

5.1. State Monitoring Standards

5.1.1. Contract Management Maturity Model (CMMM) Results

Designated Level: Structured

Rationale

- Processes and standards for monitoring the Managed Care Organizations (MCOs) are fully established, institutionalized, and mandated throughout the Medicaid and CHIP Services (MCS) Department. Formal documentation has been developed for contract management processes and standards, through tools, such as MCO Risk Assessment Instrument, Agreed-Upon Procedures (AUPs), and Quarterly Performance Reports (QPRs).
- While the population of the data in the QPRs is automated, there is significant manual effort involved in receiving and accepting deliverables from the MCOs, which are used to populate the QPRs. Some of that manual effort should be alleviated with the new portal being designed by MCS for deliverable submissions.
- To further mature its processes and standards, MCS should consider more integration of managed care oversight across divisions. MCS has efforts underway that are enabling them to move toward the "Integrated" level. For example, recent changes to the Managed Care Steering Committee governance structure to focus on MCO health, support collaborative sharing of data across MCS divisions and sections. In addition, the integrated MCO teams enable Managed Care Compliance and Operations (MCCO) staff to see trends across health plans and build capabilities to work through complex oversight issues. Lastly, some of the opportunities identified in the findings below, such building a summary compliance framework, will also help MCS move toward the "Integrated" level.

5.1.2. Findings

- **Continue Ongoing Effort to Streamline MCO Deliverables** – Due to the large volume and frequency of deliverables received from MCOs, it can be difficult to adequately review and utilize each deliverable for program improvement and compliance purposes. Prioritizing and possibly reducing the number of separately required deliverables could enable MCS to focus on in-depth reviews, target resources to address root causes, and study trends across MCOs. MCS is reviewing deliverables from MCOs as required by Rider 26 of the 2016-2017 General Appropriations Act, Regular Session, 2015, to determine if a flat-file format would better facilitate the deliverable submission process.
- **Continue Efforts to Automate Deliverable Submissions** – MCS is developing a portal to automate and integrate deliverable submissions from MCOs and communications with MCOs. The portal aims to alleviate the manual effort required in tracking and routing deliverables received from MCOs and to serve as the central document repository for MCO deliverables. Launching in April 2019, this portal will enable resources to be more focused on analysis and resolution of issues related to MCO performance. MCS plans to complete the review of deliverables prior to the portal launch.
- **Continue the MCO Risk Assessment Instrument** – MCS developed and implemented an MCO Risk Assessment Instrument to measure MCO performance and risk. The Risk Assessment Instrument has enabled HHSC to inform the agency's strategy for planning, managing, and coordinating audit resources used to verify information reported by Medicaid MCOs. There is an opportunity to incorporate complaints and appeals into the Risk Assessment Instrument to better inform upcoming reviews and/or audits.
- **Continue to Enhance Coordination of Audits and Reviews** – Several of the audits and reviews shown in **Figure 8** are standard, required, and repeated exercises that cross over financial, operational/programmatic, and clinical aspects of the Medicaid program. For instance, Federal audits and reviews coordinated by Office of Inspector General (OIG) encompasses operational aspects of the program. Other reviews, such as operational reviews, also cover both clinical and operational components. Texas Administrative Code Sections 353.6 and 371.37 and Health and Human Services (HHS)

Circular C-054 describe roles and responsibilities related to conducting audits of MCOs.[32] Further enhancing coordination and harmonizing across all the parties conducting audits and reviews would be more efficient and effective.

Figure 8. HHSC Audits and Review for State Fiscal Year (SFY) 2017.

Focus Aspect	HHSC Audits and Review for SFY2017
Financial	• Performance Audits by the SAO • Annual AUPs Engagements with External Audit Contractors & Financial Reporting and Audit Coordination (FRAC)
Clinical	• Operational Reviews by the Office of the Medical Director-Utilization Review Unit • Utilization Reviews of Star+PLUS Home- and Community-Based Services (HCBS), Medically Dependent Children Program (MDCP), and Acute Care, by the Office of the Medical Director-Utilization Review Unit • Mental Health Parity for Pharmacy Review and CMS annual Drug Utilization Review report by VDP • Psychotropic Medication Review (PMUR) Plan by Vendor Drug Program (VDP) • Clinical Prior Authorization for Pharmacy Quarterly Review by VDP • Policy and Procedures requiring clinical reviews by VDP
Operational/ Programmatic	• Desk Reviews by MCCO • Operational Reviews • Targeted Reviews by MCCO • Readiness Reviews Prior to Implementing a New Contract, New Program, New Membership, or a System or Operational Change by MCS • Third-Party Performance Audits by MCCO • Utilization Reviews of Star+PLUS HCBS, MDCP, and Acute Care, by the Office of the Medical Director-Utilization Review Unit • Encounter Sampling by Operations • Federal Audits and Reviews including the CMS Payment Error Rate Measurement (PERM) Audits, Coordinated by OIG • Legislative Implementation Reviews by MCS • Performance Audits by HHSC Internal Audit • Consulting Engagements by HHSC Internal Audit

[32] *The provisions of Texas Administrative Code Sections 353.6 and 371.37, Audit of Managed Care Organizations, were adopted to be effective in July 2016. Health and Human Services (HHS) Circular C-054, Coordination of Managed Care Organization Audit, was issued in March 2017.*

Focus Aspect	HHSC Audits and Review for SFY2017
Office of Inspector General (OIG) Initiated/ Requested Audits and Investigations	• OIG Investigations • Performance Audits by OIG • Provider Audits by OIG • Information Technology (IT) Audits by OIG • Utilization Reviews of Acute Care Providers, Acute Care Hospitals, and Nursing Facility Services by OIG • OIG Lock-In Program • OIG Inspections

- **Continue to Strengthen Integration of Managed Care Oversight across Divisions** – As depicted in **Figure 6**, there are many MCS sections and offices involved in managed care contract review and oversight. HHSC has an opportunity to formalize governance structure across sections to provide a more coordinated and integrated process to drive issue identification to resolution for managed care oversight and compliance. MCS has already initiated this by leveraging the Managed Care Steering Committee structure that has been in place since 2015 and was recently updated to focus more on the health of the MCO. Each MCO is reviewed after their operational review is completed once every two years. Continued operations in this governance structure will support increased integration for Managed Care oversight.
- **Continue with Integrated MCCO Teams** – MCCO has created teams of individuals who work together across health plans and products. This integrated approach enables MCCO staff to see trends across health plans and builds capabilities in its staff to work through complex oversight issues. Those capabilities are further developed with the certified contract specialist program, increasing the knowledge, skills, and abilities of MCCO staff.
- **Continue Accountability through the Strengthened Graduated Remediation Process and Liquidated Damages (LDs)** – HHSC may impose remedies for material non-compliance and determine the scope and severity of the remedy on a case-by-case basis in accordance with Attachment B-3 Deliverables/LDs Matrix of the Uniform Managed Care Contract (UMCC). In SFY2016, HHSC assessed

$5.2 million in LDs[33], which represented 0.03 percent of the $18.8 billion in total payments to MCOs in SFY2016. For the first two quarters in SFY2017, HHSC has assessed $9.7 million in LDs, which represented 0.04 percent of the $21.9 billion in total payments to the MCOs in SFY2017. The increase in LDs is a result of HHSC strengthening its oversight of non-compliance with the UMCC. Refer to **Appendix 5.1.5** for LDs assessed.

- **Opportunity to Introduce a Summary Compliance Framework** – The length and complexity of the contracts make it challenging for MCOs to ensure they are compliant with every requirement. A summary compliance framework to guide MCOs in their efforts to comply with the contract requirements could be a useful supporting tool. HHSC has an opportunity to update and build out Section 5.0 of the Uniform Managed Care Manual (UMCM), called the Consolidated Deliverable Matrix, into a comprehensive compliance matrix that maps policies and contract requirements to deliverables to aid MCOs and MCS in ensuring that MCOs are meeting contract policies. The framework would not relieve the MCOs of their duties required in the contract terms and conditions; however, it could serve as a useful tool to manage compliance and communicate contract policies and requirements.

5.1.3. Supporting Information

5.1.3.1. Data Collected by HHSC to Evaluate Existing Contract Requirements

To monitor compliance with standards, MCOs are required to submit deliverables for MCS to review, analyze, and approve. Section 5.0 Consolidated Deliverable Matrix of the UMCM, provides the current list of deliverables required from MCOs, as well as when and how MCOs are to submit each deliverable. Please refer to **Appendix 5.1.2** for over 100 deliverables required by business function (types included Finance, Operations, Pharmacy Operations, Quality, Systems, Fraud, and Third-Party Liability).

[33] *As of May 1, 2018 HHSC reported on liquidated damages at https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-organization-sanctions.*

Quarterly Performance Reports (QPRs) are templates that MCS staff populate with inputs from self-reported data from the MCOs and from internal entities, to evaluate MCO performance and contract compliance. MCS has two types of QPRs – Compliance Operations QPRs **(Appendix 5.1.3)** and Pharmacy QPRs **(Appendix 5.1.4).** MCCO compiles the Compliance Operations QPRs for each program and MCO to compare MCO operational performance with the contractual standards. Similarly, MCCO also compiles QPRs for reporting pharmacy operations. Currently there is significant manual effort involved in receiving and accepting deliverables from the MCOs, which are used to populate the QPRs. Some of that manual effort should be alleviated with the new portal being designed by MCS for deliverable submissions. Deliverables are mapped to the QPRs to populate the information appropriately. If HHSC revises a deliverable's structure or if a MCO does not submit the deliverables in the appropriate format, the QPR mapping must be manually reviewed and updated. Data aggregation and trending could be enhanced and made more adaptive to better accommodate changes to the deliverables and support monitoring via the QPRs.

In addition to the operational data compiled in the QPRs, other deliverables and data sets are used to evaluate MCO performance and adherence to contract requirements, including Financial Statistical Reports (FSRs) and Encounter Data. **Section 5.9. Rate Development Standards***,* and **Section 5.2 Quality of Care,** provide a description of MCS' efforts in using these data sets to effectively evaluate MCO performance*.*

5.1.3.2. Reviews and Audits Conducted by HHSC

In accordance with Texas Senate Bill (SB) 894 from the 85th legislative session, HHSC developed and implemented an MCO Risk Assessment Instrument, also known as the Risk-Based Contract Monitoring Tool. This tool measures MCO performance and risk, and to identify MCOs for targeted performance audits and reviews. HHSC completed its 2017 risk assessment in December 2017 using this new process. HHSC Internal Audit reviewed HHSC's methodology and risk assessment tool. MCS incorporated additional critical risk factors and addressed those identified in SB 894, resulting in HHSC amending the tool in the spring of 2018.

In addition to managing risk and monitoring compliance, HHSC conducts several reviews and audits as indicated below. For more information on the audits and reviews conducted by HHSC, see **Appendix 5.1.1**.

- **Readiness Reviews** – As required by 42 Code of Federal Regulations (CFR) 438.66(d)(2), MCS conducts readiness reviews at least 90 days prior to the operational start of a contract, completing the review with enough time to identify and remediate operational issues prior to contract start date.
- **Targeted Reviews** – MCS conducts targeted reviews when MCS identifies a specific problem with an MCO, for example, when claims timeliness is a significant or recurring problem. MCS may also conduct targeted reviews in response to complaints by members, providers, advocates, or other HHSC sections. The scope, entity, and focus of targeted reviews vary based on the topics raised by complaints received and past instances of non-compliance.
- **Operational Reviews** – Starting in the fall of 2017, HHSC introduced operational reviews to assess and validate the working operations of MCOs. As of May 2018, six operational reviews have been conducted. HHSC conducts desk reviews and on-site visits of one MCO per month to review self-reported data from the MCO. To date, HHSC has developed eight procedures *(*MCS calls these "modules*")* to review claims processing, websites, claims and appeals, provider training materials, provider services staff training, member services staff training, utilization reviews, and encounter data. HHSC plans to continue to develop additional modules to expand these operational reviews. MCS's Utilization Review team, Operations Section Encounters team, and MCCO conduct their on-site visits concurrently, and the HHSC OIG is invited. All sections have their own tools for data collection, with MCCO coordinating and compiling the overall findings report from the operational reviews. Findings from operational reviews may result in issuing remedies to MCOs for non-compliance.
- **Audits by External Auditors** – MCS contracts with independent auditors to perform annual performance audits of targeted MCO processes to determine whether MCOs are meeting specific contractual performance requirements. In coordination with MCS, the independent auditors also perform biennial audits of the MCO's self-reported data to monitor whether the MCOs are reporting data accurately.
- **Financial Reporting Audits** – MCS has AUP engagements with independent auditing firms to verify MCO's self-reported Financial Statistical Reports (FSRs) and validate MCO's compliance with the financial reporting requirements of applicable Federal Acquisition

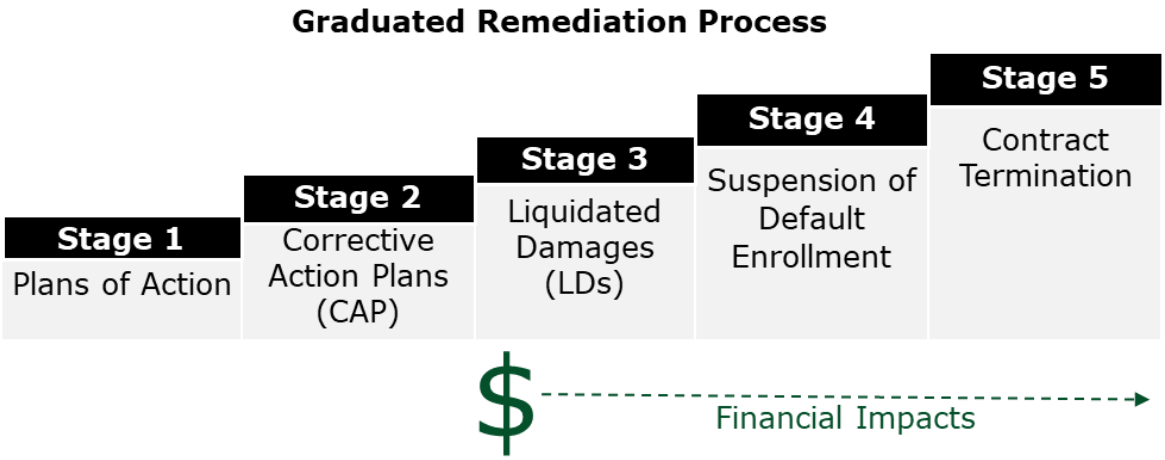
Regulation, HHSC's UMCC terms and conditions, and HHSC's UMCM. Independent auditors apply the AUPs detailed in **Appendix 5.9.2**. Findings from AUP engagements, such as instances of identified unallowable costs, may affect the amount of the experience rebates paid by MCOs to HHSC. For more information on the financial oversight audit process, see **Section 5.9 Rate Development Standards**.

- **Utilization Reviews** – The Office of the Medical Director reviews acute care services for the STAR, STAR+PLUS, STAR Kids, and STAR Health programs, and a sample of members' assessments for STAR+PLUS Home and Community-Based Services (HCBS). Soon, the Office of the Medical Director will begin reviewing a sample of members' Managed Care Long Term Services and Supports (MLTSS) for the STAR Kids and STAR Health programs. The OIG also conducts utilization reviews of acute care providers, hospitals, and nursing facilities, and administers the Lock-in Program. For more information on utilization review activities, see **Section 5.2 Quality of Care**.

5.1.3.3. Enforcing Contract Requirements through a Graduated Remediation Process

Each MCS section monitors compliance for its responsibility area through deliverables, reviews and audits. MCS sections log identified issues, and reviews instances of non-compliance with their section's leadership. MCS applies a five-stage graduated remediation process based on severity of non-compliance. Depending on the frequency and severity of the non-compliance, MCS can determine which stage(s) of graduated remediation is warranted **(Figure 9)**. For example, as MCS identifies an issue, depending on the nature of the issue, they can begin the process at Stage 3 and bypass Stages 1 and 2.

Figure 9. MCS Graduated Remediation Process.



Currently HHSC has 25 open Plans of Action with MCOs; however, HHSC has not historically tracked summarized data on Plans of Action. In SFY2016, HHSC issued 47 Corrective Action Plans (CAPs), whereas 67 CAPs were issued in SFY2017, and 96 CAPs in SFY2018. MCOs with CAPs and LDs are publicly available on HHSC website. As of April 30, 2018, HHSC had 108 CAPs in place with 17 MCOs and 2 Dental Maintenance Organizations (DMOs).[34]

More severe instances of non-compliance may escalate remediation stages and directly result in assessing LDs (Stage 3), suspension of default enrollment (Stage 4), or a contract termination (Stage 5). In SFY2016, HHSC assessed LDs for 835 instances of non-compliance. In the first two quarters of SFY2017, HHSC assessed LDs for 641 instances of non-compliance. Instances of non-compliance resulting in LDs are publicly available on HHSC website by MCO.[35] HHSC has suspended default enrollment once in 2012, and has not terminated a contract with a MCO for non-compliance.

Each HHSC program area and the OIG may recommend remedies for non-compliance. MCCO then coordinates the tracking and obtaining the MCS and

[34] *Corrective Action Plans (CAPs) as of April 30, 2018 are available at https://hhs.texas.gov/sites/default/files//documents/services/health/medicaid-chip/provider-information/expansion-managed-care/2018-cap-april-final.pdf.*

[35] *Instances of non-compliance resulting in liquidated damages (LDs) as of May 1, 2018 are available at https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-organization-sanctions.*

HHSC leadership approval. MCCO oversees the remediation process, and is responsible for tracking and obtaining MCS and HHSC leadership approval for remedies recommended, including corrective actions and/or LDs. MCCO facilitates communications among the MCO and HHSC program areas. MCS has enhanced tracking of remedies recommended and is continuing to update its business processes related to overseeing LDs. The process of reviewing remedies recommended and the amount of LDs assessed is iterative. In the last four months, MCS formalized the process for issuance and approval of LDs, which documents the approval process and clarifies which authority can issue the LDs depending on the amount of LDs assessed. See **Appendix 5.1.5** for LDs assessed in SFY2017 and SFY2016.

5.2. Quality of Care

5.2.1. Contract Management Maturity Model (CMMM) Results

Designated Level: Structured

Rationale

- There is some variability across the maturity of the quality of care elements. Some elements are optimized. For example, the use of the External Quality Review Organization (EQRO) to validate encounter data, conduct consumer and provider surveys, calculate performance measures, and perform studies of appointment availability for clinical or non-clinical services are broad and go beyond core mandatory EQRO functions; however, the EQRO's analyses are not widely shared throughout the organization and could be more integrated into other quality functions. For example, as noted in **Section 5.3 Network Adequacy and Access to Care**, the EQRO conducts appointment availability studies that could be factored into the network adequacy calculations and used to inform the available network of providers accessible to Medicaid individuals.
- Additionally, a number of the quality of care programs are new or recently redesigned and MCS' ability to successfully implement, measure and further mature these programs will be critical to move towards continued contract management maturity. Some examples include the recently redesigned Pay for Quality (P4Q) Program, the Managed Care Quality Strategy undergoing CMS review, and the Value-Based Purchasing (VBP) Program implemented in 2018.

5.2.2. Findings

- **Continue to Enhance the Texas Healthcare Learning Collaborative (THLC) Portal** – The portal is a valuable tool for viewing quality measures data from the last three years in one location for both internal and public use. In addition to other Texas Health and Human Services Commission (HHSC) websites, MCS makes an array of information publicly available related to managed care programs, including several provisions related to measuring and improving quality of care. **Figure 10** below lists a comparison of quality websites

for different states, including Texas. MCS has an opportunity to further enhance its transparency and quality oversight by cross-referencing data in the portal, such as with grievance and appeal information, utilization, outcomes, and costs. For example, cross-referencing the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[36] data with the complaints data and incorporating those within the Managed Care Report Cards would provide more comprehensive information to members for MCO selection. More details on this can be found the findings in **Section 5.5 Grievances and Appeals** and **Section 5.8 Enrollments and Disenrollments**.

HHSC currently publishes quality data on the managed care programs across five websites, which are noted in **Figure 10**.[37] As seen in other states, HHSC has an opportunity to consolidate its quality-related information and enhance its transparency by providing a single website with links to its THLC Portal, quality data, and reports.

Figure 10a. Comparison of State Medicaid Agency Quality Website Features.

Category	Feature	TX	TN	LA	MN	NY	CA
Data and Reporting	Healthcare Effectiveness Data and Information Set (HEDIS®) and/or HEDIS®-like measures	√	√	√	√	√	√
Data and Reporting	CAHPS® survey results	√	√		√	√	√
Data and Reporting	Utilization data	√	√			√	√
Data and Reporting	Public health data/vital statistics	√		√		√	√
Data and Reporting	EQRO/Quality Assurance reports	√	√		√	√	√
Data and Reporting	Grievances and Appeals				√		√
Data and Reporting	Population- or disease-specific reporting	√		√	√	√	√
Data and Reporting	Alternative Payment Models (APM)/P4P framework and/or outcomes	√			√	√	

[36] *The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).*

[37] *The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.*

Category	Feature	TX	TN	LA	MN	NY	CA
Data and Reporting	Non-quality performance data (e.g., fiscal)	√					√
Narrative and Interactive Features	Frequently Asked Questions/introductory language	√			√	√	√
Narrative and Interactive Features	Stakeholder/public meeting information	√		√	√		
Narrative and Interactive Features	News updates and/or press releases	√		√	√		
Narrative and Interactive Features	Videos				√		
Narrative and Interactive Features	Interactive data	√		√		√	√
Narrative and Interactive Features	Consumer health plan guides	√				√	
External Resources	Links to Continuing Medical Education classes for providers			√	√		
External Resources	Links to health plans' Quality Improvement websites				√		
External Resources	Links to community health resources			√	√		

Figure 10b. State Medicaid Agency Quality Websites as of May 1, 2018.

State	State Medicaid Websites as of May 1, 2018
Texas:	• https://thlcportal.com/home • https://hhs.texas.gov/services/health/medicaid-chip/programs/medical-dental-plans • https://hhs.texas.gov/about-hhs/records-statistics/data-statistics • https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement • https://healthit.hhsc.texas.gov/
Tennessee:	• https://www.tn.gov/tenncare/information-statistics/mco-quality-data.html
Louisiana:	• http://www.dhh.louisiana.gov/index.cfm/subhome/47 • https://qualitydashboard.ldh.la.gov/
Minnesota:	• https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp • http://www.health.state.mn.us/healthreform/measurement/index.html
New York:	• https://www.health.ny.gov/health_care/managed_care/reports/index.htm
California:	• http://www.dhcs.ca.gov/dataandstats/Pages/QualityMeasurementAndReporting.aspx • https://data.chhs.ca.gov/

- **Continue the Newly Redesigned P4Q Program** – MCS recently redesigned its P4Q Program for medical services. The focus areas of the redesigned P4Q effort are: prevention, chronic disease management (including behavioral health), and maternal and infant health. Measurement for the new program began in January 2018. The new program will allow MCS to more effectively assess MCO performance and target quality improvements in these focus areas.
- **Continue Use of the EQRO** – In accordance with 42 Code of Federal Regulations (CFR) 438.358, the EQRO reviews each MCO's performance annually, validates Performance Improvement Projects (PIPs) and performance measures, and determines MCO compliance with 42 CFR Part 438, Subpart D and Quality Assessment and Performance Improvement (QAPI) requirements every 3 years. The EQRO's activities are summarized in an annual report. In addition to complying with these CMS requirements, MCS also engages the EQRO to perform four additional functions: 1) validation of encounter data;

2) administration of consumer and provider surveys; 3) calculation of performance measures; and 4) focus studies of clinical or nonclinical services, including an appointment availability study. The expanded use of the EQRO is an effective tool in MCS' oversight approach.

- **Continue to Enhance Validation of Encounter Data** – HHSC has numerous groups validating encounter data, including the EQRO, which validates encounter data submitted by the MCOs to Texas Medicaid and Healthcare Partnership (TMHP). In addition, there are several efforts planned to further strengthen the encounter data validation process and develop a new oversight process to validate that claims submitted by providers align with encounters submitted by the MCOs. Opportunity exists for HHSC to build a monitoring tool and enhance the process to monitor encounter data and other data sources on a routine, regular basis to identify potential data outliers and issues.
- **Continue to Improve Guidance on Utilization Management and Medical Necessity Determinations** – Medicaid MCOs are responsible for providing all medically necessary, Medicaid-covered services to their Medicaid members, in the same amount, duration, and scope as is available through fee-for-service (FFS) Medicaid. Administrative procedures, such as prior authorization, pre-certification, and referrals may differ from FFS and from MCO to MCO. In the development of medical policies and medical necessity determinations, the Uniform Managed Care Contract (UMCC)[38] requires the MCOs to adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.[39] To supplement industry clinical criteria, such as McKesson's InterQual and MCG (previously known as the Milliman Care Guidelines), HHSC provides additional guidance and technical assistance to MCOs and providers on medically necessary criteria for certain services, such as physical, occupational, and speech therapy services and private duty

[38] *The UMCC applies for the STAR program and the service areas awarded under the UMCC for the STAR+PLUS and CHIP programs. Contracts for the STAR+PLUS expansion and rural service areas, STAR Kids, STAR Health, CHIP rural service areas, Dual Eligible Integrated Care Demonstration, and dental services are independent of the UMCC and tailored to have their own terms and conditions.*

[39] *Texas Health & Human Services Commission Uniform Managed Care Contract, Section 8.1.2, https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf.*

nursing services. The Acute Care Utilization Review Unit also reviews each MCO's policies and procedures to determine the utilization management criteria applied by the MCO, as well as the level of staff involved in the MCO's prior authorization process and medical necessity determination workflow. Furthermore, HHSC and the Texas Department of Insurance (TDI) have plans to work together on aligning requirements regarding prior authorization and timeliness to notify requestors of prior authorization determinations for members under 21 years of age.

- **Opportunity to Increase Utilization Review Resources** – Complaints, high expenditures, utilization, random samples, and targeted reviews drive the selection of services for utilization reviews conducted by the MCS Office of the Medical Director. HHSC leadership is reviewing and identifying staffing needs to enable additional utilization reviews. Below are some areas of opportunities that MCS could address with the help of additional tools and resources. The skills of resources needed would differ depending on the opportunity MCS decides to pursue:
  - Increase the sample size and types of services reviewed. Introducing a data-driven approach, in alignment with HHSC priorities for improved outcomes, could help more efficiently select cases for utilization reviews.
  - MCS could request and review the outcomes and timeliness[40] of MCO's utilization management and prior authorization activities, to see when service requests were received, the outcomes of the request (i.e., denied, approved, amended), and if appeals were received as a result of denied prior authorization requests.
  - MCS could also require inter-rater reliability (IRR) assessments of MCO staff conducting utilization management activities to ensure staff are

[40] *According to the UMCC Section 8.1.8, when making utilization management determinations, the MCO must comply with the requirements of 42 CFR 456.111 (Hospitals) and 42 CFR 456.211 (Mental Hospitals), as applicable. The MCO must issue coverage determinations, including adverse determinations, according to the following timelines:*

1. Within three business days after receipt of the request for authorization of services;

2. Within one business day for concurrent hospitalization decisions; and

3. Within one hour for post-stabilization or life-threatening conditions, except that for emergency medical conditions and emergency behavioral health conditions, the MCO must not require prior authorization.

making decisions and assessments consistent with their peers, clinical criteria, and guidelines. IRR is not a current UMCC requirement, but is a best practice for acute care utilization management and can also be valuable for assessing MCO consistency to waiver services planning and prior authorization. For example, MCS would provide sample cases to test how the MCOs conduct service planning and utilization management activities, and to determine if the MCOs are following their utilization management policies and procedures. Another example is randomly selecting individuals during operational reviews to test how the MCOs conduct service planning and utilization management activities, especially in the STAR+PLUS program.

- Lastly, MCS could conduct qualitative reviews of Dental Maintenance Organizations (DMOs) for utilization reviews. This approach would take a consistent approach across oversight across all managed care programs.

5.2.3. Supporting Information

5.2.3.1. Texas HHSC Quality Strategy

Texas's Managed Care Quality Strategy was initially developed in 2014 as part of the Texas Section 1115 Medicaid Transformation Waiver[41], and then re-released separately in July 2017. Amendments have been made to the strategy to account for managed care rule changes made in 42 CFR 438 Amendment 14. The most recent Managed Care Quality Strategy is currently being reviewed by CMS. "HHSC's fundamental commitment is to contract for results. HHSC defines a successful result as the generation of defined, measurable, and beneficial outcomes that satisfy the 22 contract requirements and support HHSC's missions and objectives," according to the Managed Care Quality Strategy. The Managed Care Quality Strategy covers the roles and responsibility of HHSC sections, advisory committees, and the EQRO in assessing and improving the quality of healthcare and services

[41] *Texas Health and Human Services, Section 1115 Medicaid Transformation Waiver, Attachment D "Quality Improvement Program and Quality Improvement Strategy", https://hhs.texas.gov/sites/default/files//documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/tx-1115-amendment-13-stc.pdf.*

provided through Texas Medicaid Managed Care programs.[42] Additionally, the Managed Care Quality Strategy aligns with HHSC's Quality Plan, which is the comprehensive plan improving the coordination and transparency of state healthcare quality initiatives.[43]

5.2.3.2. Ongoing Comprehensive QAPI Program for Services Furnished by MCOs

Out of the many quality initiatives that Texas uses to monitor MCO performance, the following are important in understanding the context of the findings mentioned earlier in this section of the report.

- **The THLC Portal** is a tool originally created to help MCOs track their performance; however, the portal is now also used to evaluate managed care contract compliance and to analyze and compare data across MCOs. Published measures include:
  - HEDIS® medical and dental measures from the National Committee for Quality Assurance (NCQA)
  - Prevention Quality Indicators and Pediatric Quality Indicators from the federal Agency for Healthcare Research and Quality (AHRQ)
  - Core set of adult and children's health care quality measures from the Centers for Medicare & Medicaid Services (CMS)
  - Potentially preventable events, including admissions, readmissions, emergency department visits, and complications
  - Dental measures from American Dental Association on behalf of the Dental Quality Alliance©
  - Measures defined by Texas HHS, such as HIV viral suppression and low birth weight infants

A new Key Performance Indicators dashboard on the THLC Portal displays some key measures, including high and minimum standards/thresholds set by HHSC. Starting with the contracting period using 2018 data, health plans

[42] *Texas Health and Human Services, Managed Care Quality Strategy, https://hhs.texas.gov/sites/default/files//documents/about-hhs/process-improvement/quality-efficiency-improvement/Quality-Strategy-2017-Draft-track-changes.pdf.*

[43] *Texas Health and Human Services Healthcare Quality Plan, https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/HHS-Healthcare-Quality-Plan-2017.pdf.*

that fail one-third or more of the minimum standards will be required to submit a corrective action plan. The dashboard currently contains metrics that are specifically selected by MCS given their importance to different programs/populations. The data received into the portal has a time lag because much of it is based upon claims data or in the case of surveys, adequate time is needed to calculate and analyze the results. Nevertheless, the dashboard provides an interactive and visual starting point to view and analyze quality-related data. The portal's quality of care and health plan performance information is supplemented with publicly available Microsoft Excel reports containing healthcare statistics, Medicaid and Children's Health Insurance Program (CHIP) FSRs, and Medicaid CHIP quality and efficiency improvements.

- **Managed Care Report Cards** were developed based on a legislative requirement to assist Medicaid and CHIP managed care enrollees in choosing a health plan for the CHIP, STAR (for adults and children), and STAR+PLUS programs in their service delivery area. The EQRO began producing annual Managed Care Report Cards in 2013 to support the state's ongoing efforts to improve consumer choice in Texas Medicaid and CHIP. Texas is one of several states including California, Maryland, New York, and Ohio that use report cards to assist Medicaid enrollees with making health care decisions. The report cards include metrics from CAHPS® and HEDIS®, along with other composite metrics that are compiled using the EQRO's methodology to generate an overall score between one star (low rating) and five stars (high rating). In the 2017 Managed Care Report Cards published in 2018, MCS expanded the Managed Care Report Cards from three-star percentile-based rating system to a five-star cluster-based rating system and introduced a tiered structure for ratings along with ratings on individual quality measures. A high rating suggests broad-based quality of care. For more information on member enrollment, please refer to **Section 5.8 Enrollments and Disenrollments**.
- **The Medical P4Q Program** creates incentives and disincentives for MCOs based on their performance on certain quality measures. Health plans that meet the at-risk measures and bonus measures may be eligible for additional funds, while health plans that do not meet their at-risk measures can lose up to 3 percent of their capitation payments. The newly redesigned Medical P4Q Program was implemented in calendar year 2018. While redesigning the program, HHSC decided not to recoup or award any capitation at risk in the medical P4Q Program

for calendar years 2014, 2015, and 2016. The Medical P4Q Program was suspended in calendar year 2017 as staff used this time to develop a redesigned program. The results from the new Medical P4Q Program will be available in 2019. The measures, methodology, and performance targets are outlined in the UMCM, Chapter 5.2.14 and posted on the HHSC website.[44] MCO performance is evaluated in three ways for the P4Q Program: performance against self (comparison of a MCOs performance to its prior-year performance), performance against benchmarks (comparison of a MCOs performance against Texas and national peers), and bonus pool measures.

- **The Dental P4Q Program** was implemented in 2014 and then redesigned in 2018. The program in calendar year 2014 through 2016 held 2 percent of each DMO's capitation at risk and now puts 1.5 percent of the DMO's capitation at risk. DMOs can earn or lose money based on how much utilization for certain services increases or declines compared to pre-specified quality goals.
- **The VBP Program** started in 2018 in accordance with HHSC's VBP Roadmap. For the VBP Program, MCOs have minimum thresholds for Medicaid alternative payment models (APMs). The results will be available in 2019. Beginning in calendar year 2018, each MCO is required beginning in calendar year 2018 to have 25 percent of provider payments in any type of VBP and 10 percent of provider payment in risk-based VBP. These percentages will increase over four years to 50 percent overall VBP and 25 percent risk-based VBP in calendar year 2021. For DMOs, the risk-based percentage start at 2 percent and increases to 10 percent over four years. See **Section 5.4 Program Integrity** on OIG's activities related to tracking VBP efforts.
- **Quality Assessment and Performance Improvement (QAPI) Programs** are developed by MCOs in accordance with the UMCM, Chapter 5.7.1. MCOs are required to develop QAPI Programs that approach all clinical and nonclinical aspects of QAPI based on principles of continuous quality improvement and total quality management. They must also evaluate performance using objective quality indicators, foster data-driven decision making, and adopt at least two evidence-based clinical practice guidelines per program (e.g., STAR

[44] *Texas Health and Human Services, Pay-for-Quality (P4Q) Program, https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program.*

and STAR+PLUS).[45] MCOs report on their QAPI programs each year, and the EQRO evaluates MCOs for their compliance with CMS' and HHSC's QAPI requirements.

- **PIPs** are required from MCOs in accordance with the UMCM, Chapter 10.2. The purpose of health care quality PIPs is to assess and improve processes, thereby improving care outcomes. MCOs are required to have PIPs that target specific areas for improvement. Topics for PIPs are determined in consultation with the EQRO, HHSC, and the health plans. MCOs create a PIP plan, report annually on the plan's progress, and provide a final report on the PIP, which the EQRO validates. HHSC requires each MCO to conduct two PIPs per program. The MCO must conduct one PIP in collaboration with other MCOs, DMOs, community-based organizations, or participants in Delivery System Reform Incentive Payment (DSRIP) projects established under the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver. This approach to PIPs with the MCOs encourages system-wide performance improvement.
- **Utilization Review (UR)** is responsible for conducting utilization reviews to ensure MCOs are authorizing, justifying, and providing appropriate, medically necessary services to Medicaid beneficiaries, without over- or under- utilization. In addition, the reviews assure MCO adherence to Federal and State laws and rules, their contracts with HHSC, and their own policies. UR consists of two units within the MCS Office of the Medical Director: Acute Care Utilization Review (ACUR), and Managed Care Long Term Services and Supports (MLTSS) UR.
  - **Acute Care:** The ACUR Unit is responsible for monitoring MCOs in all Medicaid programs to ensure prior authorization and utilization management processes are used to reduce unnecessary or inappropriate services, and ensure MCO's are not under-utilizing services or denying necessary and appropriate services. Their reviews focus on MCO's policies and procedures and their compliance with contracts, statutes, and rules; MCO's compliance with their policy; and trends in prior authorization data. A desk review of a sample set of

[45] *Texas Health and Human Services, Managed Care Quality Strategy - Page 20, https://hhs.texas.gov/sites/default/files//documents/about-hhs/process-improvement/quality-efficiency-improvement/Quality-Strategy-2017-Draft-track-changes.pdf.*

medical records is completed to monitor the implementation of the MCO's policies and procedures and to monitor how the MCO determine medical necessity. The sample set is targeted and includes a minimum of 12 private duty nursing and 10 speech therapy clinical prior authorization cases. Additional cases are added to the sample as needed based on complaints and reported non-compliance. The choice of these services was based on complaints, severity and frequency of non-compliance instances, and the high volume and cost of these services. Nurses from the ACUR team conduct an in-depth review of the sample cases for utilization review and authorization process, medical necessity determination, timeliness, and accuracy in the resolution.

After utilization review activities, conducted by the ACUR unit as part of the Operational Reviews are complete, a subsequent report is sent to Managed Care Compliance and Operations (MCCO), which consolidates the UR teams' reports and findings.

- **Managed Care LTSS:** The MLTSS UR team conducts sampled reviews of STAR+PLUS Home and Community-Based Services (HCBS) to determine MCO's conduct of assessments, MCO's procedures and related information used to determine appropriateness of member enrollment in the HCBS program. The review includes ensuring MCOs are providing services according to their assessment of service needs. The team conducts desk reviews of MCO documentation and conducts home visits with each of the members in the sample.

  Findings from MLTSS UR activities in STAR+PLUS are reported annually to the Legislature. Negative findings from any of the URs could result in graduated remediation, corrective action plans, and/or assessing Liquidated Damages (LDs). UR findings inform policy and contract clarifications, if needed; MCO consultation and/or training; internal process improvements; and remediation actions with MCOs. A responsibility of the UR teams is to coordinate and communicate with MCOs and find solutions that are consistent with HHSC's standards and expectations.

- In addition to the MCS Utilization Review Unit, the OIG conducts claims and medical record reviews on acute care, hospital, and nursing facility utilization, and the Pharmacy Lock-In Program. The OIG has clinical subject matter expertise and quality review teams that provide education to MCOs and within OIG regarding clinical documentation

and medical/dental policy interpretation. OIG performs on-site and desk reviews of hospital claims and nursing facility minimum data set forms for appropriate billing. OIG also administers the Pharmacy Lock-In Program with MCOs to monitor individual's use of prescription medications and acute care services.[46]

- The **Section 1115(a) Demonstration Waiver Evaluation** is as another method of monitoring MCO quality as part of the federal monitoring and evaluation. Monitoring of performance and quality for the Section 1115(a) is different from the EQRO's annual activities. The waiver evaluation has evolved over the years to provide more insight into performance and ongoing monitoring. As a condition for approving the Demonstration, CMS required HHSC to evaluate the expansion of Medicaid Managed Care, as well as the waiver's additional goals. The recent evaluation of the 1115(a) Texas Demonstration Waiver was published in May 2017 and is available publicly.[47]

5.2.3.3. The Role of the EQRO

The EQRO performs three mandatory functions and four optional functions. To ensure consistency of review across MCOs and programs, the EQRO assists with calculating, validating, and monitoring performance measures across the many quality initiatives. The EQRO conducts on-site visits with all the MCOs at least once every three years, which are separate and distinct from the reviews conducted by MCCO.

The EQRO is responsible for administering, calculating, and analyzing the CAHPS® survey to measure individuals' satisfaction, the CAHPS® Experience of Care and Health Outcomes (ECHO) survey to measure individuals' experiences with their MCO's behavioral healthcare providers, and the National Core Indicators – Aging and Disabilities (NCI-AD)™ survey.[48]

[46] *Texas Health and Human Services - HHSC OIG Division of Medical Services, https://oig.hhsc.texas.gov/medical-services.*

[47] *Texas Health and Human Services, Evaluation of the 1115(a) Texas Demonstration Waiver - Healthcare Transformation and Quality Improvement, May 30, 2017, https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/Evaluation-Texas-Demonstration-Waiver.pdf.*

[48] *The National Core Indicators – Aging and Disabilities (NCI-AD)™ survey is copyrighted by the National Association of States United for Aging and Disabilities (NASUAD) and the Human Services Research Institute (HSRI).*

5.2.3.4. Monitoring Claims and Encounter Data

HHSC contracts with the EQRO to validate encounter data submitted by the MCOs to the Medicaid claims administrator, TMHP. The Vendor Drug Program (VDP) also conducts its own reviews of pharmacy encounter records. In addition, the MCS Operations Management Claims Administration Unit is responsible for overseeing and providing direction to the Medicaid claims administrator regarding claims adjudication, provider enrollment, coordinating individuals' benefits, and managing claim and encounter data. HHSC performs oversight on the encounter data submitted by MCOs using several different methods:

- TMHP monitors provider enrollment and encounter data for the State. HHSC receives monthly reports from the TMHP that provide a snapshot of medical, dental, and pharmacy encounter data that has been received. These reports include data acceptance and rejection rates per MCO (actual encounters and percentages), submission timeliness, the most frequent failure and warning edits by MCO, and Present on Admission trends. TMHP also pulls professional/institutional encounters randomly for HHSC reporting and has plans to expand reporting efforts to include items specific to pharmacy encounter data.
- The MCS Operations Management Claims Administration Office also queries and reports on encounters using the SAP Business Objects XI (BOXI) tool, to spot-check encounters, perform additional business edits, and identify anomalies. For example, the Operations Management Claims Administration Office compares provider identification numbers in the encounter data with HHSC's list of all certified providers to ensure paid encounters are only with allowable certified providers. In addition, the Operations Management Claims Administration Office holds operational calls with MCOs to clarify anomalies in encounter data and realign all parties.
- MCO contracts require MCOs to submit complete and accurate data, and comparing claims to encounters is one way to ensure MCOs are submitting to HHSC what is received on the claims from providers. During operational reviews, MCS started to review provider claims and encounters for medical and dental services in March 2018, and pharmacy services in July 2018. The Operations Management Claims Administration Office is in the process of implementing a sampling and verification project. This project will allow staff by December 2018 to pull random samples of claims and encounter data to validate that the

claim received from the provider matches the encounter data submitted by the MCO.

- OIG conducts data research and data mining of encounters to identify suspected instances of fraud, waste, and abuse, and to determine the breadth and frequency of a complaint/referral. For more information on OIG's efforts, refer to **Section 5.4 Program Integrity**.
- HHSC contracts with an EQRO to review the detailed encounter data and provide certification of the data quality. The EQRO provides the data certification reports supporting rate setting activities and information related to the quality, completeness, and accuracy of the encounter data. If HHSC identifies issues with the encounter data, the Financial Reporting and Audit Coordination (FRAC) team works through the MCS Operations Support team to require encounter resubmissions with the MCOs. For more information on FRAC's efforts, refer to **Section 5.9 Rate Development Standards**.

5.2.3.5. Enhancing Health Information Exchange (HIE)

Starting in October 2015, the MCS Health Informatics Services and Quality Office began the HIE Connectivity Project with the primary objectives of advancing care coordination through increased HIE adoption and use by Texas Medicaid providers and creating additional capacity in Texas that can support that use and adoption. This project connects Medicaid providers to local HIE organizations leveraging HHSC's investment in providers' adoption of Electronic Health Record systems in three strategies. By connecting Medicaid providers with MCOs through timely electronic data transfer, HHSC aims to reduce emergency department utilization and hospital readmissions and enable better quality of care for Medicaid and CHIP members across the healthcare system by enhancing existing clinical tools. In this fiscal year, HHSC will promote initiatives that drive HIE in the State of Texas, to advance care coordination through increased HIE adoption and use by Texas Medicaid providers. These efforts could create additional capacity (e.g., connect additional HIE organizations to the state services layer) in Texas that can support that use and adoption. The HIE strategies will bring in the necessary data for measuring VBP efforts and will present an opportunity to better use clinical data to inform managed care oversight.

5.3. Network Adequacy and Access to Care

5.3.1. Contract Management Maturity Model (CMMM) Results

Designated Level: Structured

Rationale

- The processes and standards for monitoring network adequacy are fully established. Medicaid and CHIP Services Department (MCS) worked with stakeholders, including Managed Care Organizations (MCOs), Dental Maintenance Organizations (DMOs), provider groups, and member advocates to develop and implement network adequacy standards requirements, addressing the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule issued by the Centers for Medicare & Medicaid Services (CMS). During the period of this review, MCS was on track toward institutionalizing and mandating the requirements in advance of the network adequacy requirements of the Managed Care Final Rule that went into effect on July 1, 2018.
- While some automation exists in the data validation of the network data received from MCOs, in the current state, the time required for data processing is extensive and travel time calculation is performed annually. The current processes present an opportunity for HHSC to leverage automated data validation and calculation tools to increase the frequency of the network adequacy analyses. This opportunity would enable more timely identification and action for network adequacy issues.
- To continue to evolve network adequacy processes and standards, MCS could consider closer alignment and integration across the divisions in how they each use network adequacy data in their work. For example, the External Quality Review Organization (EQRO) conducts appointment availability studies that could identify providers that are reported as part of an MCO's network but might not be available to the individuals for months. To reflect the "true" network available to Medicaid individuals, results of appointment availability studies could be fed back in the network adequacy calculations.
- Another example of integration would be to leverage encounter data reviewed by EQRO to determine which providers or provider sites have

not provided recent services to the MCO's members and determine what the impact would be to MCO networks if network adequacy was calculated excluding these providers which have a high probability of not truly being available to members. These results would then be used to better inform and targeted oversight activities including utilization reviews to focus on specific geographic regions and provider specialties.

5.3.2. Findings

- **Opportunity for Process Automation** – MCS has incorporated sophisticated mathematical calculations for distance and travel time standards into its network adequacy process. In the current state, the time required for manual data processing is extensive. With the current resources and capabilities, there is a three-month lag between when files are received to when results are computed. Based on practices observed in other states, an opportunity exists for HHSC to leverage automated data validation and calculation tools, thereby decreasing processing time and resources required, and allowing for more frequent calculation of key variables like travel time.
- **Opportunity for Network Adequacy Standards for Long Term Services and Supports (LTSS) provider types** – CMS has directed states to develop and implement network adequacy standards other than time and distance for providers who travel to an individual to provide care (e.g., personal care attendants); however, CMS has not specified any particular standards that states must use for LTSS network adequacy nor if standards can differ between provider types. As MCS looks to mature its network adequacy standards for Home- and Community-Based Services (HCBS) and LTSS, they could consider practices other states are implementing to adequately oversee access to LTSS services. According to a study by the Medicaid and CHIP Payment and Access Commission (MACPAC) reviewing 33 Managed Care Long Term Services and Supports (MLTSS) contracts in 23 states and published in their June 2018 Report to U.S. Congress, the most common HCBS network standards were the following:[49]

[49] *Medicaid and CHIP Payment and Access Commission (MACPAC), June 2018 Report to Congress on Medicaid and CHIP, https://www.macpac.gov/publication/june-2018-report-to-congress-on-medicaid-and-chip/.*

- "continuity of care standards beyond federal time requirements (23 contracts), including standards to promote a smooth transition from a non-participating HCBS provider to a participating HCBS provider when a beneficiary is newly enrolled in a health plan, or when a provider discontinues participation in the health plan network;
- time and distance metrics (22 contracts) that establish the maximum allowable travel time or mileage between a beneficiary's residence and HCBS providers to which the beneficiary travels (e.g., adult day health and day rehabilitation centers);
- criteria for number of providers (16 contracts), which define a minimum number of providers by type or require reporting to the state of the total number of participating HCBS providers in a defined geographic service area;
- reporting requirements for gaps in service (14 contracts), which require reporting to the state of missed HCBS visits and gaps or delays from the time of service authorization to service delivery, and is a preferred standard by MACPAC's stakeholders; plans may also be required to demonstrate their processes for monitoring the timeliness of care provided to individuals and for addressing deficiencies.
- any willing provider provisions (14 contracts), which require that plans reimburse for care delivered by any willing HCBS provider;
- rate requirements (11 contracts) that require plans to pay providers at least Medicaid fee-for-service rates; and
- single case agreement provisions (10 contracts), through which plans provide time-limited access to out-of-network providers for continuity purposes or for services that are not otherwise available from a participating network provider (also referred to as single source agreements)."

Using this approach, MCS would be better enabled to account for differences in population and LTSS provider entity size when defining network adequacy standards and monitoring MCOs for compliance. MCS is in the process of defining network adequacy standards for LTSS provider types for the upcoming contract amendment in fall 2018.

- **Opportunity to Align Network Adequacy and Access to Care Efforts** – MCS monitors access to care through appointment availability studies, Primary Care Provider referral studies, and by monitoring MCO provider directories. Closer alignment and integration

among access to care, network adequacy data, and processes to evaluate actual network adequacy based on both provider location and availability, would enable MCS to monitor the adequacy of the provider networks more effectively. For example, when the appointment availability results identify primary care providers who are not really in-network or who are not offering timely appointments, that information should be shared with HHSC Center for Analytics and Decision Support (CADS) and MCS Managed Care Compliance and Operations (MCCO), so HHSC could remove these providers when calculating an MCO's network adequacy.

- **Opportunity to Introduce Additional Factors in Network Adequacy Analysis** – The current network adequacy assessment process results in a binary "pass/fail" assessment by provider type, county, and MCO. Currently, the report provides the total number of providers contracted with any MCO in each county. Other reports are available to MCOs upon request with details on those providers, with which MCO(s) they are contracted, or how MCOs could contact the providers. By enhancing the reporting going back to the MCOs with additional details on providers who are available but not in the MCO's network, MCS can more directly help MCOs identify potential providers to add to their networks and in turn improve compliance with network adequacy standards. There are additional opportunities to enhance monitoring of network adequacy and take corrective action by reviewing complaints from members and providers, patterns of out-of-network provider utilization, and single case agreements between MCOs and non-contracted providers. HHSC could also strengthen their monitoring of the MCO's provider directories, for example, by validating provider directories with HHSC's listing of all certified providers.

5.3.3. Supporting Information

5.3.3.1. Developing and Enforcing Network Adequacy Standards

MCS includes provider network requirements in contracts with MCOs. There requirements are designed to ensure that members have timely access to needed care. Members should be able to easily identify available providers to meet their needs, obtain appointments, and reach their appointments within reasonable distance and travel time. HHSC CADS and MCS conduct geo-

mapping studies to calculate distance and travel time between each member's residence and provider locations, collect data on timeliness of care through annual surveys, monitor complaints made by members and providers, and monitor patterns of out-of-network provider utilization, as well as single case agreements (SCAs) between MCOs and non-contracted providers. In combination, these indicators allow MCS to assess the adequacy of each MCO's provider network and performance in meeting contractual obligations. MCOs found to be noncompliant with network adequacy standards may be subject to Liquidated Damages (LDs) and must show reasonable effort to mitigate the deficiency. In addition, new managed care reporting guidelines were established to improve the MCS network adequacy oversight process.

5.3.3.1.1. Defining Network Adequacy Standards

To address the Medicaid and CHIP Managed Care Final Rule, MCS worked with stakeholders, including MCOs, DMOs, provider groups, and member advocates, to develop and implement network adequacy standards requirements with the support of the Results Management Office. Network adequacy standards are defined based on the members' residential county; counties are classified as micro, metro, and rural based on population with corresponding standards for each. Time and distance standards are then assigned to each county classification for different provider specialties, expanding on the previous method of calculating standards that accounted only for straight line distance. The time and distance standards are in Section 8.1.3.2 in the Uniform Managed Care Contract (UMCC), and included in **Appendix 5.3.1**. Time and distance standards for MCO's network adequacy can be found in the contracts for all managed care programs.

5.3.3.1.2. Collecting and Validating Provider Data

HHSC requires managed care providers to enroll with the State before undergoing any MCO credentialing, which ensures a single point of entry to the Medicaid and Children's Health Insurance Program (CHIP) managed care system. HHSC, Texas Medicaid and Healthcare Partnership (TMHP), and the enrollment broker (EB) play central roles in collecting and validating provider data used to determine network adequacy. The enrollment broker has compiled a Joint Interface Plan (JIP) that serves as a universal standard for code descriptions for all files. If there are changes, MCOs are required to submit a Medicaid provider file daily and monthly for CHIP. After receiving the files, the EB verifies formatting accuracy against the JIP. The EB then

checks the file against all Medicaid providers to validate that all providers listed are in the fee-for-service (FFS) network, screened, and enrolled with TMHP.

5.3.3.1.3. Analyzing Provider Data

The EB transmits the final correct records to CADS twice monthly for a secondary validation of completeness and accuracy for the provider types included in network adequacy standards. CADS geo-codes the data quarterly and straight-line distance calculations are performed; travel time calculation is only performed annually based on the center of each zip code where members reside due to the complexity and manual nature of the analysis. CADS utilizes the JIP to account for differences in program requirements based on member eligibility, and calculates the compliance results based on the Technical Specifications.[50] Calculations are run at the member level, with each member linked to his/her plan, county, and in-network providers appropriate for the age and gender of the member. The report provided to the MCOs is an aggregation of these member-by-member calculations showing MCO compliance on a county-by-county basis. **Appendix 5.3.2** contains HHSC's plan for reporting the results of the network adequacy calculations and issuing contract remedies for non-compliance.

5.3.3.1.4. Monitoring Terminations and Out-of-Network Usage

MCOs are contractually required to notify MCS of provider terminations and must make a good faith effort to notify members, if terminating a provider will affect more than 10 percent of members. MCCO also confirms that all members displaced by the termed provider are reassigned to new providers. MCS monitors out-of-network utilization, as seen in the Quarterly Performance Reports (QPRs) in **Appendix 5.1.3**. Through complaint and inquiry analysis, MCS also monitors SCAs between MCOs and non-contracted providers, and continuity of care after providers leave the network or if network adequacy issues are observed.

5.3.3.1.5. Issuing Corrective Action Plans

MCCO compares the network adequacy analysis results to determine if MCOs are meeting minimum adequacy criteria. The oversight of the network adequacy process has been split into two phases with an increasing number

[50] *Texas Health and Human Services, Network Adequacy Technical Specifications Draft for MCO Review, https://hhs.texas.gov/sites/default/files//documents/about-hhs/communications-events/news/20170428-technical-specifications-002-news-article.pdf.*

of requirements that MCOs must meet and more severe remediation approaches if requirements are not met. HHSC is currently assessing Corrective Action Plans (CAPs) at less than 75 percent (monitoring threshold) of members within distance or travel time. As of June 30, 2018, MCS had 16 open CAPs with MCOs to address network adequacy time and distance issues. MCS will begin to recommend LDs for MCOs failing to meet network adequacy standards for 90 percent or more of members within distance or travel time for the first quarter of SFY2019. After following the documented process for the review and approval, of LDs HHSC may decide to waive or reduce specific LDs in certain cases.

Based on the initial data collected by HHSC using the processes described, HHSC found MCO networks are meeting their network adequacy standards for access to primary care, behavioral health, and prenatal care. There appear to be gaps in access to specialists and dental providers especially in rural areas, which is typical, given that specialists tend to practice in or around urban areas where the population is sufficient to sustain a practice. Gaps in care are also observed in metro and micro areas are but could be attributed to incompleteness of provider data supplied by MCOs or MCOs failing to adhere to the rules specified in the JIP.

5.3.3.2. Ensuring Access to Care

In addition to quarterly monitoring of time and distance standards, MCS monitors MCO enrollees' access to care through appointment availability studies, Primary Care Provider referral studies, by monitoring MCO's provider directories, and by complaint analysis. The MLTSS UR team also monitors access to care though reviews of assessed service needs and home visits with members. This monitoring determines whether identified services are being provided and considers timeliness of service initiation. More information on the MLTSS Utilization Review team can be found in **Section 5.2 Quality of Care**. MCS continues to explore other methods to capture information on how long it takes members to obtain services after prior authorization. This currently includes monitoring member and provider complaints regarding extended wait times and/or for any specific issues within a MCO's network.

5.3.3.2.1. Appointment Availability Studies

MCS monitors MCO compliance with appointment availability standards for different service types through the EQRO using a secret shopper methodology. Using a sample provided by MCOs, EQRO callers pose as STAR

and STAR+PLUS members who have recently moved to the area and are looking for an initial appointment. The EQRO collects data on offered appointments, as well as wrong numbers, unanswered calls, and instances when providers indicated they were not taking new patients, not accepting Medicaid, or were out of network for the MCO for which they had been listed. Results are then presented at the program level by MCO and service area, and separately for children and adults. Appointment availability standards from Section 8.1.3.1 of the UMCC can be found in **Appendix 5.3.3.**

Quality Assurance oversees the monitoring of appointment availability studies. In 2016, no formal actions were taken against noncompliant MCOs; however, plans of action were issued to move into compliance. Starting in 2018, MCS began issuing CAPs to MCOs and MCOs may be subject to LDs if appointment availability thresholds are not met. MCS continues to explore additional ways to evaluate the wait period for members to obtain services after prior authorization, and currently monitors member and provider complaints regarding extended wait times.

5.3.3.2.2. Primary Care Provider Referral Studies

MCS conducts a Primary Care Physician Referral Study in conjunction with the EQRO. The EQRO surveys primary care physicians about their experiences obtaining specialty care appointments for pediatric and adult members with various developmental, behavioral health, and physical health conditions.

5.3.3.2.3. Monitoring MCO's Provider Directories

MCOs are required to regularly publish searchable and up-to-date online provider directories and send paper copies of provider directories to any member upon request, and all STAR+PLUS and STAR Kids members who do not opt out. To monitor MCO compliance with this requirement, MCCO reviews a sample from the MCO's online directory and places secret shopper calls to validate the information posted to each MCO's website.

5.4. Program Integrity

5.4.1. Contract Management Maturity Model (CMMM) Results

Designated Level: Integrated

Rationale

- Program Integrity processes and standards, especially related to fraud, waste, and abuse across HHSC are well coordinated and integrated by the Texas Office of Inspector General (OIG) in coordination with Medicaid and CHIP Services Department (MCS).
- Recent collaboration efforts like the Texas Fraud Prevention Partnership help increase coordination of leading practices in identifying fraud, waste, and abuse among Managed Care Organizations (MCOs), Dental Maintenance Organizations (DMOs), the Texas Health and Human Services (HHS) System, the Office of Attorney General, and the OIG.

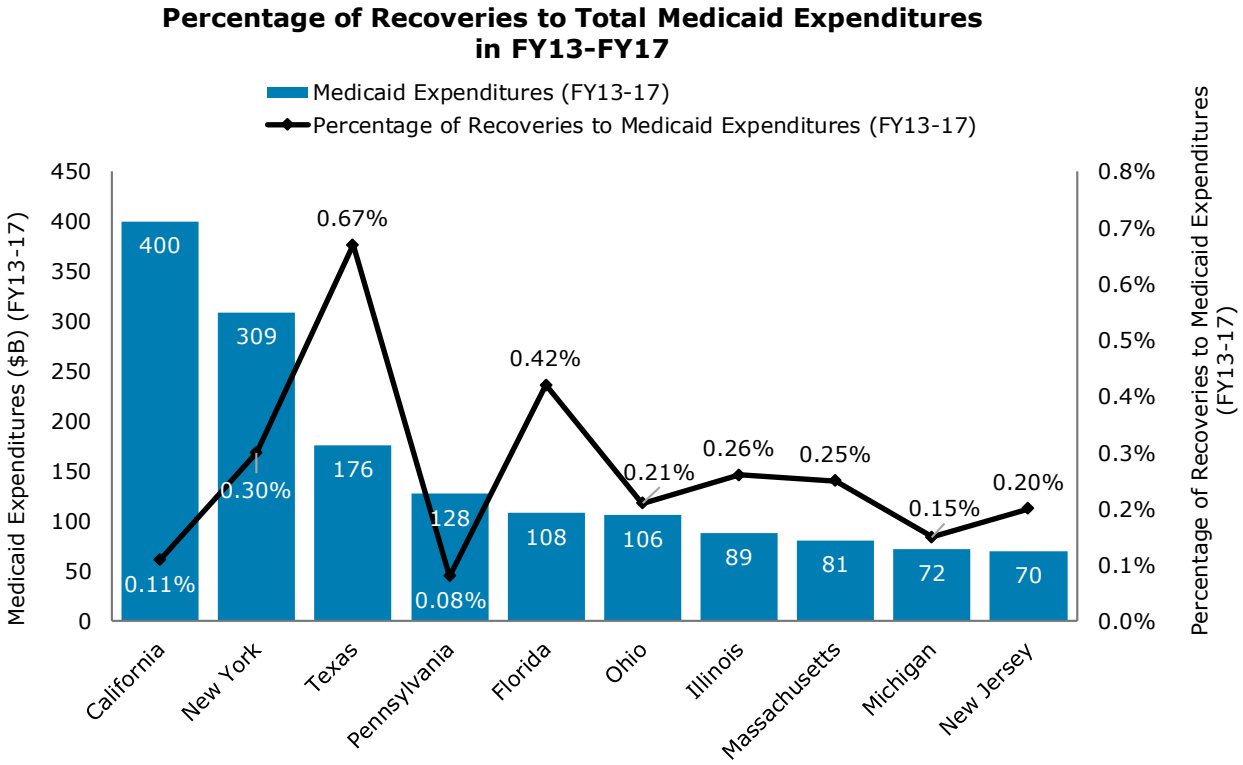
5.4.2. Findings

- **Continue Recovery Activities** – Based on the FY13-FY17 data provided by State Medicaid Fraud Control Units (MFCUs) to the OIG for the U.S. Department of Human Services[51], the percentage of recoveries[52] for Texas against the total FY13-FY17 Medicaid expenditures was 0.67 percent. It was the highest in the comparative group collection percentages, which ranged from 0.08 percent to 0.67 percent. See **Figure 11** for percentage of recoveries to total Medicaid expenditures from FY13-FY17 for the reviewed states.

[51] *U.S. Department of Health and Human Services - Office of Inspector General, Medicaid Fraud Control Units – MFCUs, https://www.oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.*

[52] *Recoveries are defined as the amount of money that defendants are required to pay as a result of a settlement, judgment, or prefilling settlement in criminal and civil cases and may not reflect actual collections. Recoveries may involve cases that include participation by other Federal and State agencies.*

Figure 11. Percentage of Recoveries to Total Medicaid Expenditures in FY13-FY17.



State	Medicaid Expenditures in Billions (FY13-17)	Percentage of Recoveries to Medicaid Expenditures (FY13-17)
California	$400	0.11%
New York	$309	0.30%
Texas	$176	0.67%
Pennsylvania	$128	0.08%
Florida	$108	0.42%
Ohio	$106	0.21%
Illinois	$89	0.26%
Massachusetts	$81	0.25%
Michigan	$72	0.15%
New Jersey	$70	0.20%

- **Continue the Texas Fraud Prevention Partnership** – According to the FY17 OIG Annual Report, the Texas Fraud Prevention Partnership is a collaboration "to exchange information between public and private payers; to share data and analytics with OIG; to identify areas of fraud, waste, and abuse in Texas Medicaid; to share trends, schemes, strategies, and effective methodologies; and to facilitate best practices between MCOs, DMOs, the Texas HHS System, the Office of Attorney General, and the OIG."[53] A series of Fraud Detection Operations were conducted using data-driven intelligence to identify proactively areas of potential vulnerability of Medicaid expenditures, to develop high quality cases, and to provide a deterrent effect. Medicaid Program Integrity (MPI) selects provider types to review during an Fraud Detection Operations based on numerous sources, including, but not limited to the following:
  - Suggestions from OIG, based on data analytics;
  - MPI Intake complaint trend reviews;
  - Stakeholder discussions with the Texas Fraud Prevention Partnership;
  - Subject matter experts' input; and/or
  - Trends in the field.

  These ten operations generated 35 cases representing 35 providers; nine were completed and six transferred to the OIG Division of Medical Services and/or Litigation for adjudication. Of the 19 cases, resolution included provider education, referrals for further action to state boards, the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) or MCOs, or are still in progress.
- **Opportunity to Update the Methodology for Measuring Program Integrity** – Historically, measurement of program integrity efforts has been focused on fraud, waste, and abuse.[54] This type of measurement was developed for a fee-for-service (FFS) environment. With the shift to managed care, the OIG has the opportunity to update its methodology for program integrity in a managed care environment, an effort which OIG reports is underway. In addition to investigating and recovering overpayments, OIG is exploring different options to

[53] *Texas Health and Human Services Office of Inspector General, Annual Report in Fiscal Year 2017, https://oig.hhsc.texas.gov/sites/oig/files/documents/IG-Quarter-4-2017-Report.pdf.*

[54] *Texas Administrative Code, Title 1, Part 15, Chapter 371, Subchapter B, Section 371.11.*

measure program integrity efforts, including quantifying and validating cost avoidance in a managed care context and adapting OIG's tools for risk-based and value-based arrangements. In June 2018, CMS announced new and enhanced initiatives to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools.[55] Several new CMS initiatives will enhance oversight of state contracts with MCOs and enforce stricter state compliance with federal rules, including:

- Stronger audit functions of the amount spent on clinical services and quality improvement versus administration and profit
- Increased beneficiary eligibility oversight by introducing new audits of state beneficiary eligibility determinations
- Increased validation of the quality and completeness of state-provided claims and provider data
- Increased knowledge sharing to help states analyze Medicaid state claim data and identify potential areas to target for investigation
- Enhanced data sharing with states to collaboration on program integrity efforts in both the Medicare and Medicaid programs
- Stronger efforts to provide effective Medicaid provider education to reduce aberrant billing, including education focused on comparative billing reports.

5.4.3. Supporting Information

5.4.3.1. MCO Program Integrity Activities

Along with the OIG and MCS, both HHSC and MCOs participate in a combined effort to protect the resources and interests of HHSC and the State of Texas. HHSC confirms and approves the program integrity activities of MCOs. Functionally, MCO's program integrity activities consist of preparing fraud, waste, and abuse compliance plans and validating encounter data and prepayment plans that are part of MCO's contract. MCO's compliance plans include details on monthly encounter data and

[55] *Centers for Medicare and Medicaid Services, Medicaid Program Integrity Strategy, https://www.medicaid.gov/state-resource-center/downloads/program-integrity-strategy-factsheet.pdf.*

pharmacy encounter data within 25 days after the date of adjudication to Texas Medicaid and Healthcare Partnership (TMHP). In addition to each MCO's fraud, waste, and abuse compliance plan, MCOs are required to report additional deliverables related to the fraud business function. See **Appendix 5.1.2** for deliverables by function.

Every MCO is required to internally operate or contract with a Special Investigative Unit (SIU) to investigate fraud, waste, and abuse. Within 30 days of identifying possible or suspected fraud, waste, and abuse, the SIU must submit a referral form to OIG through the Waste, Abuse, and Fraud Electronic Reporting System. The OIG conducts a preliminary investigation on providers referred by MCOs for fraud, waste, or abuse. If a full-scale investigation ultimately substantiates the referral, the provider may be subject to administrative enforcement actions, including but not limited to, exclusion and recoupment of overpayments. Alternatively, a provider may be referred back to the MCO for recoupment or other contractually appropriate action.

5.4.3.2. State Program Integrity Activities

The State performs listed oversight activities in collaboration with MCO-established SIUs.

- HHSC monitors MCOs and their subcontractors' disclosures on ownership and control based on the MCO disclosure statements that include a listing of the MCO's control, ownership, and any affiliations, and information regarding affiliate transactions.
- The Office of the Attorney General and the OIG collaborate and coordinate to identify and prevent fraud, waste, and abuse.[56]
- Criminal fraud investigations are conducted by the MFCU under the Office of the Attorney General.
- The OIG is responsible for the investigation, inspection, audit, and review of fraud, waste, and abuse, and for the application of administrative enforcement measures when fraud, waste, and abuse is substantiated. The OIG provides guidance and advice to Medicaid and CHIP Services Department (MCS) and MCOs on program integrity

[56] *Texas Health and Human Services – Office of Inspector General, Joint Annual Interagency Coordination Report, https://oig.hhsc.texas.gov/sites/oig/files/reports/Joint-Annual-IG-MFCU-Report-2017.pdf.*

matters and coordinated efforts, such as performance audits, administrative reviews, and on-site provider verification.

- Under the Office of Attorney General, the Civil Medicaid Fraud Division investigates and prosecutes civil fraud.

All MCOs are required to refer to the OIG cases of suspected provider fraud, waste, and abuse and must simultaneously inform MFCU about cases of suspected provider fraud. OIG conducts preliminary investigations of fraud, waste, and abuse based referrals from MCOs. Preliminary investigations typically consist of further research into billing patterns of a provider, policy research, and may include clinical consultations. Full scale investigations may include additional data analysis, interviews, and records reviews. In addition to investigations, OIG's other primary tools to combat fraud, waste, and abuse include audits, reviews and inspections.[57] Depending on the outcome, litigation, and administrative actions may follow.

The OIG is responsible for the oversight of fraud, waste, and abuse activities and provides guidance and advice to MCS and MCOs on program integrity matters and coordinated efforts, such as audits, administrative reviews, and on-site provider verification.

- **Audits** – On an ongoing basis, OIG conducts risk-based audits of various managed care topics, including STAR+PLUS enrollment, MCO special investigative units, MCO utilization management, managed care speech therapy providers, and pharmacy benefit managers. Audits fall into three categories: performance audits of the HHS System and Texas Department of Family and Protective Services (DFPS) program areas, which includes MCO or MCO's contractor performance; information technology audits of MCO security controls over confidential data; and provider audits of managed care providers. OIG also produces informational reports that contain in-depth analyses of non-audited information about managed care functions or activities, coordinates federal government audits, and serves as the single point of contact with CMS for Unified Program Integrity Contractor audits and Payment Error Rate Measurement activities. For more information on audits conducted by OIG, please refer to **Section 5.1 State Monitoring Standards**.
- **Reviews** – The OIG Utilization Review (UR) Unit performs retrospective on-site utilization reviews of nursing facility records to

[57] *Texas House of Representatives Committee on Appropriations Agenda, April 18, 2018.*

evaluate whether facilities correctly assessed and documented residents' needs; Medicaid reimbursements were appropriate for the level of care provided; and care provided was medically necessary. Based on an assessment of risk, OIG selects facilities to review and the records it reviews at selected nursing facilities. There are approximately 1,300 nursing facilities in the state of Texas. The OIG UR Unit identifies the population available for review and considers risk factors through a desk review to establish its annual work plan. Approximately 400 to 500 reviews are performed onsite each year. For more information on utilization reviews conducted by the OIG, please refer to **Section 5.2 Quality of Care** and **Appendix 5.1.1**.

- **Inspections** – Inspections of HHS programs, systems, and functions are focused on fraud, waste, abuse, and systemic issues to improve the HHS System. The inspection universe includes the departments, programs, functions, and processes within the HHS system, including services delivered through managed care, providers, and contractors.
- **Investigations** – MCOs are required to refer to the OIG all possible acts of suspected fraud, waste, and abuse reported by the MCO's SIU.

OIG also provides training for MCOs around fraud, waste, and abuse during the initial phases of managed care contracts as a component of MCO operations and the SIU, and provides training annually to MCOs through a webinar.

One of OIG's tools for detecting, deterring, and preventing fraud, waste, and abuse is performing and coordinating audits of departments, programs, functions, and processes within the HHS system and DFPS, including services delivered through managed care providers and contractors. Audits may identify improper payments or unsupported costs that lead to recoupments, and may offer recommendations to improve performance, mitigate risks, address control weaknesses, and reduce privacy and information technology security vulnerabilities. If instances of non-compliance are identified during OIG audits, OIG makes recommendations for MCS to take corrective actions and/or assess Liquidated Damages (LDs).

5.4.3.3. Recovery and Retention

MCOs are required to refer any potential fraud, waste, or abuse to the OIG.[58]

[58] *Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, Section 353.505.*

In the past, if the amount to be recovered is greater than $100,000 and the OIG assumes responsibility for the investigation and recovery efforts, then the MCO would receive any recovered amounts less the cost of the investigation. If an MCO is the sole entity conducting an investigation, it is entitled to retain any money recovered. The OIG did not retain any recovered funds under the previous structure.

House Bill 2379 from the 85th Legislative Session changed how recovered funds are distributed. Any funds recovered by an MCO, or through a joint effort between the OIG and an MCO, will be split evenly between the MCO and the OIG after the federal share is deducted. Any funds identified and recovered solely by the OIG will be retained 100 percent by the OIG. MCO's expenses are reduced by the amount of recoveries, which reduces MCO's costs included in capitation rate development. The SFY2017 *HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries* cited approximately $5 million in recovered and retained MCO funds as seen in **Appendix 5.4.1**.

In March 2018, the OIG submitted a review of MCO's cost avoidance and waste prevention activities reports to comply with Rider 152 of the 2018-2019 General Appropriations Act. A component of which was a review of the effectiveness of MCO's cost avoidance strategies. OIG recommended the use of standardized methodologies developed by the State, with stakeholders' input, to calculate and evaluate their cost avoidance savings related to fraud, waste, and abuse prevention activities. OIG also recommended that MCOs periodically review and revise algorithms for fraud, waste, and abuse detection focused data analytics.[59]

5.4.3.4. Third-Party Liability

Each MCO must annually submit a plan to the MCS Subrogation & Recovery team that outlines the MCO's process for avoiding and recovering costs for services that should have been paid through a third party. As required in Section 5.3.4 of the UMCM, MCOs report their third-party liability recoveries monthly to HHSC, and have 120 days to attempt recovery of cost of services from the date of adjudication of a claim that is subject to third-party

[59] *Texas Health and Human Services Office of Inspector General, Medicaid and CHIP Managed Care Organizations' Special Investigative Units Review and Recommendations as directed by Rider 152, Article II, 85th Legislature, https://oig.hhsc.texas.gov/sites/oig/files/reports/OIG-Rider-152-report.pdf.*

recovery.[60] After 120 days, HHSC attempts to recover any claims that the MCO did recover and will retain, in full, all funds received. The projected amount of third-party liability funds that MCOs are expected to recover may be factored into the rate setting process.

[60] *Texas Health and Human Services Uniform Managed Care Manual, https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/5.3.4.2-2012.pdf.*

5.5. Grievances and Appeals

5.5.1. Contract Management Maturity Model (CMMM) Results

Designated Level: Basic

Rationale

- Grievances and appeals are tracked in a collaborative, system-wide effort, and there are multiple avenues by which members and providers can access HHSC if they have a concern. However, the processes for logging complaints are not structured or standardized. An enterprise system HHS Enterprise Administrative Record Tracking (HEART) is used to collect most of data received directly by the State but the process of logging and tagging the data differs across departments, resulting in approximately 120 duplicative and redundant complaint types, creating a challenge in aggregating data. To help address this aggregation challenge, HHSC is in the process of revising the complaint types to map them to major complaint categories such as Accessibility/ Availability and Quality of Care. The category descriptions for the nature of issues reported in the HEART system are provided in **Appendix 5.5.2**.
- Technical definitions and processes related to complaints differ between the Office of the Ombudsman[61] and MCS[62], which presents

[61] *According to Texas Health and Human Services Circular C-052, HHS Consumer Inquiry and Complaint Policy, a complaint is defined as any expression of dissatisfaction by a consumer of an HHS program or service about HHS benefits or services. For purposes of this circular, complaints do not include: 1) allegations of abuse, neglect, or exploitation; 2) allegations of violations of civil rights, including discrimination; 3) allegations of fraud, waste, or abuse; 4) personnel and disciplinary matters; 5) requests for Fair Hearings and/or other appeals; or 6) concerns about regulated individuals (e.g., occupational licensees) and entities (e.g., nursing facilities).*

[62] *According to the Health Plan Management Desk Manual, Chapter 16.1, a complaint is defined as an expression of dissatisfaction expressed by a member or other individual designated to act on behalf of the Member, verbally or in writing to HHSC, about any matter related to the MCO other than an Action. HHSC will accept provider complaints as described in 1 TAC 353.4 (f). As provided by 42 C.F.R. 438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights.*

challenges for aligning, analyzing, and addressing grievances across the managed care system.

5.5.2. Findings

- **Continue to Improve Grievances and Appeals Data Aggregation and Identification of Trends** – HHSC has an opportunity to aggregate data on grievances, appeals and fair hearings, and report trends that compare across programs, service delivery areas, Managed Care Organizations (MCOs), and business units. Currently, each business unit has access to complaints entered into the HEART system by their own staff. For example, MCCO can access data on grievances entered into HEART by MCCO staff but needs to request for ad-hoc reports from the Ombudsman and other HHSC business units for relevant complaints entered into HEART by non-MCCO staff. Including HEART complaints data from all business units in the data aggregation and analysis will give MCS a holistic view of the complaints across HHSC.
- **Opportunity to Align Entry Points for Grievances** – As described above, HHSC has an opportunity to enhance the reporting capabilities of the HEART system and standardize the way data is reported and tracked across different departments. For example, HHSC could leverage established grievances categories and measures used by with the Centers for Medicare & Medicaid Services (CMS) (**Appendix 5.5.2** and **Appendix 5.5.3**) for Medicare STAR ratings.
- **Opportunity to Enhance Education on the Issue Resolution Process** – MCS has an opportunity to enhance staff education and training on the correct issue resolution processes. Some divisions try to resolve grievances prior to reporting them to the Ombudsman and Managed Care Compliance and Operations (MCCO), thus delaying entry of grievances into the HEART system. Prompt reporting of issues into HEART would allow for better overall tracking of issues, resulting in more timely resolutions of issues that are initially raised to other groups.

Based on a review of available MCCO data across the two sources, the HEART system and the MCO's Complaints systems, which are available to members and providers to report complaints and appeals, below are some findings and challenges in data aggregation that have been highlighted.

Additionally, trends in data on fair hearings that were reported by HHSC Office of General Counsel have been included as well.

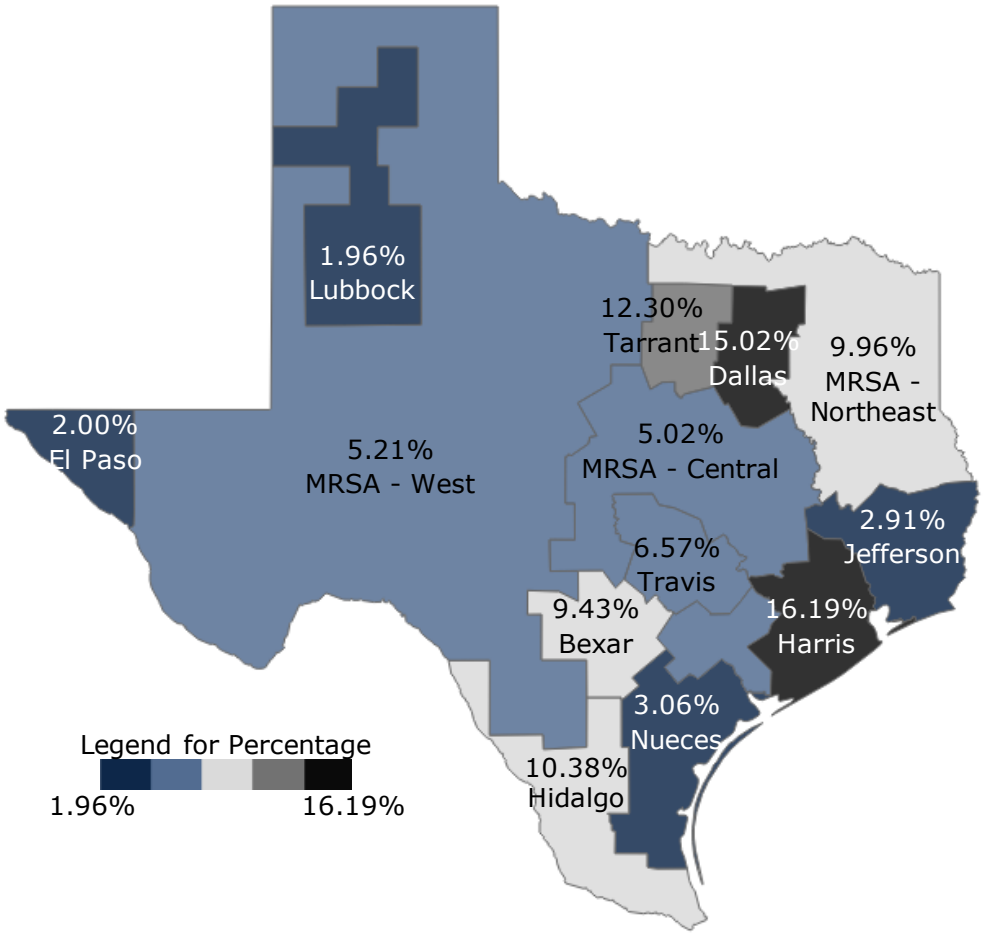
5.5.2.1. Source 1: Complaints Reported to MCCO through the HEART System

An analysis of data provided by MCCO for State Fiscal Year (SFY) 2014 through SFY2016 from the HEART system indicates the following:[63]

- **Complaints by Service Delivery Area (Figure 12)** – Of the 2,650 complaints and issues reported by MCCO from SFY2014 to SFY2016 with a known service area, 53.89 percent of the complaints and issues were reported in the Harris, Dallas, Tarrant, and Hidalgo service areas. This percentage is consistent with the population distribution, given that these service areas also have the highest number of Medicaid Managed Care members. The Lubbock and El Paso service areas have the lowest number of complaints and issues reported at 2 percent or less each.

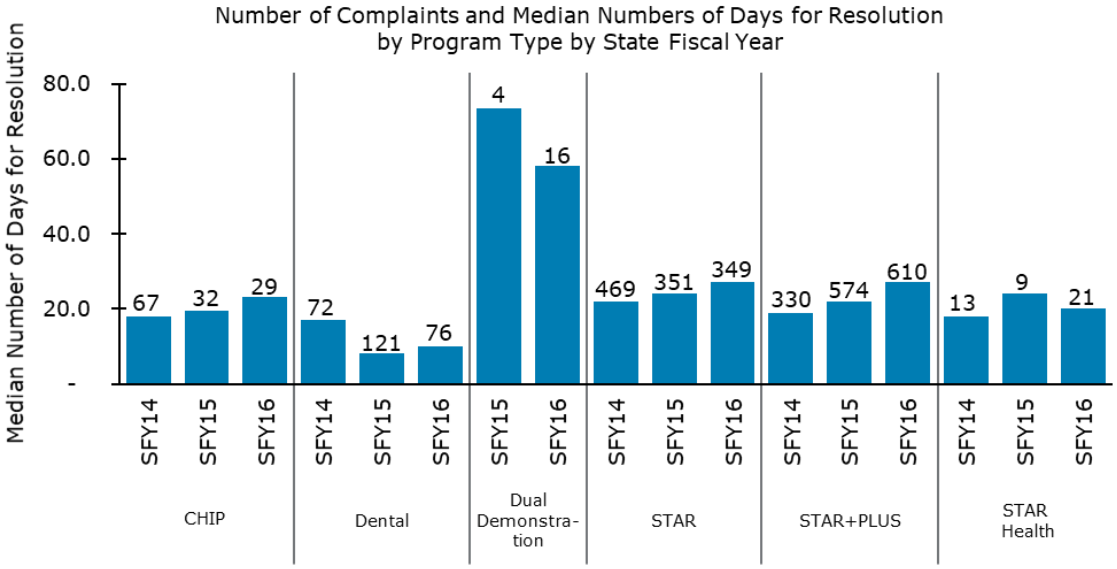
[63] *Within **Figure 12**, **Figure 13,** and **Figure 14**, justified and substantiated complaints reported to MCCO and are closed are displayed. Justified or substantiated is a complaint where research clearly indicates agency policy was violated or agency expectations were not met. Justified complaints are no longer used in HEART and have been replaced by substantiated complaints. Complaints reported to the Ombudsman or other HHSC business units are not displayed. Complaints related to unknown programs, the Primary Care Case Management program, the Integrated Care Management program, the NorthStar program, the Star Kids program, the fee-for-service (FFS) program or in the FFS service area, and the electronic visit verification contracted vendor are not displayed. Two outlier complaints in the Miscellaneous category are not displayed for State Fiscal Year 2015. The NorthStar program ended in December 2016. The Dual Demonstration program began in March 2015 in State Fiscal Year 2015, and the Star Kids program began in November 2016 in State Fiscal Year 2017.*

Figure 12. Total Complaints Reported by Service Delivery Area from SFY2014 to SFY2016.



- **Complaints by Program Type** (**Figure 13**) – Across the various Medicaid and Children's Health Insurance Program (CHIP) managed care programs, MCCO resolved and closed the majority of complaints within 30 median days, except for those related to the Dual Demonstration program. Four complaints in the Dual Demonstration Program were resolved within 74 median days in SFY2015 and 16 complaints within 58 median days in SFY2016.

Figure 13. Number of Complaints and Median Numbers of Days for Resolution by Program Type by State Fiscal Year.

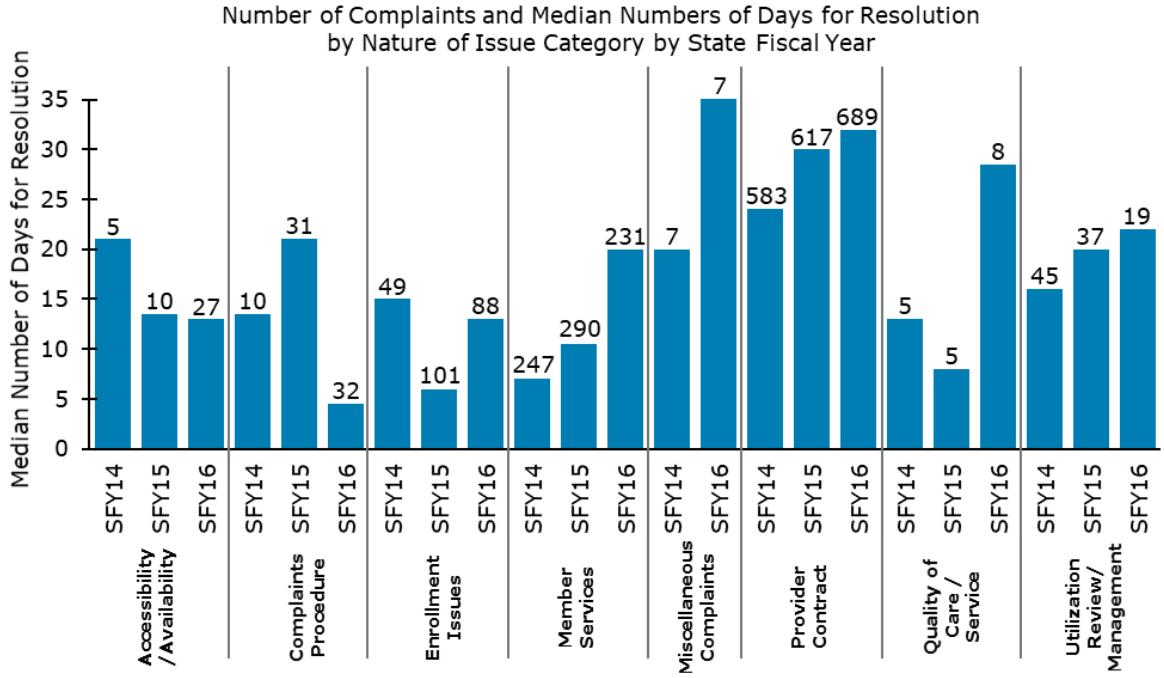


The count of complaints by fiscal year is displayed on top of each vertical bar.

Program	State Fiscal Year	Number of Complaints	Median Number of Days for Resolution
CHIP	SFY2014	67	18
CHIP	SFY2015	32	19.5
CHIP	SFY2016	29	23
Dental	SFY2014	72	17
Dental	SFY2015	121	8
Dental	SFY2016	76	10
Dual Demonstration	SFY2015	4	73.5
Dual Demonstration	SFY2016	16	58
STAR	SFY2014	469	22
STAR	SFY2015	351	24
STAR	SFY2016	349	27
STAR + PLUS	SFY2014	330	19
STAR + PLUS	SFY2015	574	22
STAR + PLUS	SFY2016	610	27
STAR Health	SFY2014	13	18
STAR Health	SFY2015	9	24
STAR Health	SFY2016	21	20

- **Complaints by Issue Category (Figure 14)** – As described previously MCCO has developed eight complaint categories to organize over 120 nature of issue codes available in HEART. **Appendix 5.5.2** provides the category descriptions for the natures of issues in the HEART system. For SFY2014 to SFY2016, the Provider Contract complaint category included the largest number of complaints reported to MCCO, and accounted for 60 percent of the total complaints. The nature of Provider Contract complaints could be related to denial of a claim(s), payment dispute(s), or a denial/delay of payment. The second largest complaint category was Member Services, which accounted for 24 percent of total complaints, and included issues such as such as access to care, benefits issues, member claim/billing issues, or issues related to durable medical equipment. HHSC resolved and closed most of the complaints and issues within 30 median days. The exceptions were some complaints in the Provider Contracts and the Miscellaneous categories, which were slightly over at 39 median days and 32 median days respectively.

Figure 14. Number of Complaints and Median Numbers of Days for Resolution by Nature of Issue Category by State Fiscal Year.



The count of complaints by fiscal year is displayed on top of each vertical bar.

Nature of Issue Category	State Fiscal Year	Number of Complaints	Median Number of Days for Resolution
Accessibility/Availability	SFY2014	5	21
Accessibility/Availability	SFY2015	10	13.5
Accessibility/Availability	SFY2016	27	13
Complaints Procedure	SFY2014	10	13.5
Complaints Procedure	SFY2015	31	21
Complaints Procedure	SFY2016	32	4.5
Enrollment Issues	SFY2014	49	15
Enrollment Issues	SFY2015	101	6
Enrollment Issues	SFY2016	88	13
Member Services	SFY2014	247	7
Member Services	SFY2015	290	10.5
Member Services	SFY2016	231	20
Miscellaneous Complaints	SFY2014	7	20
Miscellaneous Complaints	SFY2016	7	39
Provider Contract	SFY2014	583	24
Provider Contract	SFY2015	617	30
Provider Contract	SFY2016	689	32
Quality of Care / Service	SFY2014	5	13
Quality of Care / Service	SFY2015	5	8
Quality of Care / Service	SFY2016	8	28.5
Utilization Review / Management	SFY2014	45	16
Utilization Review / Management	SFY2015	37	20
Utilization Review / Management	SFY2016	19	22

5.5.2.2. Source 2: Complaints and Appeals Tracked by MCOs

Members and providers are directed to first report complaints and appeals to the MCOs. MCOs then provide HHSC with data on the complaints and appeals through deliverables that are converted by MCS into Quarterly Performance Reports (QPRs) for monitoring purposes. MCO-reported complaint and appeal data is compared to the performance standard set by HHSC, for example, 98 percent of appeals resolved within an established period. As required in Deliverable *5.4.2.19 - Member Appeals*, data reported by MCOs on member appeals has changed in the recent two fiscal years, thus making it difficult to aggregate, map, and trend certain types of

appeals. HHSC revised *Deliverable 5.4.2.19* in January 2017 for MCOs to provide additional details on 1-day and 3-day expedited member appeals, in addition to standard appeals. MCS is in the process of developing a visual dashboard to track MCO-reported complaints and appeals, which should be available in the coming six months.

5.5.2.3. Tracking and Trending Fair Hearings Data

If a member is unable to resolve their appeal with the MCO, the member may request a fair hearing with HHSC. Based on information provided by the HHSC Office of General Counsel Office, the number of fair hearings requested related to MCO appeal requests increased between SFY2016 and SFY2017, from 2,536 to 3,399 fair hearings, respectively. In SFY2018, over 2,900 fair hearings have been requested through June 24, 2018. About 12 to 14 percent of determinations were overturned in fair hearings in SFY2016 and SFY2017, whereas 19 percent were overturned in SFY2018. On average, 41 percent of determinations were dismissed in fair hearings in the past three fiscal years, with 45 percent in SFY2016, 38 percent in SFY2017, and 39 percent in SFY2018. For additional information on fair hearings outcomes related to MCO appeal requests in SFY2016 to SFY2018, refer to **Appendix 5.5.1**. MCS has an opportunity to work with HHSC Office of General Counsel to analyze the Fair Hearings data by MCOs and Service Delivery Areas as well, to help identify any systemic issues.

5.5.3. Supporting Information

5.5.3.1. Grievances and Appeals Reported to MCOs

Members are directed to their MCO to submit complaints, appeals, and inquiries. MCOs are required to have a Complaint and Appeal system that must include a Complaint process, an Appeal process, and access to HHSC's State Fair Hearing System, as well as a process to collect and track information about the MCO internal appeals of a complaint or action. The procedures must be the same for all members and must be reviewed and approved in writing by HHSC or its designee. HHSC mandates the type of staff that must have primary responsibility for managing complaint and appeal resolution and are involved in developing complaint-related policies and procedures and investigating appeals. These policies and procedures are then described in member handbooks, shared with providers, and reviewed by HHSC during readiness and operational reviews.

In accordance with the managed care contracts, each MCO must develop, implement, and maintain a system for tracking, resolving, and reporting member and provider complaints regarding its services, processes, procedures, and staff. Member and provider complaints are to be resolved within 30 days after receipt, or the MCO is subject to remedies if at least 98 percent of member complaints are not resolved within 30 days of its receipt. MCOs must also resolve provider complaints received by HHSC or referred by HHSC in the timeframes set by HHSC.

Similarly, each MCO must develop, implement, and maintain a system for tracking, resolving, and reporting Member and Provider Appeals regarding the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service. Standard and expedited member appeals must be resolved within the specified timeframes set by HHSC, unless the Member requested an extension or there is a need for additional information in the member's interest. In accordance with 42 CFR 438.410, the MCO also has an expedited review process for appeals if the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. CHIP MCOs must comply with the CHIP complaint and appeal process described in Section 8.4.2 of the UMCC.

MCOs then report on complaints and appeals to MCCO in quarterly Complaints and Appeals deliverables, per Uniform Managed Care Manual (UMCM) Chapter 5.4.2. From the deliverables on provider and member complaints, MCCO analyzes the MCO's explanation of not meeting the standard, any corrective measures the MCO is taking, the categories of provider or member complaints, and whether MCS will require additional remedies. For member appeals, MCCO conducts similar analysis, as well as tracks the volume of 14-calendar-day extensions and if member appeals are out of compliance with the timeframes. Aggregated data on the number of complaints and the percent resolved within 30 days are then monitored by MCCO within the QPRs. For more information on the QPR, refer to **Section 5.1. State Monitoring Standards** and **Appendix 5.1.3**.

MCOs must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance. The MCO must inform members that they have the right to access the State Fair Hearing process only after exhausting the MCO internal appeal system or if the MCO fails to respond to the member's appeal within the timeframe in 42 CFR 438.408. The MCO will submit the request for State Fair Hearing via Texas Integrated Eligibility

Redesign System (TIERS) to the appropriate State Fair Hearings office and prepare an evidence packet for submission to the HHSC State Fair Hearings staff and the member. A member has 60 days from the MCO's notice to request an appeal to the MCO. To ensure continuation of services, a fair hearing must be received within 10 days of the MCO's notice, in accordance with Section 8.2.6.2 of the Uniform Managed Care Contract (UMCC). **Appendix 5.5.1** describes in detail the HHSC fair hearing process.

5.5.3.2. Monitoring Grievances and Appeals Reported to the Office of the Ombudsman

The Office of the Ombudsman is responsible for dispute resolution services for all HHS agencies, as well as for performing consumer protection and advocacy functions related to HHSC programs and services. If a member's concern is not resolved to their satisfaction by the MCO, the member is directed to contact the Office of the Ombudsman. Members are expected to exhaust the MCO's complaint process before contacting the Office of the Ombudsman. Members or member advocates may submit inquiries and complaints to the Office of Ombudsman, which are received through five channels:

- Toll-free helpline
- Online form
- Email box available to HHSC staff to route member complaints to the Office of the Ombudsman from other sources and interactions
- Fax
- Postal mail

The Office of the Ombudsman also receives complaints from legislative offices, HHSC Government and Stakeholder Relations, and CMS (through MCS). The Office of Ombudsman will triage the complaint, work to resolve the member's issue, and/or coordinate with other HHSC program areas to resolve it. Ombudsman staff log inquiries and complaints into HEART. A member may also request a fair hearing via the Office of the Ombudsman. **Appendix 5.5.1** describes in detail the HHSC fair hearing process.

The Office of the Ombudsman leads the coordination of inquiry and complaint tracking, analysis, and reporting efforts of all HHSC agencies overseeing direct service delivery based on data tracked in HEART. The Agency Monthly Contact Report (AMCR) provides complaint and inquiries

data based on risk analysis, as defined in HHS Circular 052. The Office of the Ombudsman generates the Agency Monthly Contact Report (AMCR) for the Executive Commissioner based on complaints received. Once approved by the Executive Commissioner, the AMCR is distributed to HHSC programs and the HHSC Office of Policy and Rules.

5.5.3.3. Monitoring Grievances and Appeals Reported to MCS and Other Areas of HHSC (excluding the Office of the Ombudsman)

In addition to the HHSC Office of the Ombudsman, the Medicaid and CHIP Services Department (MCS), Texas Medicaid and Healthcare Partnership (TMHP), Texas Legislature, or Texas Department of Insurance (TDI) (applicable to CHIP only) may also receive complaints. All complaints, inquires, and disenrollment requests reported to HHSC are logged in the HEART system. HEART is a web-based system utilized to track complaints, provide a history of all actions taken, generate appropriate letters/emails, and view the documentation related to the case.

MCCO receives complaints via email, fax, postal mail, and stakeholders. MCCO logs the complaints into the HEART system for monitoring and resolution tracking. MCS is in the process of developing an online form to accept grievances. Many complaints and inquiries received by MCCO are initiated by providers (not members). Providers are expected to exhaust complaints and grievances with the MCO before filing a complaint with MCCO. MCCO will determine if MCCO can resolve the complaint or if other program area(s) and/or MCOs need to be involved in the resolution. Depending on the nature of the issue, the inquiry or complaint may be referred or routed to any HHSC departments/section/offices, the Enrollment Broker, the Civil Rights Office, the Office of the Inspector General (OIG) for allegations of fraud, waste, or abuse, or the Department of Family and Protective Services (DFPS) for suspected abuse, neglect, or exploitation of a member. Inquiries and complaints from the Texas Legislature, HHSC Government and Stakeholder Relations, and CMS are routed to Results Management to resolve and monitor. Results Management addresses legislative inquiries and may coordinate with MCCO depending on the inquiry.

The HEART system generates the acknowledgement letter for the complaints, as well as assigns the complaint to MCCO staff to resolve, stores

related documents, and documents the substantiated or unsubstantiated[64] resolution. If the inquiry is resolved by telephone, with no further action needed, MCCO enters the information into HEART and closes the case in HEART. For inquiries received via postal mail or email, MCCO will generate a resolution letter or email from HEART, enter the narrative information into HEART, and close the case in HEART. HHSC works in conjunction with the MCO to resolve complaints; MCCO reviews the MCO's response for completeness, accuracy, and to ensure that all members' and/or providers' issues are addressed.

MCS Policy and Program identifies program issues, works with MCOs to mitigate further problems, and develops policy and programmatic solutions to identified issues. In addition, MCS Policy and Program leads efforts to implement changes to Medicaid and CHIP policies and programs that are responsive to legislative direction, federal regulations, and member and provider concerns.

[64] *Substantiated is a complaint where research clearly indicates agency policy was violated or agency expectations were not met. Unsubstantiated is a complaint where research does not clearly indicate if agency policy was violated or agency expectations were met.*

5.6. Marketing and Communication Activities

5.6.1. Contract Management Maturity Model (CMMM) Results

Designated Level: Structured

Rationale

- The Medicaid and CHIP Services Department (MCS) has formal documentation related to the marketing and communication activities such as the Consumer (Member) Information Toolkit that is a helpful resource in supporting clear, consistent communication with members. In addition, MCS has established procedures for reviewing member and provider communications and marketing materials.
- Texas Health and Human Services Commission (HHSC) defines clearly the standards for marketing materials in the Uniform Managed Care Contract (UMCC). Marketing materials from a Managed Care Organization (MCO) are denied when language deviates from any Uniform Managed Care Manual (UMCM) critical element. Furthermore, HHSC provides its marketing specialists with defined material guidelines, enabling consistent review and approval of MCO's materials.

5.6.2. Findings

- **Continue the Consumer (Member) Information Toolkit** – MCS has created a publicly available toolkit for MCOs to use when creating communication materials for current and potential members. The toolkit contains writing tips, a style guide, and a list of preferred terms and phrases that will assist MCOs in developing materials that will be understood by members.[65] This toolkit is a helpful resource in supporting clear, consistent communication with members.
- **Opportunity to Enhance the HHSC website** – HHSC maintains a public-facing website for the Medicaid and Children's Health Insurance Program (CHIP) that is organized by services. There is an opportunity to enhance the website by organizing information in a way that better

[65] *Texas Health and Human Services, Medicaid and CHIP - Communications Resources, https://hhs.texas.gov/services/health/medicaid-chip/provider-information/texas-medicaid-chip-communications-resources.*

serves members, providers, MCOs, stakeholders, and the public. Several state Medicaid agencies organize their websites with readily available links for individuals/families, providers and/or health plans, resources, and contact information. This includes the Arizona Health Care Cost Containment System, Ohio Department of Medicaid, New York Department of Health, and Wisconsin Department of Health Services.[66] Furthermore, the Ohio Department of Medicaid and Wisconsin Department of Health Services provide a link for stakeholders with a guide to data, statistics and/or reports on the Medicaid programs. HHSC could enhance the current Medicaid and CHIP website by creating an open data portal with improved end user experience and better access to services. There are a few quick ways to achieve intended outcomes using modern technologies such as virtual assistants, contextual help, elastic search, and online chat features.

- **Opportunity to Validate New Member Onboarding** – MCS requires in its contracts that MCO member handbooks be mailed to the member within five business days following the receipt of an enrollment file from the HHSC Administrative Services Contractor, TMHP. MCS has an opportunity to leverage some exemplary practices as seen in other states. In Arizona, the state surveys a select sample of members via telephone to determine if members received their enrollment packets, if the information was understood, and if the information was received within the required period. In New York, the state provides an example member handbook to MCOs.

5.6.3. Supporting Information

5.6.3.1. MCO Communication Materials

Managed Care Compliance and Operations (MCCO) is the primary MCS section that handles oversight of MCO communications. MCCO categorizes MCO communication materials into three types: marketing materials, member materials, and provider materials.

- **Marketing materials** are any communications created by or on behalf of the MCO that are intended for *potential* members and can

[66] *Other state Medicaid agency websites accessed as of June 28, 2018, include https://www.azahcccs.gov/; http://medicaid.ohio.gov/, https://www.health.ny.gov/health_care/medicaid/, and https://www.dhs.wisconsin.gov/.*

reasonably be interpreted as intending to influence a potential member's decision to enroll with the MCO, not enroll in a different MCO, or switch from a different MCO (i.e., not health-related materials).

- **Member materials** are materials containing information concerning the program(s) and intended to be distributed to all *current* members by the MCO, with the most prominent member material being the MCO-developed member handbook.
- **Provider materials** include all written materials concerning the MCO that are distributed to in-network providers who participate in that MCO's program. Examples include the MCO Provider Manual, training materials regarding managed care program requirements, and mass communications directed to all or a large group of network providers (email or fax "blasts"). Provider materials do not include written correspondence between the MCO and a provider regarding individual business matters.

Marketing specialists within MCCO receive communication materials to review from the MCOs. Subject matter experts are consulted when materials pertain to certain topics (such as pharmacy). Marketing specialists reviews all materials. This review ensures that the MCO uses language that is required by the contract, which takes precedence over any National Committee for Quality Assurance (NCQA) requirements the MCO may follow. The material is denied when language deviates from any UMCM critical element. The MCO has the opportunity to resubmit the material with corrected language, which will be reviewed by the specialist for approval. For these reviews, HHSC has established material guidelines that must be followed:

- Marketing and member materials must be written at or below a sixth-grade reading level (excluding approved medical and legal terminology and verbiage), and must include a list of excluded words to meet reading level. Member materials must also include the form number at the lower left-hand of the document and a list of resources that were used to develop the materials.
- Marketing materials must include the program logo(s).
- Provider materials must include the form number at the lower left-hand of the document and a list of resources that were used to develop the materials.

Certain materials, such as MCO press releases and materials concerning information of a sensitive nature, are also routed through HHSC Communications in consultation with MCCO. HHSC does not review most provider materials.

MCCO also investigates instances of MCOs violating marketing guidelines (e.g., MCOs distributing materials without HHSC approval). Marketing specialists receive and investigate violation allegations to determine if they are substantiated or unsubstantiated. All allegations are tracked and substantiated allegations may require the MCOs to submit a corrective action plan (CAP).

5.7. Contract Amendments and Procurements

5.7.1. Contract Management Maturity Model (CMMM) Results

Designated Level: Structured

Rationale

- The processes and standards for contract amendments and procurements are well established and institutionalized across Texas Health and Human Services Commission (HHSC). Formal documentation exists for these processes. Please see **Appendix 5.7.1** and **Appendix 5.7.2** for detailed process flow charts and step tables.
- Some process automation exists as seen with the use of SharePoint for collaborative document editing on the contract amendments. However, the changes are manually entered and tracked in an access database. To mature its processes, MCS has an opportunity to leverage contract management tools that could assist with improving the transparency and availability of the most up-to-date amendment information, making it readily available across all MCS sections and offices.

5.7.2. Findings

- **Opportunity to Streamline Planning and Development Procurement Phase** – The MCS procurement pre-solicitation phase lasts for approximately 15 months and accounts for about 40 percent of the entire procurement cycle. In the survey results for the comparative group, the pre-solicitation stage ranged from seven months to 18 months. While pre-solicitation activities are important, an opportunity exists for HHSC to shorten the planning timeline since a long planning phase can lead to rework and more changes downstream.
- **Continue Elevation of the MCS Major Procurement Office** – In the spring of 2018, MCS elevated the Major Procurements Office (MPO) to be part of the Results Management Section. This move shifts the Managed Care Organization (MCO) procurement process to a position that is closer to the State Medicaid Director, provides more visibility across all sections, and fosters cross-section collaboration.

- **Opportunity to Improve the Manual Contracting Process** – The current process for how contract amendment requests and changes are acquired, tracked, and written into the contract is predominantly manual. It may be beneficial to use tools that assist with automating and managing processes. Technology may also assist with improving the transparency and availability of the most up-to-date amendment information, making it readily available across all MCS sections and offices.
- **Opportunity to Improve Contract Amendment Guidance** – Staff interviewed indicated that at times it can be difficult to determine what types of requests necessitate a contract amendment and what ones may be resolved through the Uniform Managed Care Manual (UMCM), memorandum, or guidance. It would be beneficial for MCS sections to receive technical assistance and education on how to differentiate what does and does not require a contract amendment. In addition, an initial review of requests to determine the level of response required (e.g., whether a change is an amendment or memorandum) may also prove beneficial. Such actions may resolve some requests without the need for an amendment. For example, the State of New York completes formal amendments only for new benefit or new population changes. Contract changes related to billing, rate setting, and service areas are made through a memorandum notification process; These Medicaid memorandums are published monthly and are enforceable through the contracts with MCOs.

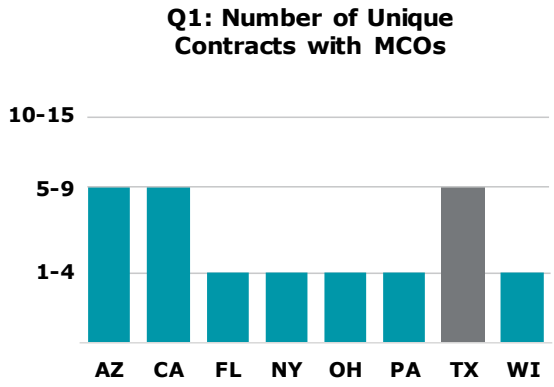
5.7.2.1. Results of Survey

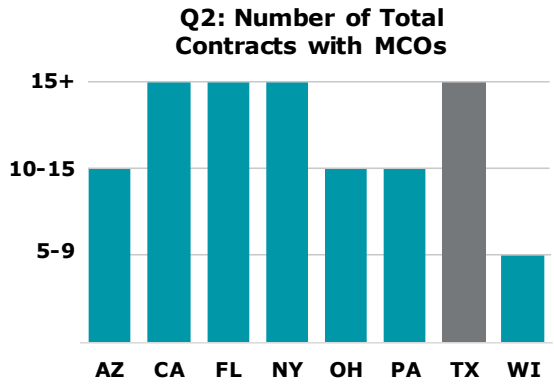
Other states were surveyed about their contract amendments and procurement processes to supplement this review. This exercise provided benchmarks by which to compare Texas's processes and identified potential leading practices. The states surveyed included Arizona, California, Florida, New York, Ohio, Pennsylvania, and Wisconsin. A survey of 10 questions was sent to the appropriate state contacts (see **Appendix 5.7.3**) and discussion sessions were held with the contacts to discuss the state's responses.

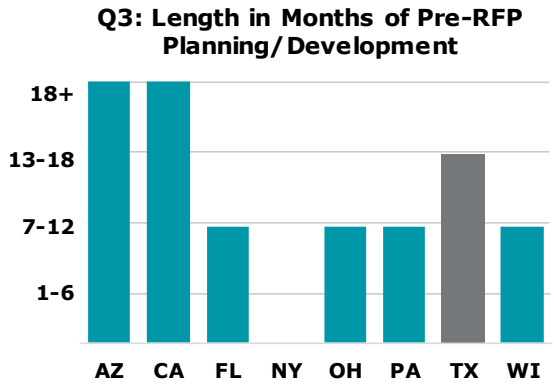
Each graph below in **Figure 15** illustrates how Texas compares to seven comparative states. The survey was conducted during April 2018 and May 2018; thus, the results reflect operations during this period. Wisconsin (WI) results refer to their Managed Care Long Term Services and Supports (MLTSS) Programs: FamilyCare, FamilyCare Partnership, and Programs of All-Inclusive Care for the Elderly (PACE).

Figure 15. Survey Results from Comparative States on Medicaid Managed Care Contract Amendments.

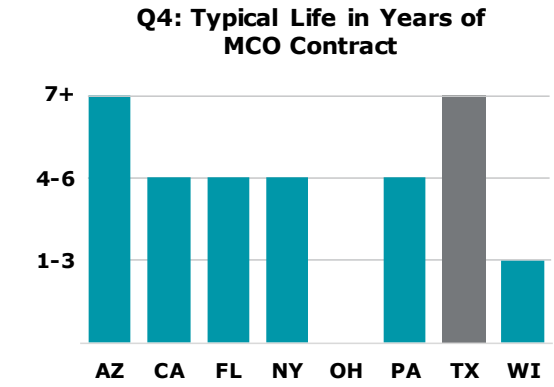
Survey Results



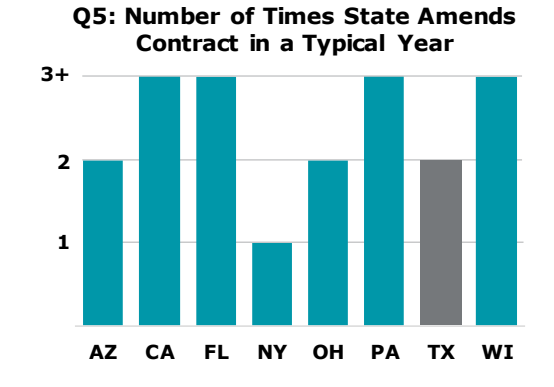


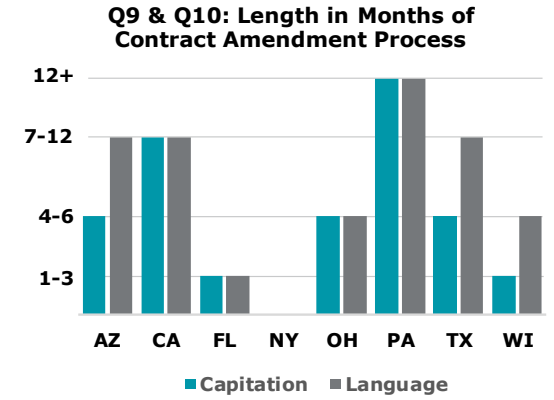


*NY does not use a comparable RFP model



*OH does not specify contract lengths between procurements





*NY does not use a comparable amendment model

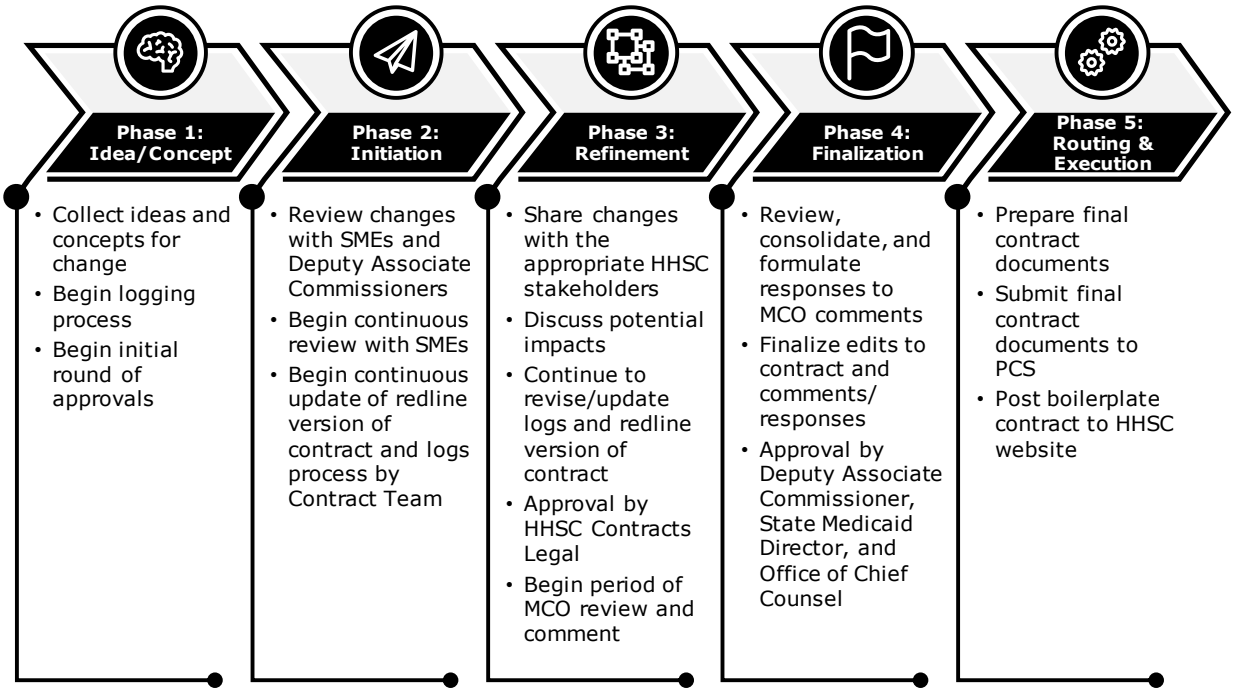
5.7.3. Supporting Information

5.7.3.1. Contract Amendment Processes

Managed Care Compliance and Operations (MCCO) within the MCS Health Plan Monitoring and Contract Services Section oversees and manages the MCO contract amendment process. The UMCC is amended at the beginning of each state fiscal year (effective September 1), at midyear (effective March 1), and as required by legislative and other mandates. MCS is moving from a twice-a-year amendment cycle to a once-a-year amendment cycle for non-emergency, non-rate-related contract changes to allow staff to engage in a more detailed amendment writing process. MCS will implement the once-a-year cycle beginning with the amendment effective September 1, 2019. At a minimum, contract language must be amended if material changes are included, or capitation rates are amended as necessary. The contract amendment timeline begins seven months before the effective date.

Figure 16 provides a high-level summary of the five phases of the contract amendment process within HHSC. Further detail of each phase is provided in separate process flow charts and step tables for each phase in **Appendix 5.7.1**.

Figure 16. Contract Amendment Process.

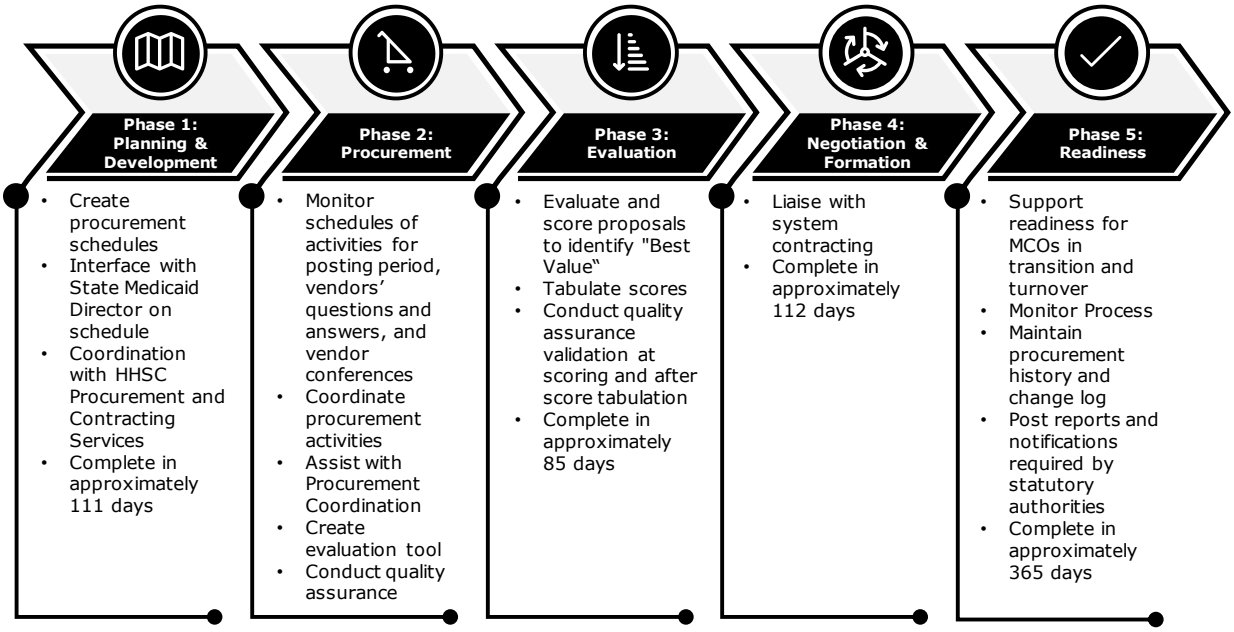


5.7.3.2. Procurement Processes

In conjunction with HHSC Procurement and Contract Services (PCS), the MPO within MCS Results Management Section oversees and manages the contract procurement process. MPO handles high-cost and high-profile procurements, which include Medicaid Managed Care procurements and many others. Throughout the Medicaid Managed Care procurement process, MPO consults with MCCO and additional HHSC agencies for subject matter expertise. The total major procurement cycle averages about three years, and the contract life cycle is about eight operational years, in addition to one year spent in the readiness phase. Recently, the Texas Legislature has adopted Rider 17.10(b), which will limit HHSC to three-year contract cycles.

Figure 17 provides a high-level summary of the five phases of the procurement process for a new managed care contract. Further detail of each phase is provided in separate process flow charts and step tables for each phase in **Appendix 5.7.2**.

Figure 17. Procurement Process.



5.8. Enrollments and Disenrollments

5.8.1. Contract Management Maturity Model (CMMM) Results

Designated Level: Structured

Rationale

- Processes and standards for member enrollments and disenrollments are fully established, institutionalized, and mandated throughout Medicaid and CHIP Services Department (MCS). Formal documentation has been developed for processes and standards including Managed Care Report Cards that are used by the members during MCO selection process. There are multiple working teams primarily responsible for oversight of member enrollment and resolving issues regarding enrollment, addresses, county codes, or any other issue preventing a health plan from serving the member across systems.
- Process automation exists especially if a member does not select an MCO and then Texas Health and Human Services Commission's (HHSC) default assignment methodologies, as described in Texas Administrative Code Sections 353.403 and 370.303 are applied.[67]
- To further mature its member MCO selection processes, HHSC has an opportunity to integrate complaints data into the scores on Managed Care reports cards, a leading practice seen in Medicare. Additionally, HHSC also has an opportunity to introduce additional factors into its automated algorithm for member assignment.

5.8.2. Findings

- **Opportunity to Enhance Managed Care Report Cards** – HHSC has an opportunity to incorporate feedback on complaint categories within the Managed Care Report Cards, which could help enrollees easily compare the health plans on quality and patient satisfaction measures. A leading practice in this regard is the Medicare Part C and D Star Ratings that provide quality and performance information to Medicare

[67] *Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter E, Section 353.403; and Texas Administrative Code, Title 1, Part 15, Chapter 370, Subchapter C, Division 1, Section 370.303.*

beneficiaries to assist them in choosing their health and drug services during the annual fall open enrollment period. The Star Ratings Program is consistent with the Quality Strategy of the Centers for Medicare & Medicaid Services (CMS) for optimizing health outcomes by improving quality and transforming the health care system. One of the domains for Part C and D is member complaints and changes in the health plan's performance, and another domain is the health plan's customer service. The measures for both these domains are in **Appendix 5.5.3**.

- **Opportunity to Introduce Additional Factors into the Default Enrollment Methodology** – According to the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, states may consider additional criteria to conduct the default/passive enrollment process when an individual does not self-select a MCO, including:
  - The previous plan assignment of the member
  - Quality assurance and improvement performance
  - Procurement evaluation elements
  - Accessibility of provider offices for people with disabilities (when appropriate)
  - Other reasonable criteria that support the objectives of the managed care program
  - HHSC may consider these additional factors when implementing a modified default enrollment process

5.8.3. Supporting Information

5.8.3.1. Member Enrollment

The MCS Program Enrollment and Support Section is primarily responsible for oversight of member enrollment and resolving issues regarding enrollment, addresses, county codes, or any other issue preventing a MCO from serving the member across systems. There are multiple working teams under the Program Enrollment and Support Section that have unique roles related to member enrollment: Enrollment Resolution Services; Product Management; Enrollment Broker Operations; Program Support and Interest List Management; Strategy and Innovation; and 1915(c) Waiver Program Enrollment.

HHSC determines members' eligibility for each of the managed care programs and disenrolls a member if she/he becomes ineligible for Medicaid or CHIP. Eligible individuals have at least 15 calendar days from the date notification is mailed to choose an MCO, Primary Care Provider (PCP), and dental home. To enroll in an MCO, the eligible individual's permanent residence must be located within the MCO's service delivery area. HHSC conducts continuous open enrollment for Medicaid-eligible individuals and the MCO must accept all persons who choose to enroll as members in the MCO or who are assigned as members in the MCO by HHSC, without regard to the member's health status or any other factor.

Managed Care Report Cards were developed based on a legislative requirement to assist Medicaid and CHIP-eligible individuals for CHIP, STAR, and STAR+PLUS program in choosing an MCO in their service delivery area.[68] Annual Managed Care Report Cards allow eligible individuals to easily compare the health plans on specific quality of care and patient satisfaction measures. The report cards include metrics from Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Healthcare Effectiveness Data and Information Set (HEDIS®), along with other composite metrics that are compiled using the External Quality Review Organization's (EQRO) methodology to generate an overall score between 1 star (low rating) and 5 stars (high rating). MCS recently expanded the Managed Care Report Cards from three stars scoring to five stars scoring. The report cards are included in the enrollment packets sent to eligible individuals to help them make better informed decisions about picking an MCO.

If the individual does not select a MCO, HHSC or the HHSC Administrative Services Contractor enrolls the eligible individual into a Medicaid or CHIP managed care program using HHSC's default assignment methodologies, as described in Texas Administrative Code Sections 353.403 and 370.303. The automated algorithm considers the individual's history with a PCP or dental home when possible, and then it considers one or more of the following factors to equitably distribute individuals among qualified MCOs:

- Whether other members of the individual's household are enrolled in the MCO
- MCO performance

[68] *Calendar Year 2017 Report Cards are available in English and Spanish at https://hhs.texas.gov/services/health/medicaid-chip/programs/managed-care-report-cards.*

- The greatest difference of the percentage of elective and default enrollments for each MCO
- Capitation rates
- Market share
- Other criteria determined by HHSC.

HHSC may implement a modified default enrollment process.

If the individual does not select a PCP or dental home, HHSC or the HHSC Administrative Services Contractor uses HHSC's default assignment methodologies to assign a PCP and/or dental home for the Medicaid or CHIP-eligible individual. To the extent possible, HHSC will make assignments based on an enrollee's prior history with a geographic proximity to a PCP.

5.8.3.2. Member Disenrollment

Managed Care Compliance and Operations (MCCO) receives written disenrollment requests from a MCO initiated by the member, or on behalf of the member, to be removed from Medicaid Managed Care, but to remain under fee-for-service (FFS) Medicaid. A complaint coordinator receives member disenrollment requests and logs them in HHS Enterprise Administrative Record Tracking (HEART), the enterprise system for managing consumer complaints. If a MCO becomes aware that a member has moved outside of the MCO's service area or is no longer Medicaid- or CHIP-eligible, the MCO is expected to inform HHSC within five days.

MCCO determines the Medicaid Managed Care enrollment status of the request and generates the appropriate communications to the MCO. Once the MCO has responded, MCCO compiles the documentation of the case and provides the same to the MCS Disenrollment Committee, which consists of the Director of MCCO, the Director of Policy and Program Development, the Medical Director, or their designees. If approved by the MCS Disenrollment Committee, an email is sent to the Program Enrollment and Support Unit requesting to have the member disenrolled from managed care. MCCO will update the narrative section within HEART to document all actions taken and close the case.

An MCO may also initiate a member disenrollment. The process is like the one described above: the request is received by the complaints coordinator; MCCO reviews the case and consults with others as needed; and the case is referred to the MCS Disenrollment Committee that makes a disenrollment determination (e.g., determines if the MCO demonstrated that the MCO has

made reasonable efforts to remedy the problem). If the request is approved, MCCO will notify the member, by letter, of the decision and include the member's right to request a fair hearing within 90 days of receipt of the letter. A "Notice of Ineligibility" letter is also mailed to the member.

5.9. Rate Development Standards

5.9.1. Contract Management Maturity Model (CMMM) Results

Designated Level: Integrated

Rationale

- The process for validation of the Managed Care Organization (MCO) reported financial data, a critical input in the development of rates, is a well-coordinated and integrated process across various divisions and departments in Texas Health and Human Services Commission (HHSC). Medicaid and CHIP Services Department (MCS) works with External Quality Review Organization (EQRO) to validate encounter data and contracts with external auditors to audit the Financial Statistical Reports (FSRs).
- To optimize its processes, an opportunity exists for MCS to build an accessible sharing platform to enable the Financial Reporting and Audit section to share data analysis efforts broadly with other MCS sections and HHSC departments. This data sharing will enable MCS to use performance metrics to make data-driven decisions across the organization.

5.9.2. Findings

- **Continue to Provide Financial Reporting Transparency** – HHSC has a leading practice in public transparency related to the data reported by the MCOs through Financial Statistic Reports (FSRs). The FSRs are publicly available on HHSC website, and HHSC makes no representation of the accuracy of the reports as posted.[69]
- **Opportunity to Leverage Performance Metrics to Make Data-Driven Decisions** – Financial Reporting and Audit Coordination (FRAC) currently shares data with the Quality Assurance group regarding administrative and Quality Improvement costs; however, it is a manual transfer of data files and the analysis is not accessible in

[69] *FSRs for Fiscal Year 2018 are available at https://hhs.texas.gov/services/health/medicaid-chip/provider-information/medicaid-chip-financial-statistical-reports.*

one central location. An opportunity exists to develop an accessible sharing platform to facilitate the ease of data sharing and aggregation which will assist the Quality groups' efforts in monitoring performance metrics for Pay for Quality (P4Q) and value-based purchasing (VBP).

- **Opportunity to Enhance Data Validation with Financial Subject Matter Expertise** – Having the FRAC section provide financial subject matter expertise throughout HHSC was noted by several interviewees as valuable to the contract review and oversight function. Additional resources focused on financial analysis would provide the opportunity to do more extensive validation of financial data and root cause analysis.

5.9.3. Supporting Information

5.9.3.1. Rate Setting Support Process

5.9.3.1.1. Validation of Encounter Data

In addition to the business edit checks that MCS Operations Management Claims Administration Office conducts on encounter data, HHSC contracts with an EQRO to review the detailed encounter data and provides certification of the data quality. For more information on the data integrity process, refer to **Section 5.2 Quality of Care**. EQRO provides the data certification reports supporting rate setting activities and information related to the quality, completeness, and accuracy of the MCO encounter data. In addition, FRAC reconciles the aggregated encounter data by plan code with the information reported on the FSRs. If HHSC identifies issues with the encounter data, FRAC works through the MCS Operations Support team to require encounter resubmissions with the MCOs.

5.9.3.1.2. Submission of FSRs

In addition to completing separate FSRs for administrative expenses and quality improvement expenses, MCOs must also submit FSRs for each program they administer. The format of program-specific FSRs changed in December 2017. The FSRs represent self-reported data prepared in accordance with the Uniformed Managed Care Contract (UMCC) and the Uniform Managed Care Manual (UMCM), and are subject to audit by external

auditors. The FSRs are publicly available on HHSC website, and HHSC makes no representation of the accuracy of the reports as posted.[70]

On the Administrative Expense FSRs, MCOs provide information on aggregate administrative expenses incurred, such as for wages, office space, equipment, supplies, depreciation, outsourced services, and administrative value-added services (VAS). Administrative expenses for the Dual Demonstration are excluded.

The Quality Improvement Cost FSR was required as of November 2016. Similar to the Administrative Expense FSR, MCOs provide information on aggregate quality improvement costs incurred, such as for wages, office space, equipment, supplies, depreciation, and outsourced services. Quality improvement expenses for the Dual Demonstration are excluded. Quality improvement expenses for care coordination/case management, disease management, health information technology, and other quality improvement efforts are distributed by program/member month based on the MCO's assessment of the level of quality improvement resources devoted to programs. Quality improvement costs within each program are allocated to plan code by the percentage of revenue method, and then gross revenue is further allocated to program and service delivery area.

The CEO, CFO, or equivalent at the MCO signs and certifies the accuracy of the FSRs submitted to HHSC. FRAC reviews the quarterly FSRs for reasonableness and year-over-year changes. The determination of appropriate administrative expenses and the allocation of these expenses by program have changed in recent years due to new regulations and further review of current costs and methodologies.

5.9.3.1.3. Contracts with Auditors to Audit FSRs

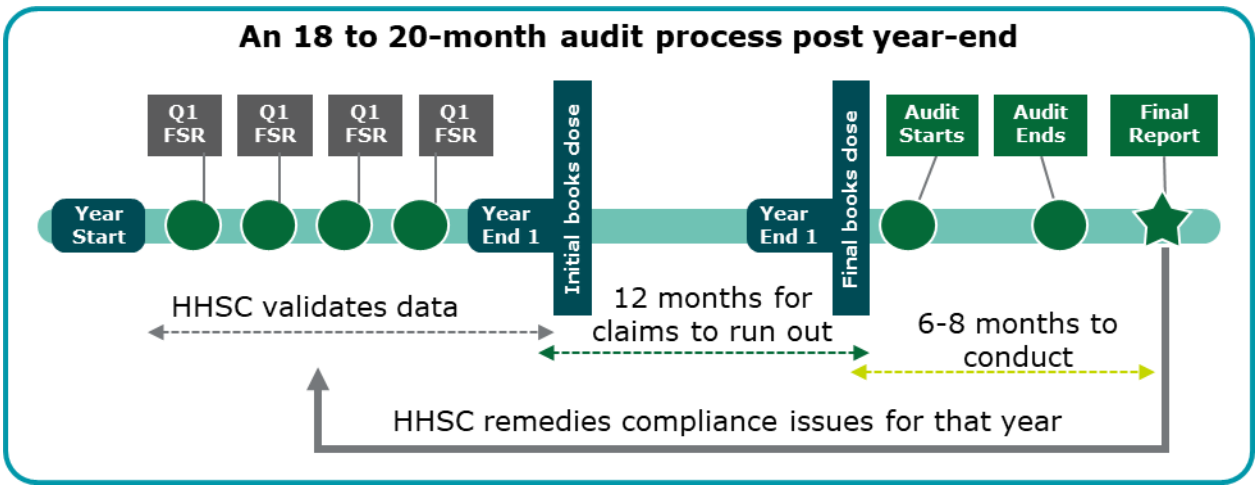
FRAC finalizes the Agreed-Upon Procedures (AUPs) arrangements every year with every MCO. Independent auditors apply the AUPs detailed in **Appendix 5.9.2** during financial audits. The AUPs are based on past findings, Centers for Medicare & Medicaid Services (CMS) and Office of the Inspector General (OIG) reviews, Texas State Auditor's Office (SAO) findings, changing regulations, and process improvements. During the AUP engagements, auditors review samples of the MCO’s reconciliation of the administrative expenses reported to their general ledger to ensure expenses are allowable

[70] *FSRs for Fiscal Year 2018 are available at https://hhs.texas.gov/services/health/medicaid-chip/provider-information/medicaid-chip-financial-statistical-reports.*

and payments occurred as reported. For further evaluation of MCO reported administrative costs, refer to the **Rider 61(d) Report Section**.

The financial oversight audit life cycle is 18 to 20 months, including quarterly FSRs, the 12-month claims run-out period, and six to eight months for the audit and development of the final report as seen in **Figure 18** below. Following the audit process, HHSC reviews and takes corrective action if needed. The MCOs pay for the cost of these financial audits; there is no additional cost to the state. For more information on the audits and reviews conducted by HHSC, see **Section 5.1. State Monitoring Standards**.

Figure 18. MCS Financial Oversight Audit Process.



The Actuarial Analysis Unit within HHSC Financial Services Division and an external actuarial vendor uses actuarial models to derive capitated premium rates to pay MCOs based primarily upon the MCO's financial experience. **Appendix 5.9.1** shows the activities for capitation rate development. For more information on the rate setting process, refer to **Rider 61(c) Report Section**.

6. Appendices

Appendix 2.1. Acronyms

Below are the acronyms from the Rider 61b report and appendices.

Figure 19. Acronyms.

Acronym	Description
ACA	Patient Protection and Affordable Care Act
ACUR	Acute Care Utilization Review
AHRQ	Agency for Healthcare Research and Quality
AMCR	Agency Monthly Contact Report
APM	Alternative Payment Models
AUPs	Agreed-Upon Procedures
BHO	Behavioral Health Organization
CADS	Center for Analytics and Decision Support
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAM	Compliance Activity Module
CAP	Corrective Action Plans
CDS	Consumer Directed Services
CEO	Chief Executive Office
CFC	Community First Choice
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMMM	Contract Management Maturity Model
CMP	Civil money penalties
CMS	Centers for Medicare & Medicaid Services
CPA	Texas Comptroller of Public Accounts
CPT®	Current Procedural Terminology
CTM	Complaint Tracking Module
CVO	Credentialing Verification Organization
DAC	Deputy Associate Commissioner
DFPS	Texas Department of Family and Protective Services
DHHS	U.S. Department of Health and Human Services
DME	Durable Medical Equipment
DMO	Dental Maintenance Organization
DMS	Division of Medical Services
DRG	Diagnosis Related Grouping
D-SNP	Dual Eligible Special Needs Plan
DSP	Delivery Supplemental Payment
DSRIP	Delivery System Reform Incentive Payment

Acronym	Description
DTS	Deliverables Tracking System
EB	Enrollment Broker
ECHO	Experience of Care and Health Outcomes
ELIG	Eligibility
ENT	Ears, Nose, and Throat
EPLS	Excluded Parties List System
EQRO	External Quality Review Organization
FAC	Financial Arrangement Codes
FAR	Federal Acquisition Regulation
FFS	Fee-for-service
FH	Fair hearing
FRAC	Financial Reporting and Audit Coordination
FSR	Financial Statistical Reports
FWC	Farmworker Child(ren)
FY	Fiscal Year
GAO	Government Accountability Office
HB	House Bill
HCBS	Home- and Community- Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HEART	HHS Enterprise Administrative Record Tracking
HHS	Health and Human Services
HHSC	Texas Health and Human Services Commission
HIE	health information exchange
HIPAA	Health Insurance Portability and Accountability Act
HISQ	Medicaid Health Informatics Services and Quality
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPM	Health Plan Monitoring and Contract Services Division
HSRI	Human Services Research Institute
IBNR	Incurred-But-Not-Reported
ID	Identification
IDD	Intellectual and Developmental Disability
IPA	Individual Practice Association
IRE	Independent Review Entity
IRR	inter-rater reliability
IT	Information Technology
JIP	Joint Interface Plan
LBB	Legislative Budget Board
LDs	Liquidated Damages
LEIE	List of Excluded Individuals/Entities
LHHS	Limited Home Health Supplies

Acronym	Description
LTSS	Long Term Services and Supports
MAO	Medical Assistance Only
MACPAC	Medicaid and CHIP Payment and Access Commission
MBCC	Medicaid for Breast and Cervical Cancer
MCCO	Managed Care Compliance and Operations
MCG	previously known as the Milliman Care Guidelines
MCNA	Managed Care of North America
MCO	Managed Care Organization
MCS	Medicaid and CHIP Services Department
MDCP	Medically Dependent Children Program
MDS	Minimum Data Set
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person
MH	Mental Health
MIS	Management Information System
MLTSS	Managed Care Long Term Services and Supports
MMP	Medicare-Medicaid Plan
MPI	Medicaid Program Integrity
MPO	Major Procurements Office
MTO	Medical Transportation Organization
MTP	Medical Transportation Program
NASUAD	National Association of States United for Aging and Disabilities
NCI-AD™	National Core Indicators — Aging and Disabilities
NCQA	National Committee for Quality Assurance
NQTL	Non-Quantitative Treatment Limitations
OB/GYN	Obstetrics and Gynecology
OIG	Office of Inspector General
OON	Out-Of-Network
PA	Prior Authorization
PACE	Programs of All-Inclusive Care for the Elderly
PBM	Pharmacy Benefits Manager
PCP	Primary Care Provider
PCS	HHSC Procurement and Contracting Services
PIAC	Promoting Independence Advisory Committee
PIP	Performance Improvement Project
PMUR	Psychotropic Medication Utilization Review
P4Q	Pay-for-Quality
PPS	Premium Payment System
QAPI	Quality Assessment and Performance Improvement
QPR	Quarterly Performance Report
RFP	Request for Proposal

Acronym	Description
SAO	Texas State Auditor's Office
SB	Senate Bill
SCA	Single Case Agreement
SDA	Service Delivery Area
SFY	State Fiscal Year
SIU	Special Investigative Unit
SME	Subject Matter Expert
SNAP	Supplemental Nutrition Assistance Program
SOP	Standard Operating Procedures
SUD	Substance use disorder
SUR	Surveillance Utilization Reviews
SVCS	Services
TAC	Texas Administrative Code
TAHP	Texas Association of Health Plans
TDI	Texas Department of Insurance
THLC	Texas Healthcare Learning Collaborative
TIERS	Texas Integrated Eligibility Redesign System
TMA	Texas Medical Association
TMHP	Texas Medicaid and Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual
TPA	Third Party Administrator
TPL	Third Party Liability
TPR	Third Party Recoveries
TQ	Targeted Data Queries
TTY	Teletypewriter
UMCC	Uniform Managed Care Contract
UMCM	Uniform Managed Care Manual
UR	Utilization Review
VAS	Value-Added Services
VBP	Value Based Purchasing
VDP	Vendor Drug Program

Appendix 3.1. Texas Managed Care Programs and Service Delivery Areas

Eighteen managed care organizations (MCOs) and two dental maintenance organizations (DMOs) provide services to Texas Medicaid and Children's Health Insurance Program (CHIP) enrollees as of May 1, 2018. Services in the STAR, STAR+PLUS, STAR Kids, and CHIP programs are administered in 13 Service Delivery Areas (SDAs) across the state. The map on the following page shows the 2018 map of Texas Medicaid and CHIP programs' SDAs from the Texas Health and Human Services (HHS) website.[71]

Figure 20. Texas Medicaid and CHIP Medical Managed Care Programs.

Program	Description
STAR	Manages care for the majority of Texas Medicaid beneficiaries. This program covers low-income families, including adults and children, pregnant women, and newborns.
STAR+PLUS	Integrates acute health services with Long Term Services and Supports (LTSS) for adults who have a disability and people who are 65 years of age or older, including many dually eligible for Medicare. The Program also provides medical services to persons with intellectual and developmental disabilities, and covers women in the Medicaid for Breast and Cervical Cancer Program.
STAR Health	Manages care for children and adolescents in state conservatorship and young adults (up to age 20 years) previously in foster care. Superior Health Plan provides all benefits. As adults, members are eligible for enrollment in STAR through age 26 years.
Texas Dual Eligible Integrated Care Demonstration Project	A fully integrated managed care model, known as the Dual Demonstration, that offers basic health care and LTSS for individuals of age 21 years or older who are dually eligible for Medicare and Medicaid and required to receive Medicaid services through the STAR+PLUS program. The demonstration operates in Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant counties.
STAR Kids	Manages care, including Medically Dependent Children Program (MDCP) services, for children and adults of ages 20 years old and younger who have disabilities. This program began on November 1, 2016.
CHIP and CHIP Perinate	Manages care for children (up to age 20 years) in families whose income is too high to qualify for Medicaid but too low to afford private insurance for their children. The CHIP Perinate program extends this coverage to pregnant women to provide CHIP perinatal care.

[71] *Texas Managed Care Service Areas Map, https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/managed-care-service-areas-map.pdf.*

Program	Description
Medicaid and CHIP Dental Services	Children and young adults of age 20 years and younger with Medicaid or CHIP coverage receive dental services through a managed care dental plan, also known as a dental maintenance organization (DMO), and a main dentist.

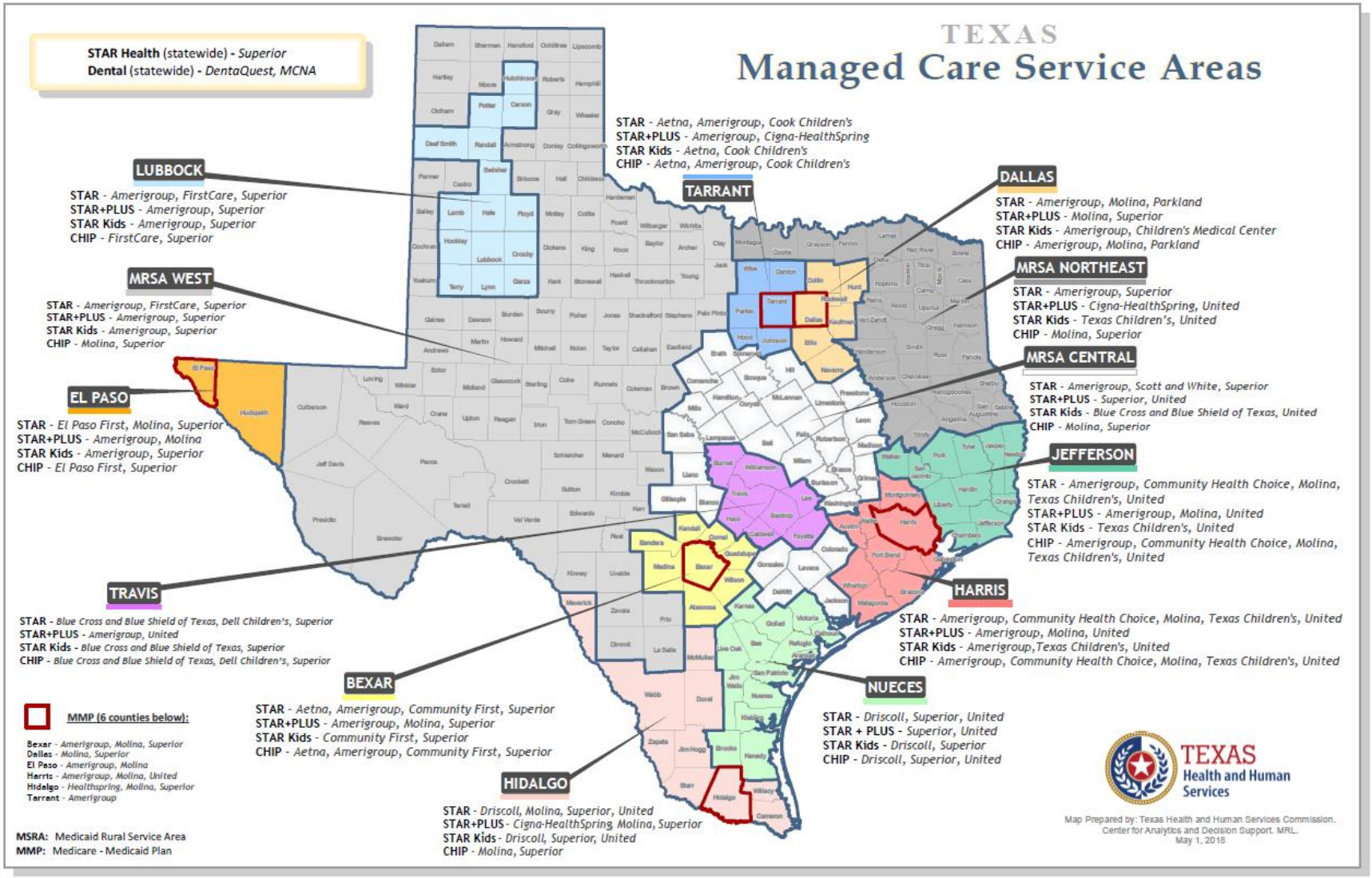
Figure 21 below provides the MCOs and DMOs participating in each managed care program as of May 2018. The Medicaid Children's Dental program and CHIP Dental program provide dental services to children. Members in STAR, STAR+PLUS, STAR Kids, and CHIP programs receive dental services through the two DMOs. Superior Health Plan provides dental services for STAR Health members. CHRISTUS Health Plan and Sendero Health Plan no longer participate in Texas Medicaid Managed Care programs as of February 1, 2018, and May 1, 2018, respectively.

Figure 21. MCOs and DMOs participating in Managed Care Programs as of May 2018.

Managed Care Organization or Dental Maintenance Organization	STAR	STAR+ PLUS / Dual Demonstra-tion	STAR Kids	STAR Health	CHIP	Medicaid Children's Dental	CHIP Dental
Aetna Better Health of Texas	√	-	√	-	√	-	-
Amerigroup	√	√	√	-	√	-	-
BlueCross BlueShield of Texas	√	-	√	-	√	-	-
Children's Medical Center Health Plan	-	-	√	-	-	-	-
Cigna-HealthSpring	-	√	-	-	-	-	-
Community First Health Plan	√	-	√	-	√	-	-
Community Health Choice	√	-	-	-	√	-	-
Cook Children's Health Plan	√	-	√	-	√	-	-
Dell Children's Health Plan (formerly Seton)	√	-	-	-	√	-	-
Driscoll Health Plan	√	-	√	-	√	-	-
El Paso First Health Plan, Inc.	√	-	-	-	√	-	-
FirstCare Health Plan	√	-	-	-	√	-	-
Molina Healthcare of Texas	√	√	-	-	√	-	-

Managed Care Organization or Dental Maintenance Organization	STAR	STAR+ PLUS / Dual Demonstra-tion	STAR Kids	STAR Health	CHIP	Medicaid Children's Dental	CHIP Dental
Parkland Community Health Plan	√	-	-	-	√	-	-
RightCare from Scott and White Health Plan	√	-	-	-	-	-	-
Superior Health Plan	√	√	√	√	√	-	-
Texas Children's Health Plan	√	-	√	-	√	-	-
UnitedHealthcare Community Plan	√	√	√	-	√	-	-
DentaQuest USA	-	-	-	-	-	√	√
Managed Care of North America (MCNA Dental)	-	-	-	-	-	√	√

Figure 22. Map of Texas's Managed Care Service Delivery Areas.



Appendix 3.2. List of Interviews/Sessions Conducted with HHSC

Figure 23 below lists the HHSC groups interviewed, topic of discussion, and meeting dates.

Figure 23. Interviews and sessions conducted with HHSC.

Section	Topic	Date in 2018
Medicaid and CHIP Services Department (MCS)	Interview	Thursday, March 8
Financial Reporting and Audit Coordination (FRAC) Section	Interview	Thursday, March 8
Quality and Program Improvement Section	Interview	Thursday, March 8
Policy and Program Section	Interview	Friday, March 9
Operations Section	Interview	Friday, March 9
Program Enrollment and Support Section	Interview	Friday, March 9
Managed Care Compliance and Waiver Operations (MCCO) within Health Plan Monitoring and Contract Services Section	Interview	Tuesday, March 20
Results Management	Interview	Tuesday, March 20
Health Plan Monitoring and Contract Services Section	Interview	Monday, March 26
Utilization Review within MCS Office of Medical Director	Session on MCO Prior Authorization (PA) Impact to Access to Care Project	Thursday, March 8
Results Management, Center for Analytics and Decision Support (CADS), and MCCO	Session on Network Adequacy	Thursday, March 8

Section	Topic	Date in 2018
Strategy and Innovation Office under Program Enrollment and Support Section	Session on Usage of data/ interfaces to interact with managed care and "operations system hub"	Friday, March 9
Policy and Program Section	Session on communication, manuals, policies, and procedures	Friday, March 9
Operations Section	Vendor Drug Program (VDP) session	Monday, March 26
Quality and Program Improvement Section	Session on Quality Monitoring Program	Tuesday, March 27
Quality and Program Improvement Section	Session on quality assurance programs	Tuesday, March 27
Quality and Program Improvement Section	Session on quality institute and quality oversight program	Monday, March 26
Health Plan Monitoring and Contract Services	Session on contract amendments, graduate remediation process, and penalties and sanctions (liquidated damages (LD))	Monday, March 26
Health Plan Monitoring and Contract Services and the Office of the Ombudsman	Session on complaints, grievances, and appeals	Tuesday, March 27
Health Plan Monitoring and Contract Services	Session with MCCO on MCO readiness reviews, targeted reviews, and performance audits conducted by/for MCCO	Monday, March 26
Health Plan Monitoring and Contract Services	Session on MCCO Deliverable Tracking System (DTS), other MCCO tools for contract oversight and the future portal	Tuesday, March 20

Section	Topic	Date in 2018
Operations Section	Session on Medicaid provider enrollment, CHIP provider enrollment, ordering, prescribing and rendering provider enrollment, and encounter data quality	Monday, March 26
Office of Inspector General (OIG) and Health Plan Monitoring and Contract Services	Session on program integrity unit, and fraud, waste, and abuse	Monday, March 26
Program Enrollment and Support Section	Session on data validation by the enrollment broker and outreach to STAR Kids	Wednesday, May 16
OIG	Session on program integrity unit, and fraud, waste, and abuse	Wednesday, May 16

Appendix 3.3. List of Information Reviewed for Rider 61b Evaluation

HHSC provided the following information for the development of this report.

Figure 24. Information Reviewed for Rider 61b Evaluation.

Primary Section/ Program Area	Document Type(s)	Description
Actuarial Analysis	Capitated Arrangement Payment	Summary of fees under a capitated arrangement, including the ACA's Health Insurance Providers Fee, risk margin, and administrative fees
Actuarial Analysis	Rate Development Timeline	SFY2018 Rate Development Timeline showing the lengthy timeline to develop, analyze, and attest newly developed premium rates for MCOs as seen in **Appendix 5.9.1**
Financial Reporting and Audit Coordination (FRAC)	Agreed-Upon Procedures (AUPs)	AUPs as seen in **Appendix 5.9.2**
OIG	OIG Presentation	Presentation from OIG for Legislative Hearing on May 9, 2018, and reports referenced
OIG	OIG's Organizational Chart	Organizational chart of the OIG's sections and units
HHSC Legal	Documents on HHSC Fair Hearing Process and Handbook	Description of HHSC fair hearing process as seen in **Appendix 5.5.1**

Primary Section/ Program Area	Document Type(s)	Description
HHSC Legal	MCO-Related Appeals Received and Fair Hearing Decisions Outcomes	The number of MCO-Related Appeals Received and Fair Hearing Decisions Outcomes from SFY 2016 to SFY 2018 as seen in **Appendix 5.5.1.** The data for the MCO report were pulled using two different parameters because this data is dynamic. To get the number of appeals received, HHSC selected the parameters for appeals sent. To get the number of decision outcomes, HHSC selected the parameters for decisions issued. This is done because appeals received in any one month are completed over any number of the succeeding months.
Major Procurements Office	Contract Procurement Process Documentation	Process for managing contract amendments and new procurements as depicted in **Appendix 5.7.1** and **Appendix 5.7.2**
MCCO	Audits	Provide findings and make recommendations for improvements of MCO monitoring and oversight from external auditors
MCCO	Senate Bill (SB) 760	Texas SB 760 language requiring HHSC to establish minimum access standards for MCO provider networks for specific provider types and related manners
MCCO	SB760 Report	Combined Report on Medicaid Managed Care Provider Network Adequacy, Monitoring, and Violations as Required by SB 760, 84th Legislature, Regular Session, 2015, and 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 81 and Rider 82)
MCCO	MCCO Organization Chart	Depiction of MCCO organizational structure within Health Plan Monitoring and Contract Services Section
MCCO	Managed Care Steering Committee	Template that provides a summary of MCO performance to Executive Leadership

Primary Section/ Program Area	Document Type(s)	Description
MCCO	Provider Directory	Interview tool used to validate that providers are adhering to appointment time standards.
MCCO	MCO Complaint and Grievance Logs	Detailed report of complaint data from HEART by type, program and MCO/DMO from SFY2014, SFY2015, and SFY2016 reports.
MCCO	Monitoring Calendar	Calendar used to track and schedule MCCO monitoring activities
MCCO	Operational Review Modules	Check contractual requirements while performing an onsite or desk review biannually or as issues are identified. MCCO Modules reviewed include Claims Processing Module, Website Module, Claims/Appeals Module, Provider Training Materials Module, and Provider Services Staff Training Module.
MCCO	Policies and Procedures	A collection of internal procedures used by MCCO staff to consistently monitor MCOs and coordinate activities. The current MCCO Desk Manual and newly revised documents are included (formerly known as the Health Plan Monitoring and Contract Services Division Desk Manual).
MCCO	Sample Quarterly Performance Report (QPR) template	A summary report, with analysis, of each MCO's performance by plan code, service area, and program. Sample templates and deliverables are also included.
MCCO	QPRs for STAR and STAR Kids programs	PDFs of the QPRs for the STAR program for SFY2015, SFY2016, SFY2017, and for STAR Kids program for SFY2017.
MCCO	Readiness Reviews	Tools used by MCCO staff to ensure that MCOs are meeting contractual performance measures prior to implementation of a new system or benefit
MCCO	Risk Assessment Instrument	A tool used to evaluate an MCO's financial impact to the agency

Primary Section/ Program Area	Document Type(s)	Description
MCCO	STAR Kids Program Dashboard	A sample dashboard to provide a high-level summary of STAR Kid's MCOs' performance to HHS Executive Leadership regarding the following areas: • Ombudsman Complaints • MCO Member and Provider Complaints • Health Plan Management Member and Provider Complaints • MCO Member Call Center Data • MCO Screening and Assessments • Enrollment and Eligibility Inquiries Received • Other Critical Updates/Items of Note
MCCO	Trainings	Educate or remind MCCO staff on new and/or existing processes and procedures
MCCO	MCO Performance Reports	MCO monthly, quarterly, etc., performance reports and related deliverables submitted by MCOs as described in Section 8.1.26.2 Reports of the STAR Health contract and corresponding sections of the other STAR, Star+PLUS, and CHIP MCO contracts
MCCO	MCO Provider Directory	Each MCO's most recently submitted provider directory
MCCO	Quarterly Geo Mapping Reports	HHSC-generated quarterly geo-access reports
MCCO	MCO Corrective Action Plans (CAPs)	MCO CAPs and related correspondence and HHSC conclusion documentation for deviancies discovered during Audits and other HHSC oversight and monitoring activities
MCCO	HHSC MCO Contract Compliance SOPs	Documented HHSC SOPs (Standard Operating Procedures) used by HHSC MCO contract compliance staff as they oversee and audit MCOs
MCCO	Additional documents requested on the contract tracking process	Screenshots of the contract amendment log and database

Primary Section/ Program Area	Document Type(s)	Description
MCCO	Concept paper for the MCCO portal	Proposed charter for the MCCO deliverable repository portal in development
MCCO	Operational Review Procedures	To outline the required steps when MCCO performs an Operational Review of a managed care organization, dental managed organization, or medical transportation organization (MCO/DMO/MTO).
MCCO	Draft Complaints and Appeals Dashboard Screenshots	Proposed complaints and appeals dashboard in development by HHSC CADS and MCS, which displays MCO-reported complaints and appeals. Please note these are still in draft form and are intended to demonstrate HHSC's work and progress in this area. The data in this dashboard comes from MCO deliverable reported to the MSC quarterly. It is self-reported and unaudited. HHSC is chartering a Complaints Workgroup to conduct more complex analysis of the complaints.
Medicaid Director's Office	Draft Senate HHS Presentation on Managed Care Oversight	Provides the Senate HHS Committee with an overview of HHS managed care oversight activities.
Medicaid Director's Office	Review and Audits	List of recent audits and reviews as seen in **Appendix 5.1.1**
Medicaid Director's Office	MCO Oversight Presentation	Provides an overview of managed care oversight functions
Medicaid Director's Office	HHS Presentation on Managed Care Oversight	Provides the Texas House of Representatives Committee on Appropriations on April 18, 2018 with an update on HHS managed care oversight activities, as available at http://tlchouse.granicus.com/MediaPlayer.php?view_id=40andclip_id=15069

Primary Section/ Program Area	Document Type(s)	Description
Ombudsman	HHS Circular C-052	This circular outlines the HHS policy on complaint tracking, analysis, and reporting. It also outlines the responsibilities of the Office of the Ombudsman to report on those complaints through the Agency Monthly Contact Report (AMCR).
Operations	Documents from Operations Management	Describes encounter data validation governance model, project charter, procedures for issue monitoring and onsite visits, and related encounter data standards
Operations	Medicaid Health Informatics Services and Quality (HISQ) program	Brief overview of the entire HIE Connectivity project housing the three strategies for enhancing health information exchange (HIE)
Policy and Program	Health Passport Monitoring Policy and Process	Process for monitoring the Health Passport, which is an electronic health information system created by HHSC, under the direction of Texas Family Code, Section 266.006. Its purpose is to ensure that children and their health care providers and medical consenters have access to their health-related information while the child is in foster care.
Policy and Program	STAR Health Meeting – once a month jointly with Texas Department of Family and Protective Services (DFPS), HHSC, and the MCOs	Sample of communications for STAR Health meetings coordinating services, processes, and initiatives among DFPS, HHSC, and the MCOs
Policy and Program	MCO Notices and Alerts	Sample of communications shared electronically on a weekly basis to an MCO distribution list
Policy and Program	Non-Quantitative Treatment Limitations (NQTL) Assessment Tools	MCOs are asked to use this tool to report on their analysis of each benefits package they provide. This is a result of final federal rules on mental health parity for Medicaid and CHIP MCOs.
Policy and Program	Presentation to MCOs on mental health parity	Provides information to MCOs on the Mental Health Parity and Addiction Equity Act and the application of mental health parity to Texas Medicaid and CHIP

Primary Section/ Program Area	Document Type(s)	Description
Policy and Program	Meetings and calls with MCOs on mental health parity	Sample communications related to working with MCOs on the requirements for mental health parity
Policy and Program	Quarterly STAR/CHIP MCO calls	Sample communications related to quarterly meetings to bring the STAR and CHIP MCOs together on a regular basis for HHSC to provide updates, share important information, and answer questions
Policy and Program	STAR+PLUS Calls with MCOs	Sample communications related to HHSC calls with the MCOs regarding the STAR+PLUS program
Policy and Program	Medicaid for Breast and Cervical Cancer (MBCC) Transition Log	HHSC-provided questions and answers for the MCOs regarding transition of MBCC benefit to managed care
Policy and Program	Reinstitutionalization Report	Identifies the Money Follows the Person (MFP) Demonstration participants who have been reinstitutionalized
Policy and Program	Quarterly Ventilator Data Report (example from one STAR+PLUS plan provided)	This report is a result of the Promoting Independence Advisory Committee (PIAC) and serves two purposes: 1. ensures the MCO service coordinators are visiting these members quarterly and 2. ensures the MCO is helping to transition nursing facility members who have answered 'Yes' to a Minimum Data Set (MDS) question under section Q (would you like to talk with someone about returning to the community?)
Policy and Program	MCO Impact Response Template	MCOs response to HHSC's request for input on Medicaid and CHIP-related bills during the 85th Legislative Session, 2017
Policy and Program	Intellectual and Developmental Disabilities (IDD) System Redesign Advisory Committee	The IDD System Redesign Advisory Committee, created by Senate Bill (SB) 7 of the 83rd Texas Legislature (Regular Session), will advise HHSC on the implementation of the acute care services and LTSS system redesign for people with intellectual and developmental disabilities. A few agendas are provided that include managed care discussions and improvements recommended for members with IDD.

Primary Section/ Program Area	Document Type(s)	Description
Policy and Program	Prescription Information Booklet	An information booklet the System Redesign Advisory Committee created in collaboration with HHSC to improve IDD member information
Policy and Program	Medicare-Medicaid Plan (MMP) SOPs	An information manual that lists the operating procedures for the MMP program
Policy and Program	MMP Monthly Meeting	Demonstrates how HHSC operates the managed care program as it relates to the Dual Demonstration. These meeting agendas show the collaborative approach to oversight with all three parties to the contract represented the Centers for Medicare and Medicaid Services (CMS), HHSC, and the 5 MMPs). Each meeting focuses on discussing updates and other high-level questions that arise.
Policy and Program	STAR Kids Managed Care Advisory Committee	The STAR Kids Managed Care Advisory Committee, created by Senate Bill 7 of the 83rd Texas Legislature (Regular Session), advises HHSC on the establishment and implementation of the STAR Kids Medicaid Managed Care program.
Policy and Program	STAR Kids Calls with MCOs	A sample agenda for a call conducted by HHSC with the MCOs regarding the STAR Kids program.
Policy and Program	State Medicaid Managed Care Advisory Committee	The State Medicaid Managed Care Advisory Committee provides recommendations and ongoing input to HHSC on the statewide implementation and operation of Medicaid Managed Care.
Policy and Program	Texas Council on Consumer Direction	Sample communications related to the Council whose purpose is to advise HHSC on the development, implementation, expansion, and delivery of services through consumer direction, in all programs offering LTSS that enhance a consumer's ability to have freedom and exercise control and authority over the consumer's choices, regardless of age or disability. This includes LTSS provided by MCOs.

Primary Section/ Program Area	Document Type(s)	Description
Policy and Program	Psychotropic medication review group	Sample communications related to Policy and Program's participation in the group facilitated by DFPS that reviews the number of psychotropic medication reviews conducted by Superior Health Plan and identifies any trends on a quarterly basis.
Policy and Program	HHSC Email Boxes and Sample Emails	Summary of provider and MCO-emailed inquiries about the STAR+PLUS program
Policy and Program	Handbook Process	Outlines the steps and responsibilities to develop, revise, and submit STAR+PLUS and STAR Kids handbook sections, appendices, and forms. It also serves as a guide for routing the revisions for publication.
Policy and Program	Managed Care Contracts and Manuals	The contracts and associated manuals provide contractual requirements for provision of prescription drugs under managed care, available at https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-contracts-manuals. In addition, the web site provides requirements for all other programs.
Policy and Program	House Bill (HB) 10, 85R, Implementation	Link to Texas Department of Insurance (TDI) webpage describing coordination effort among TDI, HHSC, and MCOs. This includes data collection tool discussion and development along with monitoring of HB 10 compliance, https://tdi.texas.gov/health/hb10.html
Policy and Program	Creation of the MBCC webpage	Starting September 1, 2017, women in the MBCC program will receive all their Medicaid services, including cancer treatment, through the STAR+PLUS health plan they pick. This webpage provides information on the program.

Primary Section/ Program Area	Document Type(s)	Description
Policy and Program	STAR+PLUS Handbook	Provides STAR+PLUS policy to MCOs. MCOs review any handbook changes and provide feedback. Handbook revisions are twice a year – March and September. Note: MCS Policy and Program meets with the MCOs monthly to provide feedback on any MCO-suggested changes not incorporated.
Policy and Program	Email Boxes	MCS Policy and Program manages several email boxes, which allow MCOs and providers to submit questions and get feedback on STAR+PLUS.
Policy and Program	STAR Kids Handbook	Provides STAR Kids policy to MCOs. MCOs review any handbook changes and provide feedback. Handbook revisions are twice a year – March and September. Note: MCS Policy and Program meets with the MCOs monthly to provide feedback on any MCO-suggested changes not incorporated.
Policy and Program	Medicaid State Plan	The state plan provides requirements applicable to Medicaid as administered in Texas. The state plan includes all CMS-approved requirements applicable to Medicaid as administered in Texas, in addition to the relevant state and federal statute and regulation.
Policy and Program	Texas Medicaid Provider Procedures Manual (TMPPM)	The TMPPM provides medical and pharmacy policy applicable to fee-for-service (FFS) providers. In addition, MCOs must provide the benefits as described in the TMPPM (unless otherwise excluded from MCO coverage) in the same amount, duration, and scope.
Policy and Program	Texas Medicaid and CHIP in Perspective (the Pink Book)	The “Pink Book” is a high-level description of Medicaid and CHIP in Texas.
Policy and Program	Managed Care Final Rules	The managed care final rules provide the federal regulatory environment within which MCOs and states must operate.
Policy and Program	CHIP State Plan	The state plan includes all CMS-approved requirements applicable to CHIP as administered in Texas, in addition to the relevant state and federal statute and regulation.

Primary Section/ Program Area	Document Type(s)	Description
Program Enrollment and Support	Premium Payment System (PPS) request	Number of PPS adjustments and errors – summary of the natures and number of adjustments and errors, per program handled by PPS team
Program Enrollment and Support	Enrollment broker meeting	Description of enrollment reports and meetings conducted with the enrollment broker and MCS
Program Enrollment and Support	STAR Kids Outreach	Number of calls made to inform STAR Kids enrollees on the appeal process regarding medical necessity
Program Enrollment and Support	Joint Interface Plan (JIP)	Enrollment Broker JIP for Enrollment Broker Operation and Texas Health Steps Outreach and Informing
Quality Assurance	Appointment Availability	Provides phone survey data on appointment availability
Quality Assurance	Texas Healthcare Learning Collaborative (THLC) Portal	Access to the THLC Portal developed by the External Quality Review Organization (EQRO)
Quality Assurance	Documents explaining Pay-for-Quality (P4Q) and measures at risk	The Uniform Managed Care Manual (UMCM) describes the P4Q program in detail, including measures and methodology.

Primary Section/ Program Area	Document Type(s)	Description
Quality Assurance	Quality Assurance (QA) additional documentation	• An overview of medical and dental P4Q redesign, including the 2018 measures (medical P4Q legislative update and dental P4Q legislative update) • Performance indicator dashboard standards methodology (10-1-14 UMCM Performance Indicator Dashboard for Quality Measures) • Additional detail regarding Performance Improvement Project (PIP) evaluation • QA's draft proposal for Operational Review • LTSS nursing facility quality measures for STAR+PLUS • Data types used by the EQRO • Appointment availability methodology
Quality Assurance	MCO Report Cards	The EQRO produced 50 unique report cards (differentiated by service area/plan) and instruction sheets in English and Spanish for print and online publication, available at https://hhs.texas.gov/services/health/medicaid-chip/programs/managed-care-report-cards
Quality Assurance	Texas Medicaid Managed Care and CHIP EQRO Contract Year 2016 Report	Evaluation of aggregated information on quality, timeliness, and access to health care services by a health plan for its Medicaid enrollees, in compliance with 42 CFR Part 438
Quality Assurance	Texas Medicaid Managed Care and CHIP EQRO Contract Year 2016 Report Addendum	Summarizes evaluation activities to meet federal requirements. Supplement to annual document, including PIP and encounter data validation information.
Quality Assurance	Delivery System Reform Incentive Payment (DSRIP) Program Measures	Bundled measures in use by the DSRIP Program
Quality Assurance	Managed Care in Other States	Publicly available information on Medicaid Managed Care spending and enrollment in comparative states

Primary Section/ Program Area	Document Type(s)	Description
Quality Institute and Oversight	Link to website for alternative payment models, etc.	Website to publicly available quality reports and information, including the Value-Based Purchasing (VBP) Roadmap, Managed Care Quality Strategy, Hospital Quality-Based Payment Program, quality efficiency data reports, HHSC Healthcare Quality Plan, and meetings with MCOs related to quality improvement
Results Management (formerly Cross Division Coordination)	Managed Care Steering Committee Charter	Outlines purpose, membership, and expectations for the managed care steering committee
Results Management (formerly Cross Division Coordination)	Network Adequacy Data Reports	Sample of data fields reporting the results of network adequacy compliance

Primary Section/ Program Area	Document Type(s)	Description
Results Management (formerly Cross Division Coordination)	Review of HHSC's Contract Management and Oversight Function for Medicaid and CHIP Managed Care and FFS Contracts	This report provides an update on the infrastructure and business process improvements initiated to ensure comprehensive oversight of the Medicaid and CHIP managed care and FFS contracts. Recent enhancements to MCS's oversight processes have focused on roles and responsibilities within MCS and increased cross-departmental visibility into identified issues and trends. To this end, MCS has increased the use of data in driving decision-making and facilitates regular conversations through an established steering committee process where various metrics are reviewed in assessing contractor compliance and system performance. The report was required by the 2016-2017 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 56, published in February 2017, and available at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/rider56-medicaid-chip-contract-management-oversight-feb-2017.pdf.
Utilization Review	Utilization Review Documents	Various documents pertaining to utilization review
Utilization Review	Utilization Review in STAR+PLUS Managed Care	Clinical oversight of MCO delivery of Managed Care LTSS
Vendor Drug Program	VDP QPR Template – UMCM 5.13.4	Psychotropic Medication Utilization Review (PMUR) Report template as referenced in UMCM Chapter 2.2 Section H. Psychotropic Medication Utilization Review and as seen in **Appendix 5.1.4**

Appendix 5.1.1 Reviews and Audits conducted by HHSC

The table below provides information on the types of reviews and audits conducted by HHSC and the Texas State Auditor's Office (SAO) in the past fiscal year.

Figure 25. Purpose, Frequency, and Effectiveness of Reviews and Audits Conducted by HHSC

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Desk Reviews	MCS MCCO	MCCO and other MCS program areas	Review of managed care operations within the MCO	Desk review covers specific periods. Length of time to perform review depends on what is being reviewed.	As needed	MCOs/ DMOs/ MTOs	Desk reviews identify deficiencies in MCO performance and assist staff in effectively and efficiently monitoring the MCOs.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Operational Reviews	MCS MCCO	MCCO and other MCS program areas	Onsite review of managed care operations within the MCO organization	Onsite visit could take four to seven days (not counting travel)	Biennial	MCOs/ DMOs/ MTOs	Onsite operational reviews assist HHSC staff in reviewing MCO operations to see if the information reported by the MCO is an accurate representation of how the MCO meets contract requirements and provides services to the members. The reviews also enable HHSC staff to identify problems or issues that may affect future performance and to work with the MCO on how to best remedy them.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Targeted Reviews	MCS MCCO	MCCO and other MCS program areas	Onsite review of area where deficiency has been identified or suspected.	Onsite visit takes approximately three to five days	As needed	MCOs/ DMOs/ MTOs	Onsite targeted reviews assist staff in determining if a deficiency exists and the root cause. Targeted reviews also establish what the performance plan will be, in order to remedy the problem/ issue and establish the timeframe for the deficiency to be addressed.
Readiness Reviews	MCS MCCO	MCCO and other MCS program areas	Review of MCO to certify MCO ability to perform services per federal requirements	Six to nine months in total	As needed	MCOs/ DMOs/ MTOs	Readiness reviews are an effective tool to determine if the MCO is capable of providing the services that they are being contracted to provide. This is a federal statutory requirement with which all states must comply.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Third-Party Performance Audits	MCS MCCO	External audit vendors	External entity review of self-reported data to verify and validate reported information.	Audit covers a specific period. Length of time to perform review depends on what is being reviewed.	Every two years until findings are resolved or are minimal	MCOs/ DMOs	Third-party performance audits are conducted by independent auditors of the MCOs' self-reported data and are an effective tool to monitor whether the MCOs are reporting data accurately. MCS also has targeted performance audits, which occur once a year depending on the results of the risk assessment and can look at any identified operational issue or concern.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
STAR+PLUS Home- and Community-Based Services (HCBS) reviews required by S.B. 348 (83rd regular session)	MCS Office of the Medical Director – Utilization Review	Managed Care LTSS Utilization Review (UR)	Statutory Requirement (SB 348, 83rd Regular Session)	Once per fiscal year	Annual	MCOs delivering STAR+PLUS HCBS	Results of the review are reported to the legislature each December. Findings help inform contract and policy issues and need for technical assistance. Findings may result in contract actions, such as CAPs or LD.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
MDCP Utilization Review	MCS Office of the Medical Director – Utilization Review	Managed Care LTSS UR	To review compliance with CMS's required performance measures, and Review compliance per leadership direction to ensure assessment driven service planning, appropriate conduct of assessment, and ensure members receive services.	Once per fiscal year	Annual (anticipated to begin in FY 2019)	MCOs delivering MDCP services	Ensure compliance with CMS's required performance measures, identify issues in contract or policy, and assess MCO compliance with contract and policy. Findings help inform technical assistance needs of MCOs or revision to the contract. Findings may also result in contract actions, such as CAPs.

Acute Care Utilization Review	MCS Office of the Medical Director – Utilization Review	Acute Care Utilization Review (ACUR)	The ACUR is mandated by Texas Government Code 531.076 (B) and the 42 Code of Federal Regulations (CFR) 438.66 (b), et seq. The purpose of the review is to ensure the efficacy of each MCO's PA and UR processes to reduce authorization of unnecessary and inappropriate services and to ensure Medicaid MCOs are not limiting access to care by denying necessary and appropriate Medicaid services. The ACUR review	The ACUR has both onsite and desk review components. The preparation for the review begins 60 days in advance with a request for documentation. The desk review lasts approximately two weeks. The onsite visit is conducted for two to three days, and the team completes the report approximately two weeks following the onsite review. This timeframe does not include follow-up for	HHSC MCCO conducts reviews monthly as part of operational review lead. All MCOs are on a two-year cycle.	Individual MCO's utilization management programs. All Medicaid programs are included in the review (STAR, STAR Kids, STAR+PLUS, and STAR Health). CHIP is not included in the review. Currently ACUR is not reviewing DMOs.	The reviews identified deficiencies in the MCO's PA processes. Issues were escalated to the Medical Director, HHSC Policy and Programs, HHSC Legal, and MCCO for clarification. Individual findings were included in CAPs for each MCO. Risks of overutilization, access to care (underutilization), and miscellaneous issues with contract compliance were identified.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
			is a module of the MCCO operational review and focuses on the following: • Review of MCO policy and procedures for contract compliance; and • Review of the operationalization of the policies and procedures through a desk review of PA records and PA staff interviews	CAPs. The timeframe may be extended if collaboration with legal, policy, or medical directors is needed to complete the report.			

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Performance Audit	SAO	SAO	To evaluate if HHSC and the Office of the Inspector General have sufficient Medicaid Managed Care contract management processes and related controls in accordance with contract terms, applicable laws, regulations, and agency policies and procedures	Covered HHSC's Medicaid Managed Care contracted audit activities from fiscal year 2011 through fiscal year 2015, performance audits conducted by the OIG from fiscal year 2011 through fiscal year 2015, and the Commission's EQRO contract for fiscal years 2014 and 2015.	Based on a risk assessment and conducted as needed	Health and Human Services Commission	The SAO conducts performance audits as the independent auditor for Texas state government of any entity receiving state funds, including state agencies. The audits are comprehensive, and the scope is developed after preliminary data collection and fieldwork has begun. The findings identify any gaps in contract compliance and may prompt amendments to the contract.

Targeted Performance Audit	SAO	SAO	To evaluate whether the MCO's financial processes and related controls are designed and operating to ensure (1) the accuracy and completeness of data that the Medicaid MCO reports to the HHSC and (2) compliance with applicable requirements	The scope of this recent audit covered Superior Health Plan's contracts with HHSC to deliver the Texas Medicaid program. It covered Superior Health Plan's financial statistical reports (FSRs) and its reported medical claims and pharmacy claims for fiscal year 2016. It also included the Commission's management over its contract with Superior Health Plan, including the two most	Based on a risk assessment and conducted as needed	Superior Health Plan, and Health and Human Services Commission	The audit methodology included selecting an MCO based on risk by obtaining and reviewing information from HHSC. SAO conducted this performance audit in accordance with generally accepted government auditing standards. Auditors also assessed the reliability of data used in the audit. Based on the findings, SAO provided improvement recommendations to Superior Health Plan and HHSC. The findings identify any gaps in contract compliance and prompted amendments to the contract.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
				recent AUP engagements for which it contracted with an external audit firm.			
Encounter Sampling and Verification	MCS Operations/ Operations Management	MCS Operations/ Operations Management	To compare claims submitted by providers with encounter data reported by MCOs	To begin by December 2018	Monthly	MCOs	HHSC will spot-check and verify that the encounters reported by MCOs to HHSC accurately reflect the claims submitted by providers to the MCOs.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
AUP Engage-ments	MCS FRAC	External audit vendors	To validate MCO compliance with the financial reporting requirements of the managed care contracts [Uniform Managed Care Contract (UMCC) and Uniform Managed Care Manual (UMCM)]	AUP engagements are conducted after the 334-day FSRs are received from the MCOs. AUP engagements begin approximately 15 months after the close of the fiscal year.	Each MCO is audited every year.	MCOs	AUP engagements identify instances of unallowable costs being included on the MCO's self-reported financial statements (FSRs). AUP engagement findings may affect the amount of experience rebates paid by MCOs to HHSC.

Mental Health Parity	MCS	MCS Policy and other program areas	To review whether MCOs offering Medicaid and CHIP services ensure that financial requirements and treatment limitations of mental health and substance use disorder (MH/SUD) conditions are no more restrictive than those applied to medical and surgical health conditions. This will determine if MCOs are compliant with federal requirements from the Mental Health Parity and Addiction Equity Act.	N/A	Any time the MCO/ Pharmacy Benefits Manager (PBM) makes a change to any of the processes that may impact compliance with federal Mental Health Parity law	MCO/ PBM	This new process went into effect in October 2017. CMS is reviewing the results of the agency analysis, and has not communicated any issues as of March 2018.
Legislative Implement-ations	MCS	MCS	To legislative directives get implemented	N/A	As needed	MCO/ PBM	MCS develops the policy and works with the MCOs/

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
related to all Medicaid benefits			timely and in accordance with law and contract requirements.				DMOs/ PBMs on implementation, and to determine if a reoccurring deliverable is needed for monitoring.
PMUR Plan	MCS VDP	MCS	To evaluate the MCO/PBM plan for PMUR for appropriatene ss.	State fiscal year (SFY)	Annual	MCO/ PBM	This is a new process that went into effect on April 1, 2018.
Clinical Prior Authoriz-ations (PAs) for Pharmacy Quarterly Review	MCS VDP	MCS	To ensure MCO/PBM clinical PAs are no more stringent than HHSC's	N/A	Quarterly (minimum) and reviewed as needed outside of scheduled review	MCO/ PBM	VDP Pharmacist perform this review. Additionally, MCOs submit a deliverable on clinical PAs they have implemented and whether it was implemented exactly as FFS or less stringent.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Policy and Procedures	MCS VDP	MCS	To review policies and procedures when outpatient drug benefit subject matter expertise is needed.	N/A	As needed	MCO/ PBM	Since October 2017, VDP has supported MCCO by providing subject matter expertise.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Annual Drug Utilization Review Report	MCS VDP	MCS	On an annual basis, states are required to report on their state's prescribing habits, cost savings generated from their DUR programs and their program's operations, including adoption of new innovative DUR practices via the Medicaid Drug Utilization Review Annual Report.	Federal Fiscal Year	Annual	MCOs	This is a new report for managed care, and the first submission will be in Summer 2019.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Investig-ations	HHSC OIG's Medicaid Program Integrity Division	OIG	To investigate allegations of fraud, waste, and abuse primarily in payments to Medicaid providers in both traditional FFS and managed care.	Tex. Gov't. Code Chapter 531 sets a 45-day period for preliminary investigation and a 180-day time period for full-scale investigation.	Investigations are ongoing throughout the year.	Medicaid and CHIP providers, MCOs, and DMOs	In SFY 2017, Medicaid provider investigations resulted in $4,880,011 (all funds) total recoveries from FFS and managed care recoveries.

Audit – Performance	HHSC OIG's Audit Division	OIG	To the effectiveness and efficiency of HHS System and DFPS program performance and operations. These audits may identify questioned costs or unsupported costs, which may be recovered or recouped, or may make recommendations that result in the assessment of liquidated damages by responsible program areas.	Six to nine months	Ongoing throughout the year with concurrent audit teams conducting audits	HHS System; DFPS; MCOs, DMOs, and other contractors; subcontractors	In SFY2017, a series of MCO special investigative unit (SIU) audits resulted in $829,300.00 in recoveries. This series of audits, which ended in SFY2017, also resulted in MCOs reporting a $5.3 million increase in SIU spending, which represents a drastic increase in MCO fraud prevention and detection efforts (pursuant to state and federal law, managed care requires joint oversight of Medicaid expenditures by MCO SIUs and the OIG). In addition, HHSC, MCOs, and the OIG increased collaboration to address fraud, waste, and abuse, which included expanding the content of

							quarterly meetings between SIUs and the OIG and collaboration efforts through the Texas Fraud Prevention Partnership, and the OIG made recommendations for MCS to consider contractual remedies to compel MCOs to perform SIU activities effectively. In SFY2018, an additional $36,500.00 was recovered as a result of the audits. The OIG is continuing to perform MCO SIU audits. In SFY2016, the OIG completed an audit of HHSC's management of MCO delivery supplemental claims; the audit was reissued in SFY 2017 to include amended

							MCO overpayment totals. In the audit, the OIG made recommendations for MCS to pursue the net recovery of $2,711,062 from MCOs as a result of exceptions identified in the audit; implementation of the OIG's recovery recommendations is pending. The OIG also recommended that critical delivery supplemental payment claims processing functions be placed within the organizational area best suited to provide the necessary guidance and support to perform the functions. This resulted in HHS organizational changes made in SFY2017 that should help strengthen the

							operational effectiveness of the associated functions, which process hundreds of millions of dollars in delivery supplemental claims annually. Lastly, in SFY2018, the Uniform Managed Care Manual (UMCM) was amended to solidify delivery supplemental claim requirements as a result a recommendation made in the audit. A series of MCO utilization management audits ending in FY2017 prompted a proposal for a joint initiative between HHS and the Texas Department of Insurance (TDI) to establish consistent timeliness requirements for

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
							notice of prior authorization determinations, which should result in operational and contract changes in SFY 2018.

Audit – Provider	HHSC OIG's Audit Division	OIG	To evaluate contractor or provider compliance with criteria contained in legislation, rules, guidance, or contracts, and determine whether funds were used as intended. These audits may identify questioned costs or unsupported costs, which may be recovered or recouped.	Six to nine months	Ongoing throughout the year with concurrent audit teams conducting audits	Medicaid and CHIP providers, and MCOs	These audits provide MCS department with insight on how providers for the MCOs are performing. They can highlight areas where providers are not following the contract with the MCO, which can result in the MCO not following the UMCC. The OIG is continuing to perform Medicaid and CHIP provider audits. With the passage of House Bill 2379, 85th Legislature, Regular Session, 2017, if the audits identify managed care overpayments, the OIG will send demand letters to the providers requesting payment.
Audit – Information Technology (IT)	HHSC OIG's Audit Division	OIG	To assess compliance with applicable	Six to nine months	Ongoing throughout the year with concurrent	HHS System, DFPS, and MCOs	As a result of an Information Technology audit completed in

			information technology requirements and examine the effectiveness of selected security controls for systems that support HHS System and DFPS programs, or are used by contractors or business partners who process and store information on behalf of HHS System and DFPS programs. These audits may make recommendations that result in the assessment of LD by responsible program areas.		audit teams conducting audits		SFY2017, new requirements for MCO security plans are being included in the March 2018 UMCC Amendment, which will help ensure MCOs submit complete security plans in accordance with managed care contract requirements. MCOs have also implemented and developed corrective actions to strengthen MCO control areas in order to further protect confidential HHS System information from unauthorized access, loss, or disclosure.
Audit – Federal	HHSC OIG's Audit Division is	Primarily U.S. Department of	To assess the effectiveness	One to five years	Ongoing throughout	The report is directed to	As a result of federal audits

Audits and Review	the single point of contact with federal oversight entities that perform audits and reviews of HHSC programs, contractors, and providers.	Health and Human Services Office of Inspector General (DHHS OIG), Government Accountability Office (GAO), and Centers for Medicare and Medicaid Services (CMS)	of programs, operations, grantees, contractors, and program integrity efforts to determine whether federal funds are being spent efficiently and effectively, states are complying with applicable federal requirements, and government programs and policies are meeting their objectives. Among other things, these audits help promote efficiency, identify noteworthy program integrity initiates to be shared with		the year with concurrent teams conducting audits and reviews.	the state. However, in addition to reviewing the HHS System, auditors can also review Medicaid and CHIP providers, capitation payments made to MCOs and DMOs, and the MCOs and DMOs themselves.	issued in SFY2017, Medicaid Managed Care program integrity activities and associated roles and responsibilities have been clarified, and oversight strengthened. In addition, to address another federal audit, OIG Inspections is conducting an inspection to determine whether there are unallowable monthly Medicaid Managed Care payments associated with members who are assigned more than one Medicaid identification number. As a result of that same audit, HHSC implemented strategies to mitigate the creation of duplicate identification

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
			other states, and help prevent and reduce fraud, waste, and abuse throughout DHHS.				numbers, thus helping to prevent future unallowable payments.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Audit - Payment Error Rate Measurement (PERM)	OIG's Audit Division is the single point of contact for the Centers for Medicare and Medicaid Services' (CMS) PERM program.	CMS contractors	To measure improper payments in Medicaid and CHIP by conducting (a) medical reviews of FFS claims to determine whether the service was medically necessary, reasonable, provided in the appropriate setting, billed correctly, and coded accurately and (b) data processing reviews.	28 months	Occurs every three years.	The report is directed to the state. However, in addition to reviewing the HHS System, the contractors also review Medicaid and CHIP provider claims, as well as capitation payments made to MCOs and DMOs.	The FY 2017 report will not be issued until November 2018.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Utilization Review – Acute Care	HHSC OIG's Division of Medical Services	OIG	To identify patterns of irregular billing, performs Surveillance Utilization Reviews (SURs) required by CMS, develops and runs targeted data queries (TQs) to identify acute care billing outliers, researches the results, and collects Medicaid overpayments .	*SUR:* Time frame depends on complexity of the case; average time per case is nine months. *TQs:* Time frame depends on the TQ; average time to complete is six months per TQ.	Ongoing, throughout the year. Case selection is based on SURProfiler+ results, referrals and complaints, data queries to identify billing outliers or potential violations.	Medicaid acute care providers and dental providers (FFS and managed care)	In SFY 2017, OIG's Division of Medical Services' (DMS) Acute Care Surveillance audits recovered $5,944,702 (all funds) in Medicaid overpayments from providers.

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Utilization Review – Acute Care Hospitals and Nursing Facility	HHSC OIG's Division of Medical Services	OIG	Conducts retrospective URs of hospitals and nursing facilities.	*Hospital UR:* The number of claims reviewed is projected by sample quarter of each fiscal year, about 50,000 claims per year; review time per claim = ~1 hour per claim. *Nursing Facilities UR:* each on-site review takes approximately four to five days.	*Hospital UR:* Ongoing, throughout the year. Case selection for hospital UR is based on statistically valid random sampling and/or focused selection of paid inpatient claims as described in 1 TAC 371.201. *Nursing Facilities UR:* Ongoing, throughout the year.	Medicaid providers of hospital inpatient services and nursing facility services (FFS and managed care)	In SFY 2017, the reviews of hospital UR resulted in $27,549,491 (all funds) recovered from hospital inpatient providers, and the nursing facilities UR resulted in $3,961,925 (all funds) recovered from nursing homes as part of the total $37,700,400 (all funds) recoveries.

Lock-in Program	HHSC OIG's Division of Medical Services	OIG, MCOs	To conduct reviews and analysis of data and incoming referrals from MCOs, medical providers, state agencies, law enforcement officials, and members of the general public to identify Texas Medicaid recipients who may meet criteria for lock-in to a single-designated pharmacy, and for FFS, a single primary care provider (PCP), if it finds that: • A recipient received duplicative, excessive, contraindicated, or conflicting	Varies based on the types of review: • FFS: initial or continued lock ~4 hours per case • Managed Care: ~2 hours per case • Managed Care AutoLock: ~1 hour per case	Ongoing, throughout the year. Case selection is based on MCO referrals and data analysis of recipient use of pharmacy services.	Medicaid recipients and MCOs participating in OIG's Managed Care AutoLock project (FFS and managed care)	The Lock-in Program operates in accordance with 1 TAC Ch. 354 Subchapter K and 42 CFR 431.54(e). The primary purpose is to ensure the health and safety of Medicaid recipients and to prevent fraud, waste and abuse of pharmacy services. The Lock-in Program's review and analysis of data and referrals result in a lock-in action if it finds a recipient received duplicative, excessive, contraindicated, or conflicting health services, including drugs; or a review indicates abuse, misuse, or fraudulent actions related to Medicaid benefits and services. Total cost avoided due to the Lock-in Program in SFY 2017 was

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
			health care services, including drugs. • Abuse, misuse, or fraudulent actions related to Medicaid benefits and services are likely to exist.				$210,673 (all funds).

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
Inspections	HHSC OIG's Inspections Division	OIG	To conduct inspections of Texas Health and Human Services (HHS) programs, systems, and functions focused on fraud, waste, and abuse and systemic issues to improve the HHS System.	Four to six months for final report	Ongoing throughout the year	Medicaid and CHIP providers, MCOs, and DMOs	Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of fraud, waste, and abuse. Inspections may result in recommendations to strengthen program effectiveness and efficiency.

Performance Audits	HHSC Internal Audit	HHSC Internal Audit	To evaluate the efficiency and effectiveness of programs and operations; assess the adequacy and effectiveness of management control systems; and track and report on the implementation status of audit recommendations.	As needed based on the continuous risk assessment	As needed based on the continuous risk assessment	HHS which may include MCS and MCOs/ DMOs	HHSC Internal Audit has a continual risk assessment process that is designed to estimate the likelihood and the effect of potential events, which, if they were to occur, could result in adverse outcomes in HHSC. Internal Audit develops recommendations to executive management about which programs, processes, or systems could most benefit from an audit. Internal Audit reviews the effectiveness of agency processes and controls for the areas selected for audit.
Consulting Engage-ments	HHSC Internal Audit	HHSC Internal Audit	Advisory and related client services activities, the nature and	As needed and upon management request	As needed and upon manage-ment request	HHS, which may include MCS and MCOs/ DMOs	Internal auditors must exercise due professional care during a consulting engagement by

Review or Audit Type	Section/ Office Responsible for Review/ Audit	Entity Conducting Review/ Audit	Purpose of Review/ Audit	Time frame for Review/ Audit	Frequency of Review/ Audit	Entity Being Audited/ Reviewed	Describe Effectiveness of Review/ Audit
			scope of which are agreed with the client, are intended to add value and improve an organization's governance, risk management, and control processes without the internal auditor assuming management responsibility.				considering the need and expectations of clients, including the nature, timing, and communication of engagement results and relative complexity and extent of work needed to achieve the engagement's objectives. During consulting engagements, internal auditors must address risk consistent with the engagement's objectives and be alert to the existence of other significant risks.

Appendix 5.1.2 Deliverables by Function

Below is the list of deliverables required from MCOs/DMOs and organized by functional component, as defined in Section 5.0 Consolidated Deliverables Matrix in the Uniform Managed Care Manual (UMCM).[72]

Figure 26. Deliverables Required by Business Function.

Functional Component(s)	Deliverable Name
Finance/Operations/ Systems	Encounter Data
Finance/Operations/ Systems	Encounter Data Certification Form
Finance	Affiliate Report
Finance	Annual Financial Statements (as submitted to TDI)
Finance	Audit Reports (internal and external)
Finance	Claims Lag Report
Finance	Claims Summary Report
Finance	Delivery Supplemental Payment (DSP) Report – CHIP
Finance	DSP Report – STAR
Finance	Employee Bonus/Incentive Payment Plan
Finance	Fidelity Bond
Finance	Financial Statistical Reports (FSR)
Finance	Insurance Coverage Proof
Finance	Legal and Other Proceedings and Related Events Report
Finance	MCO Disclosure Statement
Finance	Other Existing Financial Reports (as may be distributed to others)
Finance	Performance Bond
Finance	Registration Statement ("Form B")
Finance	Solvency Issues Notification
Finance	TDI Examination Report
Finance	TDI Filings — annual figures for controlled risk-based capital; quarterly financial statements

[72] *HHSC Uniform Managed Care Manual, https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/5-0.pdf.*

Functional Component(s)	Deliverable Name
Finance	Third-Party Recovery (TPR) Reports
Fraud	Fraud and Abuse Compliance Plan
Fraud	Fraud and Abuse – Subcontractors
Fraud	Fraudulent Practices Report
Fraud	Lock-in Claims Data Report
Fraud	Lock-in Review Form
Fraud	Lock-in Transaction Report
Fraud	MCO Lock-in Policies
Fraud	MCO Open Case List Report
Fraud	Total MCO Member Lock-in Report
Operations	Board Certification Status of Providers
Operations	Children of Migrant Farmworkers Annual Plan
Operations	Children of Migrant Farmworkers Annual Report (Farmworker Child(ren) (FWC) Annual Report)
Operations	Corrective Action Plan (CAPs)
Operations	Cultural
Operations	Electronic Visit Verification Contractor Compliance Report
Operations	Electronic Visit Verification Summary Report
Operations	Frew Quarterly Monitoring Report
Operations	Geo-Mapping Report
Operations	Hotline Reports
Operations	Hotline Reports – Nurse
Operations	Historically Underutilized Business Reports
Operations	Key Personnel Changes
Operations	LTSS Utilization Report
Operations	Marketing Materials
Operations	Material Subcontractor Changes
Operations	MCO Website
Operations	Medicaid Managed Care Texas Health Steps Medical Checkups
Operations	Medicaid Member Complaint and Appeal System
Operations	Member Handbook
Operations	Member ID Cards

Functional Component(s)	Deliverable Name
Operations	Members with Special Health Care Needs Report
Operations	Migrant Incentives Supporting Documentation Tracking Log
Operations	Medicaid Managed Care Texas Health Steps Outreach Materials
Operations	Model Provider Contracts
Operations	Notices of Action/Incomplete Prior Authorizations (PAs)
Operations	Online Provider Directory
Operations	Operational Policies and Procedures
Operations	Out-of-Network Utilization Reports
Operations	Perinatal Risk Report (17P Report)
Operations	Pharmaceutical Delivery Fee Payment Methodology
Operations	Physician Incentive Plans
Operations	PMUR Report
Operations	Process for Resolution of HHSC-Referred Complaints
Operations	Provider Complaints, Member Complaints, and Member Appeals
Operations	Provider Contract Termination
Operations	Provider Directory
Operations	Provider Enrollment/Credentialing Denial Report
Operations	Provider Manual
Operations	Provider Materials
Operations	Provider Network and Capacity Report
Operations	Provider Termination Report
Operations	Provider Training
Operations	Provider Validation Report
Operations	QAPI Program Annual Summary
Operations	Special Exception Request
Operations	STAR Health Liaison Summary Report
Operations	STAR Health Network Summary
Operations	STAR Health PCP Texas Health Steps Enrollment Report
Operations	STAR Health Service Management Report
Operations	STAR+PLUS Service Coordination Report
Operations	TDI Certificate of Authority
Operations	TDI Filings of Delegation Agreements

Functional Component(s)	Deliverable Name
Operations	Turnover Plan
Operations	Turnover Results Report
Operations	Value-Added Services (VAS) Utilization
Operations	VAS Templates
Operations/Systems	Geo-Mapping Provider Interface
Operations/Systems	LTSS Provider Layouts
Operations/Finance	Third-Party Agreements
Pharmacy Operations	MCO Pharmacy Quarterly Report
Pharmacy Operations	MCO Pharmacy Website Required Critical Elements
Quality	Abuse, Neglect, and Exploitation Reports
Quality	Critical Incidents and Abuse, Neglect, and Exploitation Quarterly Report
Quality	LTSS Report
Quality	MCO Value-Based Contracting
Quality	Performance Improvement Projects (PIPs)
Quality	Plan for Special Populations Program
Quality	Service Coordinators Consumer-Directed Services (CDS) Training Report
Systems	Business Continuity Plan
Systems	Business Continuity Plan/Disaster Recovery Plan Checklist
Systems	Claims Processing System Changes
Systems	Disaster Recovery Plan
Systems	Joint Interface Plan
Systems	Joint Interface Plan Checklist
Systems	Organizational Chart for Management Information Systems (MIS)
Systems	Risk Management Plan
Systems	Risk Management Plan Checklist
Systems	Security Plan
Systems	Security Plan Checklist
Systems	System Change Notifications
Systems	Systems Quality Assurance Plan

Functional Component(s)	Deliverable Name
Systems	Systems Quality Assurance Plan Checklist
Third-Party Liability (TPL)	Third Party Recovery (TPR) MCO Referral Form

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Appendix 5.1.3 Quarterly Performance Report Template for Managed Care Compliance Operations

Below is the template for the Quarterly Performance Report (QPR) for the STAR+PLUS program that MCCO populates for each MCO and each Service Delivery Area (SDA) in the STAR+PLUS program.

Figure 27. QPR Template for STAR+PLUS.

MCO:			-------		
Program:			STAR+PLUS		
Service Area:			-------		
Plan Code:			-------		
	Health Plan Manager:	-------	-------	-------	-------
	Health Plan Specialist:	-------	-------	-------	-------
SFY:	YYYY	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
I. Enrollment Data					
Source: Confirmed Eligibles Report					
Program Enrollment					
Total Enrollment for Month 1 of the Quarter:	0	0	0	0	
Total Enrollment for Month 2 of the Quarter:	0	0	0	0	
Total Enrollment for Month 3 of the Quarter:	0	0	0	0	
Enrollment Change					
	Month 3 of Previous Quarter:	0	0	0	0
	Month 3 of Current Quarter:	0	0	0	0

MCO:			-------		
	Number Change:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
STAR+PLUS Medical Assistance Only (MAO) Enrollment					
Source: HHSC Finance					
Total Enrollment for the Quarter:	0	0	0	0	
Enrollment Change					
	Month 3 of Previous Quarter:	0	0	0	0
	Month 3 of Current Quarter:	0	0	0	0
	Number Change:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Analysis/Concerns Re: Enrollment and Outreach:					
Q1: -------					
Q2: -------					
Q3: -------					
Q4: -------					
II. Provider Network					
Provider Network Status					
Source: MCO Provider Files/Operations Coordination and Data Analytics					
All Providers					
In Area					
	# of Providers of Previous Quarter:	0	0	0	0
	# of Providers of Current Quarter:	0	0	0	0
	# Change:	0	0	0	0
Out of Area					

MCO:			-------		
	# of Providers of Previous Quarter:	0	0	0	0
	# of Providers of Current Quarter:	0	0	0	0
	# Change:	0	0	0	0
Total					
	# of Providers of Previous Quarter:	0	0	0	0
	# of Providers of Current Quarter:	0	0	0	0
	# Change:	0	0	0	0
PCPs					
In Area					
	# of PCPs of Previous Quarter:	0	0	0	0
	# of PCPs of Current Quarter:	0	0	0	0
	# Change:	0	0	0	0
	# of PCPs with Open Panel Previous Quarter:	0	0	0	0
	# of PCPs with Open Panel Current Quarter:	0	0	0	0
	Percent of PCPs with Open Panel **(Benchmark: 80%)**:	0.00%	0.00%	0.00%	0.00%
	# Change:	0	0	0	0

MCO:			-------		
	Ratio of Members per PCP:	0:1	0:1	0:1	0:1
Out of Area					
	# of PCPs of Previous Quarter:	0	0	0	0
	# of PCPs of Current Quarter:	0	0	0	0
	# Change:	0	0	0	0
	# of PCPs with Open Panel Previous Quarter:	0	0	0	0
	# of PCPs with Open Panel Current Quarter:	0	0	0	0
	Percent of PCPs with Open Panel **(Benchmark: 80%)**:	0.00%	0.00%	0.00%	0.00%
	# Change:	0	0	0	0
	Ratio of Members per PCP:	0:1	0:1	0:1	0:1
Total					
	# of PCPs of Previous Quarter:	0	0	0	0
	# of PCPs of Previous Quarter:	0	0	0	0
	# of PCPs of Current Quarter:	0	0	0	0

MCO:			-------		
	# of PCPs with Open Panel Previous Quarter:	0	0	0	0
	# of PCPs with Open Panel Current Quarter:	0	0	0	0
	Percent of PCPs with Open Panel **(Benchmark: 80%)**:	0.00%	0.00%	0.00%	0.00%
	# Change:	0	0	0	0
	Ratio of Members per PCP:	0:1	0:1	0:1	0:1
STAR+PLUS Medical Assistance Only (MAO)					
In Area					
	Ratio of Members per PCP:	0:1	0:1	0:1	0:1
Out of Area					
	Ratio of Members per PCP:	0:1	0:1	0:1	0:1
Total					
	Ratio of Members per PCP:	0:1	0:1	0:1	0:1
Pediatricians					
In Area					
	# of Pediatricians of Previous Quarter:	0	0	0	0
	# of Pediatricians of Current Quarter:	0	0	0	0

MCO:			-------		
	# Change:	0	0	0	0
	# of Pediatricians with Open Panel Previous Quarter:	0	0	0	0
	# of Pediatricians with Open Panel Current Quarter:	0	0	0	0
	Percent of Pediatricians with Open Panel:	0.00%	0.00%	0.00%	0.00%
	# Change:	0	0	0	0
Out of Area					
	# of Pediatricians of Previous Quarter:	0	0	0	0
	# of Pediatricians of Current Quarter:	0	0	0	0
	# Change:	0	0	0	0
	# of Pediatricians with Open Panel Previous Quarter:	0	0	0	0
	# of Pediatricians with Open Panel Current Quarter:	0	0	0	0
	Percent of Pediatricians with Open Panel:	0.00%	0.00%	0.00%	0.00%
	# Change:	0	0	0	0
Total					
	# of Pediatricians of Previous Quarter:	0	0	0	0

MCO:			-------		
	# of Pediatricians of Current Quarter:	0	0	0	0
	# Change:	0	0	0	0
	# of Pediatricians with Open Panel Previous Quarter:	0	0	0	0
	# of Pediatricians with Open Panel Current Quarter:	0	0	0	0
	Percent of Pediatricians with Open Panel:	0.00%	0.00%	0.00%	0.00%
	# Change:	0	0	0	0
Specialists					
In Area					
	# of Specialists of Previous Quarter:	0	0	0	0
	# of Specialists of Current Quarter:	0	0	0	0
	# Change:	0	0	0	0
Out of Area					
	# of Specialists of Previous Quarter:	0	0	0	0
	# of Specialists of Current Quarter:	0	0	0	0
	# Change:	0	0	0	0
Total					
	# of Specialists of Previous Quarter:	0	0	0	0

MCO:			-------		
	# of Specialists of Current Quarter:	0	0	0	0
	# Change:	0	0	0	0
LTSS Providers					
Source: UMCM 5.4.1.12 Provider Network and Capacity Report; DTS Code: BEL; refer to deliverable for provider details					
	Total # Unduplicated LTSS Providers:	0	0	0	0
	Total # Duplicated LTSS Providers:	0	0	0	0
Facility Based					
Adult Day Care/Day Activity and Health Services (X1)					
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Respite Care/Assisted Living (X4)					
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Adult Foster Care (X5)					
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Nursing Facility (X7)					
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Statewide					
Primary Home Care/Nursing Services (X2)					

MCO:			-------		
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Value Added (X3)					
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Emergency Response System (X6)					
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Home-Delivered Meals (X8)					
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Adaptive Aides/Medical Equipment (X9)					
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Minor Home Modifications (XA)					
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Physical Therapy (XB)					
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Occupational Therapy (XC)					
	# This Quarter:	0	0	0	0

MCO:		-------		
# Previous Quarter:	0	0	0	0
Percent Change:	0.00%	0.00%	0.00%	0.00%
Speech Therapy (XD)				
# This Quarter:	0	0	0	0
# Previous Quarter:	0	0	0	0
Percent Change:	0.00%	0.00%	0.00%	0.00%
Employment Assistance (XE)				
# This Quarter:	0	0	0	0
# Previous Quarter:	0	0	0	0
Percent Change:	0.00%	0.00%	0.00%	0.00%
Agency Adult Foster Care (XF)				
# This Quarter:	0	0	0	0
# Previous Quarter:	0	0	0	0
Percent Change:	0.00%	0.00%	0.00%	0.00%
Habilitation (XH)				
# This Quarter:	0	0	0	0
# Previous Quarter:	0	0	0	0
Percent Change:	0.00%	0.00%	0.00%	0.00%
Primary Home Care/Nursing Services/Attendant Care/Community First Choice (CFC) (XN)				
# This Quarter:	0	0	0	0
# Previous Quarter:	0	0	0	0
Percent Change:	0.00%	0.00%	0.00%	0.00%
Supported Employment (XS)				
# This Quarter:	0	0	0	0
# Previous Quarter:	0	0	0	0
Percent Change:	0.00%	0.00%	0.00%	0.00%
Financial Management Services (XU)				
# This Quarter:	0	0	0	0
# Previous Quarter:	0	0	0	0

MCO:			-------		
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Transition Assistance Services (XY)					
	# This Quarter:	0	0	0	0
	# Previous Quarter:	0	0	0	0
	Percent Change:	0.00%	0.00%	0.00%	0.00%
Provider Terminations					
Source: UMCM 5.4.1.11 Provider Termination Report; DTS Code: AFL; refer to deliverable for provider details and termination reasons					
	# of Providers Termed:	0	0	0	0
	# of PCPs:	0	0	0	0
	# of PCPs Termed:	0	0	0	0
	Percent of PCPs Termed:	0.00%	0.00%	0.00%	0.00%
	# of Specialists:	0	0	0	0
	# of Specialists Termed:	0	0	0	0
	Percent of Specialists Termed:	0.00%	0.00%	0.00%	0.00%
	# of Nursing Facilities:	0	0	0	0
	# of Nursing Facilities Termed:	0	0	0	0
	Percent of Nursing Facilities Termed:	0.00%	0.00%	0.00%	0.00%

MCO:			-------		
	# of LTSS Providers:	0	0	0	0
	# of LTSS Providers Termed:	0	0	0	0
	Percent of LTSS Providers Termed:	0.00%	0.00%	0.00%	0.00%
# of Members Impacted					
	PCPs:	0	0	0	0
	Specialists:	0	0	0	0
	Nursing Facilities:	0	0	0	0
	LTSS Providers:	0	0	0	0
# of Members Reassigned					
	PCPs:	0	0	0	0
	Nursing Facilities:	0	0	0	0
Voluntary/Involuntary Terminations					
	# of Voluntary Terminations:	0	0	0	0
	Percent of Voluntary Terminations:	0.00%	0.00%	0.00%	0.00%
	# of Involuntary Terminations:	0	0	0	0
	Percent of Involuntary Terminations:	0.00%	0.00%	0.00%	0.00%

Provider Termination Reasons

Quarter 1 Top 3 Reasons for Provider Terminations

1) -------

2) -------

3) -------

Quarter 2 Top 3 Reasons for Provider Terminations

MCO:	-------
1) -------	
2) -------	
3) -------	
Quarter 3 Top 3 Reasons for Provider Terminations	
1) -------	
2) -------	
3) -------	
Quarter 4 Top 3 Reasons for Provider Terminations	
1) -------	
2) -------	
3) -------	

Analysis of Provider Network/Action Taken:

Q1: -------

Q2: -------

Q3: -------

Q4: -------

III. MCO Hotline Reports

Member Hotline Performance

Source: UMCM 5.4.3.12 Member Hotline Report; DTS code: AFP; based on aggregated data

	Subcontractor:	-------	-------	-------	-------
	Total Calls Received in the Quarter:	0	0	0	0
Month 1					
	Total Calls Received:	0	0	0	0
	# Calls Answered:	0	0	0	0
	Percent Calls Answered:	0.00%	0.00%	0.00%	0.00%

MCO:			-------		
	# Call Abandonment Rate:	0	0	0	0
	Percent Call Abandonment Rate: **Performance Standard: ≤7%**	0.00%	0.00%	0.00%	0.00%
	# Busy Signal Rate:	0	0	0	0
	Percent Busy Signal Rate: **Performance Standard: ≤1%**	0.00%	0.00%	0.00%	0.00%
	# Call Pickup Rate:	0	0	0	0
	Percent Call Pickup Rate: **Performance Standard: 99%**	0.00%	0.00%	0.00%	0.00%
	# Call Hold Rate:	0	0	0	0
	Percent Call Hold Rate: **Performance Standard: 80% within 30 seconds**	0.00%	0.00%	0.00%	0.00%
	# Average Hold Time in Seconds:	0	0	0	0
	Average Hold Time: **Performance Standard: ≤2 min**	0:00:00	0:00:00	0:00:00	0:00:00
Month 2					
	Total Calls Received:	0	0	0	0
	# Calls Answered:	0	0	0	0
	Percent Calls Answered:	0.00%	0.00%	0.00%	0.00%

MCO:			-------		
	# Call Abandonment Rate:	0	0	0	0
	Percent Call Abandonment Rate: **Performance Standard: ≤7%**	0.00%	0.00%	0.00%	0.00%
	# Busy Signal Rate:	0	0	0	0
	Percent Busy Signal Rate: **Performance Standard: ≤1%**	0.00%	0.00%	0.00%	0.00%
	# Call Pickup Rate:	0	0	0	0
	Percent Call Pickup Rate: **Performance Standard: 99%**	0.00%	0.00%	0.00%	0.00%
	# Call Hold Rate:	0	0	0	0
	Percent Call Hold Rate: **Performance Standard: 80% within 30 seconds**	0.00%	0.00%	0.00%	0.00%
	# Average Hold Time in Seconds:	0	0	0	0
	Average Hold Time: **Performance Standard: ≤2 min**	0:00:00	0:00:00	0:00:00	0:00:00
Month 3					
	Total Calls Received:	0	0	0	0
	# Calls Answered:	0	0	0	0
	Percent Calls Answered:	0.00%	0.00%	0.00%	0.00%

MCO:			-------		
	# Call Abandonment Rate:	0	0	0	0
	Percent Call Abandonment Rate: **Performance Standard: ≤7%**	0.00%	0.00%	0.00%	0.00%
	# Busy Signal Rate:	0	0	0	0
	Percent Busy Signal Rate: **Performance Standard: ≤1%**	0.00%	0.00%	0.00%	0.00%
	# Call Pickup Rate:	0	0	0	0
	Percent Call Pickup Rate: **Performance Standard: 99%**	0.00%	0.00%	0.00%	0.00%
	# Call Hold Rate:	0	0	0	0
	Percent Call Hold Rate: **Performance Standard: 80% within 30 seconds**	0.00%	0.00%	0.00%	0.00%
	# Average Hold Time in Seconds:	0	0	0	0
	Average Hold Time: **Performance Standard: ≤2 min**	0:00:00	0:00:00	0:00:00	0:00:00

Analysis of Member Hotline/Action Taken:

Q1: -------

Q2: -------

Q3: -------

Q4: -------

MCO:		-------			

Behavioral Health (BH) Hotline Performance

Source: UMCM 5.4.3.14 Behavioral Health Hotline Report; DTS code: AJA; refer to deliverable for non-crisis and crisis call breakdown, based on aggregated data

	Subcontractor:	-------	-------	-------	-------
	Total Non-Crisis Calls Received in the Quarter:	0	0	0	0
	Total Crisis Calls Received in the Quarter:	0	0	0	0
	Total in the Quarter:	0	0	0	0
Month 1					
	Total Non-Crisis Calls Received:	0	0	0	0
	Total Crisis Calls Received:	0	0	0	0
	Total:	0	0	0	0
	Total Calls Answered:	0	0	0	0
	# Calls Answered:	0	0	0	0
	Percent Calls Answered:	0.00%	0.00%	0.00%	0.00%
	# Call Abandonment Rate:	0	0	0	0
	Percent Call Abandonment Rate: **Performance Standard: ≤7%**	0.00%	0.00%	0.00%	0.00%
	# Busy Signal Rate:	0	0	0	0

MCO:			-------		
	Percent Busy Signal Rate: **Performance Standard: 0%**	0.00%	0.00%	0.00%	0.00%
	# Call Pickup Rate:	0	0	0	0
	Percent Call Pickup Rate: **Performance Standard: 99%**	0.00%	0.00%	0.00%	0.00%
	# Call Hold Rate:	0	0	0	0
	Percent Call Hold Rate: **Performance Standard: 80% within 30 seconds**	0.00%	0.00%	0.00%	0.00%
	Sum of Hold Time in Seconds:	0	0	0	0
	Average Hold Time: **Performance Standard: ≤2 min**	0:00:00	0:00:00	0:00:00	0:00:00
Month 2					
	Total Non-Crisis Calls Received:	0	0	0	0
	Total Crisis Calls Received:	0	0	0	0
	Total:	0	0	0	0
	Total Calls Answered:	0	0	0	0
	# Calls Answered:	0	0	0	0
	Percent Calls Answered:	0.00%	0.00%	0.00%	0.00%

MCO:			-------		
	# Call Abandonment Rate:	0	0	0	0
	Percent Call Abandonment Rate: **Performance Standard: ≤7%**	0.00%	0.00%	0.00%	0.00%
	# Busy Signal Rate:	0	0	0	0
	Percent Busy Signal Rate: **Performance Standard: 0%**	0.00%	0.00%	0.00%	0.00%
	# Call Pickup Rate:	0	0	0	0
	Percent Call Pickup Rate: **Performance Standard: 99%**	0.00%	0.00%	0.00%	0.00%
	# Call Hold Rate:	0	0	0	0
	Percent Call Hold Rate: **Performance Standard: 80% within 30 seconds**	0.00%	0.00%	0.00%	0.00%
	Sum of Hold Time in Seconds:	0	0	0	0
	Average Hold Time: **Performance Standard: ≤2 min**	0:00:00	0:00:00	0:00:00	0:00:00
Month 3					
	Total Non-Crisis Calls Received:	0	0	0	0
	Total Crisis Calls Received:	0	0	0	0
	Total:	0	0	0	0

MCO:			-------		
	Total Calls Answered:	0	0	0	0
	# Calls Answered:	0	0	0	0
	Percent Calls Answered:	0.00%	0.00%	0.00%	0.00%
	# Call Abandonment Rate:	0	0	0	0
	Percent Call Abandonment Rate: **Performance Standard: ≤7%**	0.00%	0.00%	0.00%	0.00%
	# Busy Signal Rate:	0	0	0	0
	Percent Busy Signal Rate: **Performance Standard: 0%**	0.00%	0.00%	0.00%	0.00%
	# Call Pickup Rate:	0	0	0	0
	Percent Call Pickup Rate: **Performance Standard: 99%**	0.00%	0.00%	0.00%	0.00%
	# Call Hold Rate:	0	0	0	0
	Percent Call Hold Rate: **Performance Standard: 80% within 30 seconds**	0.00%	0.00%	0.00%	0.00%
	Sum of Hold Time in Seconds:	0	0	0	0
	Average Hold Time: **Performance Standard: ≤2 min**	0:00:00	0:00:00	0:00:00	0:00:00

MCO:			-------		
Analysis of BH Hotline/Action Taken:					
Q1: -------					
Q2: -------					
Q3: -------					
Q4: -------					
Provider Hotline Performance					
Source: UMCM 5.4.3.13 Provider Hotline Report; DTS code: AIY, based on aggregated data					
	Subcontractor:	-------	-------	-------	-------
	Total Calls Received in the Quarter:	0	0	0	0
Month 1					
	Total Calls Received:	0	0	0	0
	# Calls Answered:	0	0	0	0
	Percent of Calls Answered:	0.00%	0.00%	0.00%	0.00%
	# Call Abandonment Rate:	0	0	0	0
	Percent Call Abandonment Rate: **Performance Standard: ≤7%**	0.00%	0.00%	0.00%	0.00%
	# Busy Signal Rate:	0	0	0	0
	Percent Busy Signal Rate: **Performance Standard: ≤1%**	0.00%	0.00%	0.00%	0.00%
	# Call Pickup Rate:	0	0	0	0

MCO:			-------		
	Percent Call Pickup Rate: **Performance Standard: 99%**	0.00%	0.00%	0.00%	0.00%
	# Average Hold Time in Seconds:	0	0	0	0
	Average Hold Time: **Performance Standard: ≤2 min**	0:00:00	0:00:00	0:00:00	0:00:00
Month 2					
	Total Calls Received:	0	0	0	0
	# Calls Answered:	0	0	0	0
	Percent of Calls Answered:	0.00%	0.00%	0.00%	0.00%
	# Call Abandonment Rate:	0	0	0	0
	Percent Call Abandonment Rate: **Performance Standard: ≤7%**	0.00%	0.00%	0.00%	0.00%
	# Busy Signal Rate:	0	0	0	0
	Percent Busy Signal Rate: **Performance Standard: ≤1%**	0.00%	0.00%	0.00%	0.00%
	# Call Pickup Rate:	0	0	0	0
	Percent Call Pickup Rate: **Performance Standard: 99%**	0.00%	0.00%	0.00%	0.00%
	# Average Hold Time in Seconds:	0	0	0	0

MCO:			-------		
	Average Hold Time: **Performance Standard: ≤2 min**	0:00:00	0:00:00	0:00:00	0:00:00
Month 3					
	Total Calls Received:	0	0	0	0
	# Calls Answered:	0	0	0	0
	Percent of Calls Answered:	0.00%	0.00%	0.00%	0.00%
	# Call Abandonment Rate:	0	0	0	0
	Percent Call Abandonment Rate: **Performance Standard: ≤7%**	0.00%	0.00%	0.00%	0.00%
	# Busy Signal Rate:	0	0	0	0
	Percent Busy Signal Rate: **Performance Standard: ≤1%**	0.00%	0.00%	0.00%	0.00%
	# Call Pickup Rate:	0	0	0	0
	Percent Call Pickup Rate: **Performance Standard: 99%**	0.00%	0.00%	0.00%	0.00%
	# Average Hold Time in Seconds:	0	0	0	0
	Average Hold Time: **Performance Standard: ≤2 min**	0:00:00	0:00:00	0:00:00	0:00:00
Analysis of Provider Hotline/Action Taken:					
Q1: -------					

MCO:	-------
Q2: -------	
Q3: -------	
Q4: -------	

IV. MCO Complaints and Appeals

Member Complaints					
Source: UMCM 5.4.2.17 Member Complaints Report; DTS code: AFJ; refer to deliverable for further breakdown					
	Subcontractor/TPA:	-------	-------	-------	-------
Total Complaints					
	Total Member Complaints:	0	0	0	0
	Complaints per 1,000 Members:	0	0	0	0
	Percent Resolved within 30 Days: **Performance Standard: 98%**	0.00%	0.00%	0.00%	0.00%
	Percent Resolved more than 30 Days:	0.00%	0.00%	0.00%	0.00%
	Pending Resolution:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
Complaint Category					
Complaints specific to Nursing Facility and Pharmacy are excluded from the aggregate totals under the Complaint Category section.					
	Quality of Care of Services:	0	0	0	0

MCO:			-------		
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Accessibility/Availability of Services:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Complaint Procedures:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Marketing:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0

MCO:			-------		
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Claims Processing:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Complaints Regarding Dental Organization:	0	0	0	0
	Complaints Regarding Behavioral Health Organization (BHO):	0	0	0	0
	Complaints Regarding Vision Organization:	0	0	0	0
	Complaints Regarding Nursing Facility Services:	0	0	0	0
	Complaints Regarding PBM:	0	0	0	0
	Complaints Regarding Individual Practice Association (IPA):	0	0	0	0
	Miscellaneous:	0	0	0	0

MCO:			-------		
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
			Miscellaneous Top 3 Reasons:		
	1):	-------	-------	-------	-------
	2):	-------	-------	-------	-------
	3):	-------	-------	-------	-------
Nursing Facility Specific					
	Quality of Care of Services:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Accessibility/Availability of Services:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Complaint Procedures:	0	0	0	0

MCO:			-------		
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Marketing:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Claims Processing:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Emergency Dental:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%

MCO:			-------		
	Rehabilitative Services - Physical Therapy:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Rehabilitative Services - Speech Therapy:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Rehabilitative Services - Occupational Therapy:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%

MCO:			-------		
	Durable Medical Equipment:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Customized Power Wheelchair:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Augmentative Communication Device:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Miscellaneous:	0	0	0	0
	# Substantiated:	0	0	0	0

MCO:			-------		
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Miscellaneous Top Reason:	-------	-------	-------	-------
Pharmacy Specific					
	72-hour Emergency Supply Prescription:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Limited Home Health Supplies (LHHS):	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Medicaid Formulary and/or Preferred Drug List:	0	0	0	0
	# Substantiated:	0	0	0	0

MCO:			-------		
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Prescription Drug PAs:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Pharmacy Miscellaneous:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
Breakdown of Complaints Received					
	Received by MCO:	0	0	0	0
	Subcontractor/TPA:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0

MCO:			-------		
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Received by BHO Subcontractor:	0	0	0	0
	BHO:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Received by Vision Subcontractor:	0	0	0	0
	Vision Organization:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Received by Dental Subcontractor:	0	0	0	0
	Dental Organization:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0

MCO:			-------		
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Received by PBM Subcontractor:	0	0	0	0
	PBM:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Received by IPA Subcontractor:	0	0	0	0
	IPA:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%

Analysis of Member Complaints/Action Taken:

Q1: -------

Q2: -------

Q3: -------

Q4: -------

Member Appeals

Source: UMCM 5.4.2.19 Member Appeals Report; DTS code: AGF; refer to deliverable for further breakdown

	Subcontractor/TPA:	-------	-------	-------	-------

MCO:			-------		
Total Appeals					
	Total Appeals Received in the Quarter:	0	0	0	0
	Appeals per 1,000 Members:	0	0	0	0
Appeal Outcomes					
Adverse Action Outcomes					
	Total Complete Denial:	0	0	0	0
	Percent Denial:	0.00%	0.00%	0.00%	0.00%
	Total Partial Denial:	0	0	0	0
	Percent Partial Denial:	0.00%	0.00%	0.00%	0.00%
	Total Reduction:	0	0	0	0
	Percent Reduction:	0.00%	0.00%	0.00%	0.00%
Appeal Outcomes					
	Total Upheld:	0	0	0	0
	Percent Upheld:	0.00%	0.00%	0.00%	0.00%
	Total Withdrawn:	0	0	0	0
	Percent Withdrawn:	0.00%	0.00%	0.00%	0.00%
	Total Dismissed:	0	0	0	0
	Percent Dismissed:	0.00%	0.00%	0.00%	0.00%
	Total Overturned:	0	0	0	0
	Percent Overturned:	0.00%	0.00%	0.00%	0.00%
Expedited Appeals					
1 Day Appeals					
	Total Received:	0	0	0	0
	Total Resolved:	0	0	0	0

MCO:			-------		
	Percent Resolved: **Performance Standard 98%**	0.00%	0.00%	0.00%	0.00%
3 Day Appeals					
	Total Received:	0	0	0	0
	Total Resolved:	0	0	0	0
	Percent Resolved: **Performance Standard 98%**	0.00%	0.00%	0.00%	0.00%
	14-Day Extensions Received:	0	0	0	0
	14-Day Extensions Resolved:	0	0	0	0
	Percent Resolved with 14-Day Extensions (17 Days): **Performance Standard 98%**	0.00%	0.00%	0.00%	0.00%
Standard 30-Day Appeals					
	Total Received:	0	0	0	0
	Total Resolved:	0	0	0	0
	Percent Resolved (30 days): **Performance Standard: 98%**	0.00%	0.00%	0.00%	0.00%
	# Resolved more than 30 Days:	0	0	0	0
	Percent Resolved more than 30 Days:	0.00%	0.00%	0.00%	0.00%

MCO:			-------		
	14-Day Extensions Received:	0	0	0	0
	14-Day Extensions Resolved:	0	0	0	0
	Percent Resolved with 14-Day Extensions (44 Days): **Performance Standard: 98%**	0.00%	0.00%	0.00%	0.00%
	Pending Resolution:	0	0	0	0
Appeal Category					
	Plan Administration:	0	0	0	0
	Benefit Denial or Limitation:	0	0	0	0
Breakdown of Appeals Received					
	Received by MCO:	0	0	0	0
	Subcontractor/TPA:	-------	-------	-------	-------
	Received by BHO Subcontractor:	0	0	0	0
	BHO:	-------	-------	-------	-------
	Received by Vision Subcontractor:	0	0	0	0
	Vision Organization:	-------	-------	-------	-------
	Received by Dental Subcontractor:	0	0	0	0
	Dental Organization:	-------	-------	-------	-------
	Received by PBM Subcontractor:	0	0	0	0
	PBM:	-------	-------	-------	-------

MCO:			-------		
	Received by IPA Subcontractor:	0	0	0	0
	IPA:	-------	-------	-------	-------
Analysis of Member Appeals/Action Taken:					
Q1: -------					
Q2: -------					
Q3: -------					
Q4: -------					
Provider Complaints					
Source: UMCM 5.4.2.18 Provider Complaints Report; DTS code: AFK; refer to deliverable for further breakdown					
	Subcontractor/TPA:	-------	-------	-------	-------
Total Complaints					
	Total Provider Complaints:	0	0	0	0
	Complaints per 100 Providers:	0	0	0	0
	% Resolved within 30 Days: **Performance Standard: 98%**	0.00%	0.00%	0.00%	0.00%
	% Resolved more than 30 Days:	0.00%	0.00%	0.00%	0.00%
	Pending Resolution:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%

MCO:		-------			
Complaint Category					
Complaints specific to Pharmacy are excluded from the aggregate totals under the Complaint Category section.					
	Quality of Care of Services:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Plan Administration:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Utilization Review or Management:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Claims Processing:	0	0	0	0
	# Substantiated:	0	0	0	0

MCO:			-------		
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Enrollee Services:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Complaints Regarding Dental Organization:	0	0	0	0
	Complaints Regarding BHO:	0	0	0	0
	Complaints Regarding Vision Organization:	0	0	0	0
	Complaints Regarding Nursing Facility Services:	0	0	0	0
	Complaints Regarding PBM:	0	0	0	0
	Complaints Regarding IPA:	0	0	0	0
Nursing Facility Specific					
	Quality of Care of Services:	0	0	0	0

MCO:			-------		
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Plan Administration:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Utilization Review or Management:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Claims Processing:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%

MCO:		-------		
Enrollee Services:	0	0	0	0
# Substantiated:	0	0	0	0
Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
# Unsubstantiated:	0	0	0	0
Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
Applied Income:	0	0	0	0
# Substantiated:	0	0	0	0
Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
# Unsubstantiated:	0	0	0	0
Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
Rehabilitative Services - Physical Therapy:	0	0	0	0
# Substantiated:	0	0	0	0
Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
# Unsubstantiated:	0	0	0	0
Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
Rehabilitative Services - Speech Therapy:	0	0	0	0
# Substantiated:	0	0	0	0

MCO:			-------		
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Rehabilitative Services - Occupational Therapy:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Durable Medical Equipment:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Customized Power Wheelchair:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0

MCO:			-------		
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Augmentative Communication Device:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
Pharmacy Specific					
	72-hour Emergency Supply Prescription:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Limited Home Health Supplies (LHHS):	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%

MCO:		-------			
	Medicaid Formulary and/or Preferred Drug List:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Prescription Drug PAs:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Plan Administration:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Utilization Review or Management:	0	0	0	0
	# Substantiated:	0	0	0	0

MCO:			-------		
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Claims Processing:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Enrollee Services:	0	0	0	0
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
Breakdown of Complaints Received					
	Received by MCO:	0	0	0	0
	Subcontractor/TPA:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%

MCO:			-------		
	Received by BHO Subcontractor:	0	0	0	0
	BHO:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Received by Vision Subcontractor:	0	0	0	0
	Vision Organization:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Received by Dental Subcontractor:	0	0	0	0
	Dental Organization:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%

MCO:			-------		
	Received by PBM Subcontractor:	0	0	0	0
	PBM:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%
	Received by IPA Subcontractor:	0	0	0	0
	IPA:	-------	-------	-------	-------
	# Substantiated:	0	0	0	0
	Percent Substantiated:	0.00%	0.00%	0.00%	0.00%
	# Unsubstantiated:	0	0	0	0
	Percent Unsubstantiated:	0.00%	0.00%	0.00%	0.00%

Analysis of Provider Complaints/Action Taken:

Q1: -------

Q2: -------

Q3: -------

Q4: -------

V. Complaints Received by State Agencies

Complaints to HHSC

Source: HEART HPM Complaints

Disenrollment Requests

MCO:			-------		
	Total Disenrollment Requests:	0	0	0	0
	Member Initiated:	0	0	0	0
	Substantiated:	0	0	0	0
	Unsubstantiated:	0	0	0	0
	MCO Initiated:	0	0	0	0
	Substantiated:	0	0	0	0
	Unsubstantiated:	0	0	0	0
Legislative Complaints					
	Total Legislative Complaints:	0	0	0	0
	Member Complaints:	0	0	0	0
	Substantiated:	0	0	0	0
	Unsubstantiated:	0	0	0	0
			Top 3 Reasons for Substantiated Complaints:		
	1)	-------	-------	-------	-------
	2)	-------	-------	-------	-------
	3)	-------	-------	-------	-------
	Provider Complaints:	0	0	0	0
	Substantiated:	0	0	0	0
	Unsubstantiated:	0	0	0	0
			Top 3 Reasons for Substantiated Complaints:		
	1)	-------	-------	-------	-------
	2)	-------	-------	-------	-------
	3)	-------	-------	-------	-------
Member Complaints					
	Member Complaints for the Quarter:	0	0	0	0

MCO:			-------		
	Substantiated:	0	0	0	0
	Unsubstantiated:	0	0	0	0
	Pended:	0	0	0	0
			Top 3 Reasons for Substantiated Complaints:		
	1)	-------	-------	-------	-------
	2)	-------	-------	-------	-------
	3)	-------	-------	-------	-------
Provider Complaints					
	Provider Complaints for the Quarter:	0	0	0	0
	Substantiated:	0	0	0	0
	Unsubstantiated:	0	0	0	0
	Pended:	0	0	0	0
			Top 3 Reasons for Substantiated Complaints:		
	1)	-------	-------	-------	-------
	2)	-------	-------	-------	-------
	3)	-------	-------	-------	-------
Complaints to Medicaid Managed Care Helpline					
Source: Office of the Ombudsman					
	Member Complaints for the Quarter:	0	0	0	0
	Substantiated:	0	0	0	0
	Unsubstantiated:	0	0	0	0
	Pended:	0	0	0	0
			Top 3 Reasons for Substantiated Complaints:		
	1)	-------	-------	-------	-------
	2)	-------	-------	-------	-------
	3)	-------	-------	-------	-------
Analysis of Complaints Received by State Agencies:					

MCO:	-------
Q1: -------	
Q2: -------	
Q3: -------	
Q4: -------	

VII. Encounter Reconciliation

Source: HHSC Finance

Medical Encounters

	Encounters Included in warehouse as of (date):	-------	-------	-------	-------
	FSR - Total $ Amount:	$0.00	$0.00	$0.00	$0.00
	Medical Encounters - Total $ Amount:	$0.00	$0.00	$0.00	$0.00
	FSR to Encounter Variance - Total $ Amount:	$0.00	$0.00	$0.00	$0.00
	Percent of FSR Paid Claims: **Standard: 2% Variance**	0.00%	0.00%	0.00%	0.00%

Encounter Submissions for Financial Arrangement Codes (FAC)

Month 1 Submitted Encounters - MCO Compliant (Y/N)	-------	-------	-------	-------
Month 2 Submitted Encounters - MCO Compliant (Y/N)	-------	-------	-------	-------
Month 3 Submitted Encounters - MCO Compliant (Y/N)	-------	-------	-------	-------

MCO:	-------
Analysis of Encounter Data Performance:	
Q1: -------	
Q2: -------	
Q3: -------	
Q4: -------	

Pharmacy Encounters

	Encounters Included in warehouse as of (date):	-------	-------	-------	-------
	FSR - Total $ Amount:	$0.00	$0.00	$0.00	$0.00
	Pharmacy Encounters - Total $ Amount:	$0.00	$0.00	$0.00	$0.00
	FSR to Encounter Variance - Total $ Amount:	$0.00	$0.00	$0.00	$0.00
	Percent of FSR Paid Claims: **Standard: 2% Variance**	0.00%	0.00%	0.00%	0.00%

Encounter Submissions for Financial Arrangement Codes (FAC)

Month 1 Submitted Encounters - MCO Compliant (Y/N)	-------	-------	-------	-------
Month 2 Submitted Encounters - MCO Compliant (Y/N)	-------	-------	-------	-------
Month 3 Submitted Encounters - MCO Compliant (Y/N)	-------	-------	-------	-------

MCO:		-------		
Analysis of Encounter Data Performance:				
Q1: -------				
Q2: -------				
Q3: -------				
Q4: -------				

VIII. Out-of-Network Utilization

Source: UMCM 5.3.8 Out-of-Network (OON) Utilization; DTS code: AIB

Source: UMCM 5.3.8 OON Utilization Special Consideration Calculation; DTS code: AIF; Submit Folder: DELIV

Source: UMCM 5.15 Special Exception Request Template; DTS code: BEZ; Submit Folder: DELIV

Hospital Admissions					
	Total # of Hospital Admissions:	0	0	0	0
	Total # of OON Hospital Admissions:	0	0	0	0
	# OON, in area:	0	0	0	0
	# OON, out of area:	0	0	0	0
	Total Percent of Hospital Admissions OON: **Standard: 15%**	0.00%	0.00%	0.00%	0.00%
OON Hospital Admissions Special Exception Request					
	Request Submitted (Y/N):	-------	-------	-------	-------
	Approved or Denied:	-------	-------	-------	-------
	Approved or Denied Date:	-------	-------	-------	-------

MCO:			-------		
	Percent of Hospital Admissions with Special Consideration:	0.00%	0.00%	0.00%	0.00%
Emergency Room Visits					
	Total # of Emergency Room Visits:	0	0	0	0
	Total # of OON Emergency Room Visits:	0	0	0	0
	# OON, in area:	0	0	0	0
	# OON, out of area:	0	0	0	0
	Total Percent of Emergency Room Visits OON: **Standard: 20%**	0.00%	0.00%	0.00%	0.00%
OON Emergency Room Visits Special Exception Request					
	Request Submitted (Y/N):	-------	-------	-------	-------
	Approved or Denied:	-------	-------	-------	-------
	Approved or Denied Date:	-------	-------	-------	-------
	Percent of Emergency Room Visits with Special Consideration:	0.00%	0.00%	0.00%	0.00%
Other Outpatient Services					

MCO:			-------		
	Total Percent of Dollars Billed for "Other Outpatient Services" OON: **Standard: 20%**	0.00%	0.00%	0.00%	0.00%
OON Other Outpatient Services Special Exception Request					
	Request Submitted (Y/N):	-------	-------	-------	-------
	Approved or Denied:	-------	-------	-------	-------
	Approved or Denied Date:	-------	-------	-------	-------
	Percent of Other Outpatient Services with Special Consideration:	0.00%	0.00%	0.00%	0.00%
Analysis of OON Reporting/Special Exception Request/Action Taken:					
Q1: -------					
Q2: -------					
Q3: -------					
Q4: -------					

IX. Comments

Note: Comments from HHSC Finance are saved as attachments in the respective MCO QPRs folder.

Q1: -------

Q2: -------

Q3: -------

Q4: -------

Appendix 5.1.4 Quarterly Performance Report Template for Vendor Drug Program

Below is the template for the QPR for the Vendor Drug Program (VDP) that Medicaid and CHIP Services Department (MSC) populates for each MCO and each Service Delivery Area (SDA) participated in the VDP. Each MCO must complete and submit the requested Psychotropic Medication Utilization Review (PMUR) Report using the template provided by HHSC as referenced in UMCM Chapter 2.2 Section H. Psychotropic Medication Utilization Review.

PMUR Quarterly Report

[Insert MCO Name] PMUR Quarterly Report (Quarter ___, 20XX) for Medicaid Beneficiaries under the Age of 18

Figure 28. PMUR Quarterly Report.

DFPS Parameter*	A. Total Number of Members Identified	B. Total Members Identified for Peer-to-Peer (P2P) Discussion	C. Number of Prescribers to Whom Letters Were Sent	D. Number of Prescribers to Whom Calls Were Made	E. Number of P2P Requests from Prescribers
≥ 4 Psychotropic medications					
≥ 2 Stimulants					
≥ 2 Alpha agonists					
≥ 2 Antidepressants					
≥ 2 Antipsychotics					
≥ 3 Mood stabilizers					
High dose					
Stimulant < 3 y/o					
Alpha agonist < 4 yo					
Antidepressant < 4 yo					
Mood stabilizer < 4 yo					
Antipsychotic < 5 yo					

* DFPS Parameters as defined in the most current version of the guidelines for foster care. http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp.

Appendix 5.1.5 Liquidated Damages

Below is the amount of Liquidated Damages (LDs) assessed from MCOs and DMOs for the past six quarters, from SFY 2016 (September 2015–August 2016) and SFY 2017 (September 2016–August 2017). HHSC makes LDs assessed publicly available at https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-organization-sanctions.

Figure 29. LD Amounts by MCO/DMO.

Managed Care Organization or Dental Maintenance Organization	Q1 Sept. 2016 to Nov. 2016	Q2 Dec. 2016 to Feb. 2017	Total Remedies Imposed in Q1 and Q2 SFY 2017	Q1 Sept. 2015 to Nov. 2015	Q2 Dec. 2015 to Feb. 2016	Q3 March 2016 to May 2016	Q4 June 2016 to August 2016	Total Remedies Imposed in SFY 2016
Aetna	$30,500	$8,025	**$38,525**	$33,250	$2,300	$36,000	$5,500	**$77,050**
Amerigroup Texas, Inc.	$3,017,000	$3,529,700	**$6,546,700**	$302,250	$297,500	$147,200	$2,260,000	**$3,006,950**
Blue Cross Blue Shield	$12,500	$22,100	**$34,600**	$2,500	$12,750	$10,000	$18,500	**$43,750**
Children's Medical Center	$0	$5,750	**$5,750**	Not Applicable	Not Applicable	Not Applicable	Not Applicable	**$0**
Christus	$144,100	$37,500	**$181,600**	$39,000	$44,000	$95,900	$19,100	**$198,000**
Cigna-HealthSpring	$534,400	$500,000	**$1,034,400**	$82,500	$268,500	$246,000	$477,000	**$1,074,000**
Community First Health Plans, Inc.	$1,700	$83,807	**$85,507**	$0	$5,000	$0	$0	**$5,000**

Managed Care Organization or Dental Maintenance Organization	Q1 Sept. 2016 to Nov. 2016	Q2 Dec. 2016 to Feb. 2017	Total Remedies Imposed in Q1 and Q2 SFY 2017	Q1 Sept. 2015 to Nov. 2015	Q2 Dec. 2015 to Feb. 2016	Q3 March 2016 to May 2016	Q4 June 2016 to August 2016	Total Remedies Imposed in SFY 2016
Community Health Choice, Inc.	$14,600	$26,600	**$41,200**	$2,000	$0	$0	$0	**$2,000**
Cook Children's Health Plan	$500	$26,675	**$27,175**	$0	$0	$5,000	$0	**$5,000**
Dell Children's Health Plan (Formerly Seton)	$4,900	$1,588	**$6,488**	$1,500	$11,200	$79,600	$1,600	**$93,900**
Driscoll Health Plan	$2,600	$20,699	**$23,299**	$21,500	$5,000	$0	$18,000	**$44,500**
El Paso Health	$0	$1,532	**$1,532**	$0	$0	$0	$0	**$0**
FirstCare Health Plan	$0	$30,650	**$30,650**	$10,100	$1,050	$4,625	$8,500	**$24,275**
Molina Healthcare of Texas	$5,200	$38,040	**$43,240**	$1,250	$900	$0	$200	**$2,350**
Parkland Community Health Plan	$0	$26,600	**$26,600**	$1,000	$0	$1,000	$0	**$2,000**
Right*Care* from Scott and White Health Plan	$70,500	$600	**$71,100**	$10,000	$12,500	$400	$11,700	**$34,600**

Managed Care Organization or Dental Maintenance Organization	Q1 Sept. 2016 to Nov. 2016	Q2 Dec. 2016 to Feb. 2017	Total Remedies Imposed in Q1 and Q2 SFY 2017	Q1 Sept. 2015 to Nov. 2015	Q2 Dec. 2015 to Feb. 2016	Q3 March 2016 to May 2016	Q4 June 2016 to August 2016	Total Remedies Imposed in SFY 2016
Sendero	$117,200	$9,800	**$127,000**	$1,100	$0	$3,000	$2,400	**$6,500**
Superior Health Plan	$30,550	$564,390	**$594,940**	$8,700	$1,200	$18,200	$100	**$28,200**
Texas Children's Health Plan	$23,500	$145,048	**$168,548**	$2,000	$0	$34,000	$0	**$36,000**
United Healthcare	$424,200	$160,878	**$585,078**	$155,250	$201,000	$77,500	$60,100	**$493,850**
Subtotal for MCOs	**$4,433,950**	**$5,239,982**	**$9,673,932**	**$673,900**	**$862,900**	**$758,425**	**$2,882,700**	**$5,177,925**
DentaQuest (DMO)	$60,900	$5,000	**$65,900**	$250	$0	$0	$9,100	**$9,350**
MCNA (DMO)	$0	$0	**$0**	$1,000	$2,000	$4,000	$0	**$7,000**
Subtotal for DMOs	**$60,900**	**$5,000**	**$65,900**	**$750**	**$2,000**	**$4,000**	**$9,100**	**$15,850**
Total Remedies Imposed	**$4,494,850**	**$5,244,982**	**$9,739,832**	**$674,650**	**$864,900**	**$762,425**	**$2,891,800**	**$5,193,775**

The table below compares the amount of LDs assessed from MCOs/DMOs to the total payments received by MCOs/DMOs in SFY 2016 (September 2015–August 2016).

Figure 30. SFY 2016 LD Amounts Compared to Total Payments by MCO/DMO.

Managed Care Organization (MCO) / Dental Maintenance Organization (DMO)	Total Remedies Imposed in SFY 2016	Total MCO/DMO Payments in SFY 2016	Remedies Imposed as Percent of Total Payments in SFY 2016
Aetna	$77,050	$231,934,067	0.03%
Amerigroup Texas, Inc.	$3,006,950	$3,618,064,013	*0.08%*
Blue Cross Blue Shield	$43,750	$93,897,581	*0.05%*
Children's Medical Center	Not Applicable	Not Applicable	Not Applicable
Christus	$198,000	$19,676,222	*1.01%*
Cigna-HealthSpring	$1,074,000	$867,143,572	*0.12%*
Community First Health Plans, Inc.	$5,000	$309,015,258	*0.00%*
Community Health Choice, Inc.	$2,000	$783,087,676	*0.00%*
Cook Children's Health Plan	$5,000	$314,270,662	*0.00%*
Dell Children's Health Plan (Formerly Seton)	$93,900	$58,973,647	*0.16%*
Driscoll Health Plan	$44,500	$471,350,282	*0.01%*
El Paso First Health Plans, Inc.	$0	$172,298,352	*0.00%*
FirstCare Health Plan	$24,275	$279,904,588	*0.01%*
Molina Healthcare of Texas, Inc.	$2,350	$1,924,400,766	*0.00%*
Parkland Community Health Plan	$2,000	$485,525,990	*0.00%*
Right*Care* from Scott and White Health Plan	$34,600	$125,239,823	*0.03%*
Sendero Health Plans	$6,500	$41,742,325	*0.02%*
Superior Health Plan	$28,200	$4,389,213,568	*0.00%*

Managed Care Organization (MCO) / Dental Maintenance Organization (DMO)	Total Remedies Imposed in SFY 2016	Total MCO/DMO Payments in SFY 2016	Remedies Imposed as Percent of Total Payments in SFY 2016
Texas Children's Health Plan	$36,000	$966,392,255	*0.00%*
United Healthcare	$493,850	$2,303,532,158	*0.02%*
Subtotal for MCOs	**$5,177,925**	**$17,455,662,805**	***0.03%***
Subtotal for DentaQuest and MCNA (DMOs)	**$16,350**	**$1,360,523,802**	***0.00%***
Grand Total for MCOs and DMOs	**$5,194,275**	**$18,816,186,607**	**0.03%**

DentaQuest had $9,350 in total remedies imposed in SFY 2016, and MCNA had $7,000 in total remedies imposed in SFY 2016. Please note SFY 2016 Total Payments were not available by individual DMO. The total dental costs in SFY 2016 for Medicaid and CHIP beneficiaries were $1,360,523,802.

No LDs in SFY 2016 were reported for Children's Medical Center Health Plan or El Paso First Health Plans, Inc.

Appendix 5.3.1 Time and Distance Standards

Below is MCS distance and time standards for network adequacy.[73] HHSC organized counties into three categories denoted as metro, micro, and rural based on population and density. Standards are set for distance and travel time, in which Medicaid Managed Care members in either metro, micro, or rural counties must travel to the provider types denoted below. LTSS and Pharmacy standards proposed to be implemented in September 2018 managed care contracts.

Figure 31. Network Adequacy Distance and Time Standards.

Standards by Provider Type for Distance in Miles and Travel Time in Minutes	Distance for Metro	Distance for Micro	Distance for Rural	Travel Time for Metro	Travel Time for Micro	Travel Time for Rural
Behavioral Health – Outpatient	30	30	75	45	45	90
Hospital – Acute Care	30	30	30	45	45	45
Prenatal	10	20	30	15	30	40
Primary Care Provider (PCP)	10	20	30	15	30	40
Specialty Care Provider - Cardiovascular Disease	20	35	60	30	50	75
Specialty Care Provider - ENT (Otolaryngology)	30	60	75	45	80	90
Specialty Care Provider - General Surgeon	20	35	60	30	50	75
Specialty Care Provider - OB/GYN (Non-primary Care Physician)	30	60	75	45	80	90
Specialty Care Provider - Ophthalmologist	20	35	60	30	50	75

[73] *Network Adequacy Technical Specifications Draft For MCO Review, https://hhs.texas.gov/sites/default/files//documents/about-hhs/communications-events/news/20170428-technical-specifications-002-news-article.pdf.*

Standards by Provider Type for Distance in Miles and Travel Time in Minutes	Distance for Metro	Distance for Micro	Distance for Rural	Travel Time for Metro	Travel Time for Micro	Travel Time for Rural
Specialty Care Provider - Orthopedist	20	35	60	30	50	75
Specialty Care Provider - Pediatrician (Non-primary Care Physician)	20	35	60	30	50	75
Specialty Care Provider - Psychiatrist	30	45	60	45	60	75
Specialty Care Provider - Urologist	30	45	60	45	60	75
Specialty Care Provider - Other Physician Specialties	30	60	75	45	80	90
Occupational, Physical, or Speech Therapy	30	60	60	45	80	75
Nursing Facility	75	75	75	N/A	N/A	N/A
Main Dentist (General or Pediatric)	30	30	75	45	45	90
Dental Specialists - Pediatric Dental	30	30	75	45	45	90
Dental Specialists - Endodontist, Periodontist, or Prosthodontist	75	75	75	90	90	90
Dental Specialists - Orthodontist	75	75	75	90	90	90
Dental Specialists - Oral Surgeons	75	75	75	90	90	90

HHSC adopted its county designations based on those used by Medicare Advantage. CMS uses five county type designations based upon the population size and density parameters: Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations. HHSC's designation for Metro combines parameters for Medicare Advantage's designations for Large Metro and Metro; and HHSC's Rural designation combines parameters for Medicare

Advantage's designations for Rural and Counties with Extreme Access Considerations. HHSC's Micro designation is the same as Medicare Advantage's Micro designation.

A county must meet both the population and density thresholds for inclusion in a given county type designation. For example, in Medicare Advantage, a county with a population greater than one million and a density greater than or equal to 1,000/mile2 is designated as Large Metro.

For simplified presentation purposes, the following are the population size parameters for HHSC's three county designations.

- Metro = county with a population of 200,000 or greater
- Micro = county with a population between 50,000 and 199,999
- Rural = county with a population of 49,999 or less

Appendix 5.3.2 Network Adequacy Reporting

Below is HHSC's plan for reporting the results of the network adequacy calculations and issuing contract remedies for noncompliance based on the Technical Specifications.[74] HHSC analyzes network adequacy compliance of distance standards quarterly and of travel time standards annually. MCS is phasing in enforcement of the network adequacy requirements for MCOs, starting with assessing the compliance of network adequacy standards for PCPs and dental providers in July 2017 for MCO/DMO contracts effective March 2017. MCS will continue to assess the network adequacy standards for additional provider types and additional programs in the fourth quarter of SFY 2017 and the first quarter of SFY 2018. MCS will then issue CAPs to MCOs/DMOs that fail to meet the distance or travel time standard for certain percentages of their covered members in a county in the second quarter of SFY 2018. HHSC is currently assessing CAPs at less 75 percent (monitoring threshold) members within distance or travel time. MCS will assess all provider types (as identified in **Appendix 5.3.1**) starting in the fourth quarter of SFY 2018. MCS will begin to recommend LDs for MCOs/DMOs failing to meet network adequacy standards for 90 percent or more of members within distance or travel time in the first quarter of SFY 2019. LDs might not be applied in all cases; however, HHSC does anticipate granting exceptions.

Figure 32. MCO Technical Specifications for Network Adequacy.

Fiscal Quarter	Q1	Q2	Q3	Quarterly Monitoring	Baseline Report	HHSC-Generated Report Due Date (New)	Milestone/ Health Plan Remedies
SFY2017 Q3	MAR*	APR	MAY	Pilot Testing (PCP/Main Dentist)	Pilot Testing (PCP/Main Dentist)	July 2017	• March 2017 Contract effective • PCP and Main Dentist Analysis Complete

[74] *Network Adequacy Technical Specifications Draft For MCO Review, https://hhs.texas.gov/sites/default/files//documents/about-hhs/communications-events/news/20170428-technical-specifications-002-news-article.pdf.*

Fiscal Quarter	Q1	Q2	Q3	Quarterly Monitoring	Baseline Report	HHSC-Generated Report Due Date (New)	Milestone/ Health Plan Remedies
SFY2017 Q4	JUN*	JUL	AUG		√	Nov 14, 2017	Phase 1: Distance and Travel Time Baseline complete (Selected Provider Types, excluding STAR+PLUS) **
SFY2018 Q1	SEP*	OCT	NOV		√	Jan 2018	• Phase 2: Distance and Travel Time Baseline complete (Selected Provider Types)***
SFY2018 Q2	DEC*	JAN	FEB	√		Apr 2018	• 75% Threshold (CAP Only)
SFY2018 Q3	MAR*	APR	MAY	√		July 2018	• 75% Threshold (CAP Only)
SFY2018 Q4	JUN*	JUL	AUG		√	Oct 2018	• 75% Threshold (CAP Only) • Distance Baseline Complete****
SFY2019 Q1	SEP*	OCT	NOV	√		Jan 2019	• 90% Standard (CAP and LD)
SFY2019 Q2	DEC*	JAN	FEB	√		Apr 2019	• 90% Standard (CAP and LD)
SFY2019 Q3	MAR*	APR	MAY	√		July 2019	• 90% Standard (CAP and LD)

Fiscal Quarter	Q1	Q2	Q3	Quarterly Monitoring	Baseline Report	HHSC-Generated Report Due Date (New)	Milestone/ Health Plan Remedies
SFY2019 Q4	JUN*	JUL	AUG		√	Oct 2019	• 90% Standard (CAP and LD) • Distance Baseline Complete****
SFY2020 Q1	SEP*	OCT	NOV	√		Jan 2020	• 90% Standard (CAP and LD)
SFY2020 Q2	DEC*	JAN	FEB	√		Apr 2020	• 90% Standard (CAP and LD)
SFY2020 Q3	MAR*	APR	MAY	√		July 2020	• 90% Standard (CAP and LD)
SFY2020 Q4	JUN*	JUL	AUG		√	Oct 2020	• 90% Standard (CAP and LD) • Distance and Travel Time Baseline Complete****

** Network adequacy analysis will be derived from the second provider reconciliation file from the first month of the quarter analysis, and member eligibility file for the same month.*
*** Provider types analyzed for FY 2017 Q4 include Cardiovascular Disease, ENT, Occupational, Physical, or Speech Therapy, Hospital – Acute Care, Psychiatrist, Nursing Facility, Prenatal, OB/GYN, Dental – all specialists.*
**** Provider types analyzed for FY 2018 Q1 include Behavioral Health – outpatient, Prenatal, General Surgeon, Ophthalmologist, Orthopedist, Pediatric Subspecialists, and Urologist.*
***** Analysis will include all provider types.*

Appendix 5.3.3 Appointment Availability Standards

Through its Provider Network composition and management, the MCO must ensure that the following standards for appointment accessibility, as required in Section 8.1.3.1 of the UMCC, are met. The standards are measured from the date of presentation or request, whichever occurs first.

1. Emergency services must be provided upon member presentation at the service delivery site, including at non-network and out-of-area facilities;
2. An Urgent Condition[75], including urgent specialty care and behavioral health services, must be provided within 24 hours; treatment for behavioral health services may be provided by a licensed behavioral health clinician.
3. Primary routine care must be provided within 14 days;
4. Specialty routine care must be provided within 21 days;
5. Initial outpatient behavioral health visits must be provided within 14 Days (this requirement does not apply to CHIP Perinate);
6. Community LTSS for members must be initiated within seven days from the start date on the Individual Service Plan as outlined in Section 8.3.4.1 or the eligibility effective date for non-waiver LTSS unless the referring provider, member, or STAR+PLUS Handbook states otherwise;
7. Pre-natal care must be provided within 14 days for initial appointments except for high-risk pregnancies or new members in the third trimester, for whom an initial appointment must be offered within five days, or immediately, if an emergency exists. Appointments for

[75] Urgent Condition means a health condition including an Urgent Behavioral Health Situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the member's PCP or PCP designee to prevent serious deterioration of the member's condition or health.

Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within 24 hours but which does not place the member in immediate danger to himself or herself or others and the member is able to cooperate with treatment.

ongoing care must be available in accordance to the treatment plan as developed by the provider;

8. Preventive health services including annual adult well checks for members 21 years of age or older must be offered within 90 days; and
9. Preventive health services for members less than 6 month of age must be provided within 14 days. Preventive health services for members 6 months through age 20 must be provided within 60 Days. CHIP members should receive preventive care in accordance with the American Academy of Pediatrics (AAP) periodicity schedule. Medicaid members should receive preventive care in accordance with the Texas Health Steps periodicity schedule. MCOs must encourage new members 20 years of age or younger to receive a Texas Health Steps checkup within 90 days of enrollment. For purposes of this requirement, the terms "New Member" is defined in Chapter 12.4 of the UMCM.

Appendix 5.4.1 HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries

Below is the annual report on certain fraud and abuse recoveries by MCOs/DMOs in SFY 2017.[76]

Figure 33. Fraud and Abuse Recoveries by MCOs in SFY 2017.

HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries by MCOs/DMOs — SFY 2017

MCO/Special Investigative Unit	Amount Recovered by MCO/DMO	Amount Retained by MCO/DMO
Aetna Better Health of Texas	$128,312.20	$128,312.20
Amerigroup Texas	$824,816.44	$824,816.44
BlueCross BlueShield of Texas	$40,387.62	$40,387.62
Children's Medical Center Health Plan	$0	$0
CHRISTUS Heath	$1,875.00	$1,875.00
Cigna-HealthSpring	$48,565.15	$48,565.15
Community First Health Plan	$557,215.96	$557,215.96
Community Health Choice	$58,285.19	$58,285.19
Cook Children's Health Plan	$6,047.53	$6,047.53
Dell Children's Health Plan (Formerly Seton)	$0	$0
Driscoll Health Plan	$37,552.01	$37,552.01
El Paso First Health Plan, Inc.	$58,387.38	$58,387.38
FirstCare Health Plan	$31,746.75	$31,746.75
Molina Healthcare of Texas	$52,437.00	$52,437.00

[76] *HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries by MCOs — SFY 2017, https://oig.hhsc.texas.gov/sites/oig/files/reports/Annual-Report-on-Certain-Fraud-and-Abuse-Recoveries-FY-2017.pdf.*

MCO/Special Investigative Unit	Amount Recovered by MCO/DMO	Amount Retained by MCO/DMO
Parkland Community Health Plan	$84,071.22	$84,071.22
Scott and White Health Plan	$0	$0
Sendero Health Plan	$0	$0
Superior Health Plan	$1,092,634.49	$1,092,634.49
Texas Children's Health Plan	$164,953.09	$164,953.09
UnitedHealthcare Community Plan	$858,404.81	$858,404.81
DMOs:		
DentaQuest USA	$754,708.54	$692,579.72*
Managed Care of North America (MCNA Dental)	$870,142.44	$870,142.44
TOTAL	**$5,670,542.82**	**$5,608,414.00**

Total reflects overpayments reported as recovered by SIUs on investigations that were not referred to the OIG or referred but returned to the MCO.
*Some DentaQuest recovery dollars were returned to their MCO clients.

Appendix 5.5.1 HHSC Fair Hearings Process

HHSC hearings officers conduct fair hearings for six different programs and approximately 105 types of benefits, services, and assistance.

Clients appealing an action taken by an MCO must appeal internally, first. The client has 60 days from the date of the notice of adverse action to appeal to the MCO. The MCO has 30 days to complete the internal appeal and issue the internal resolution letter.

After an internal appeal with the MCO has been exhausted, the client may request a fair hearing. The client has 120 days from the date of the internal resolution letter to request a fair hearing.

Clients appealing an action taken by an agency, designee, or department other than an MCO have direct access to a fair hearing.

Expedited Processing

When the MCO determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function the appeal must be processed within 72 hours.

Creating the Appeal

When a client or an applicant requests a fair hearing, the agency that took the action on appeal creates an “appeal” in the Texas Integrated Eligibility Redesign System (TIERS). This should be done within five days of the date the request.

Expedited Fair Hearing Process

If a fair hearing is requested and the expedited criteria is met, the MCO must indicate expedited processing is requested when creating the fair hearing request in TIERS. The fair hearing must be scheduled and heard and a fair hearing decision issued within 3 working days after the hearings officer receives the case file and information from the MCO.

Scheduling

If the appeal is not an expedited request, and within five days of receiving the fair hearing request, the hearings office will batch the non-expedited fair hearing appointment in TIERS.

Notice of Hearing

TIERS generates a notice of hearing for each scheduled hearing the day after it is batched. The notice of hearing includes the date, time, and instructions for participating in the hearing, including the toll-free number to call and a participant code to enter. The notices of hearing are printed and mailed by a print vendor to the clients and their representatives and/or witnesses.

TIERS also generates an alert for each HHSC, MCO, and Texas Medicaid and Healthcare Partnership (TMHP) employee who is listed as a participant. The alerts notify the participants that a hearing has been scheduled for the appeal.

The Hearing

On the day of the hearing, the hearings officer, the client, the client's representative, the MCO representative, and any witnesses call the toll-free number listed on the notice of hearing and enter the participant code to participate in the hearing.

The hearings officer will introduce himself, identify all other participants, notify the participants that the hearing is being recorded, place all participants under oath, confirm the issue on appeal, and explain the process.

Next, the hearings officer will ask the MCO to present its documentary evidence, offer an opportunity for objections, accept, admit, and label the evidence, ask the client to present his documentary evidence, offer an opportunity for objections, and accept, admit, and label the evidence.

Then, the hearings officer will ask the MCO to present its testimony, allow for questions and cross-examination, ask the client to present his testimony, and allow for questions and cross-examination. The Hearings Officer may ask questions to develop the hearing record and will explain that he will review all the information provided and issue a written decision no later than (whatever the due date is), and close the record.

After the Hearing

The hearings officer will review all documentary evidence and any notes taken during the hearing, listen to the recording if necessary, and issue a written decision.

The Decision

The hearings officer must issue a written decision: within 60 days of the request for fair hearing involving a Supplemental Nutrition Assistance Program (SNAP) appeal; within 90 days of the date the internal appeal is filed, not including the number of days between the date of the internal resolution letter and the date the fair hearing is requested, for managed care appeals; and within 90 days of the fair hearing request date for all other appeals.

For certain medical necessity cases the decisions are reviewed by Hearings Department management prior to issuance.

If the hearings officer's decision sustains the MCO action, the decision is shared with all the participants, and no further action is required.

If the hearings officer's decision reverses the MCO action, the order will include instructions to the MCO. The decision is shared with all the participants, and the MCO must implement the decision within the required time frames (72 hours for MCO actions and 10 days for all other actions).

Administrative Review

If the client disagrees with the hearings officer's decision, he can request an administrative review of the record by an HHSC attorney within 30 days of the hearing decision, pursuant to Section 531.019, Government Code. Instructions for requesting an administrative review are included on the cover letter sent with the decision. Instructions for requesting an administrative review are included on the cover letter sent with the decision.

If a client requests an administrative review, the request is assigned to one of HHSC's regional attorneys. The regional attorney listens to the recording, reviews all documentary evidence to determine whether the decision by the hearings officer was appropriate, and issues a decision to the hearings officer and the client.

If the regional attorney upholds the hearings officer's decision, no further action is required.

If the regional attorney remands or reverses the hearings officer's decision, the order will include instructions for the hearings officer, the MCO, or both.

If the client disagrees with the regional attorney's decision, he may file for judicial review in the Travis County Court within 30 days of the regional attorney's decision.

Exception Process

If the MCO disagrees with the hearings officer's decision, it may take exception to the decision. The MCO takes exception by sending an email or letter to the manager of the hearings officer. The manager will review the exception letter and the hearing record and respond to the MCO.

The exception process is to ensure MCO staff and hearings officers consistently apply appropriate policies. The exception does not change the result of the appeal.

MCO-Related Appeals Received and Fair Hearing Decisions Outcomes from SFY2016 to SFY2018

Below are the fair hearing requests and fair hearing results from MCO-related appeals received in SFY2016, SFY2017, and SFY2018. This includes statistics for hearings regarding actions taken by the MCO for service denials/reductions. This also includes hearings regarding program denials wherein the appealed action was a medical necessity denial taken by TMHP, based on information provided by the MCO.

The fair hearing requests and fair hearing results from MCO-related appeals received were prepared using two different parameters. The number of appeals received are based on the appeals sent by HHSC in the specified State Fiscal Year. The number of decision outcomes are based on the parameters for decisions issued in the specified State Fiscal Year. Appeals received in any one month are completed over any number of the succeeding months and may extend into the next State Fiscal Year.

Figure 34. MCO-Related Appeal Requests and Fair Hearing Outcomes in SFY2016.

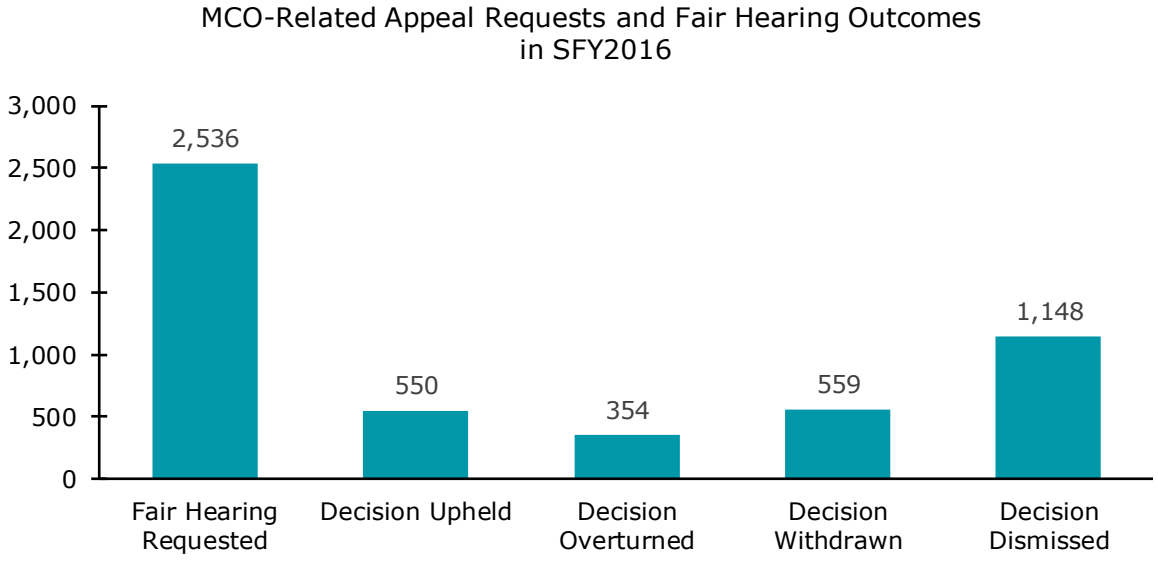


Figure 35. MCO-Related Appeal Requests and Fair Hearing Outcomes in SFY 2017.

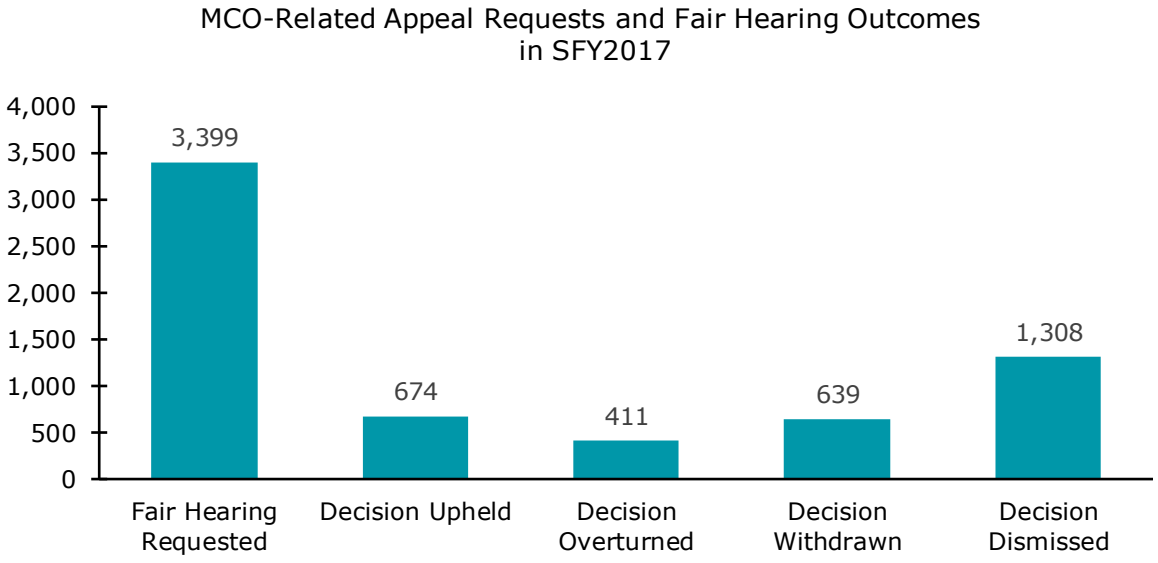
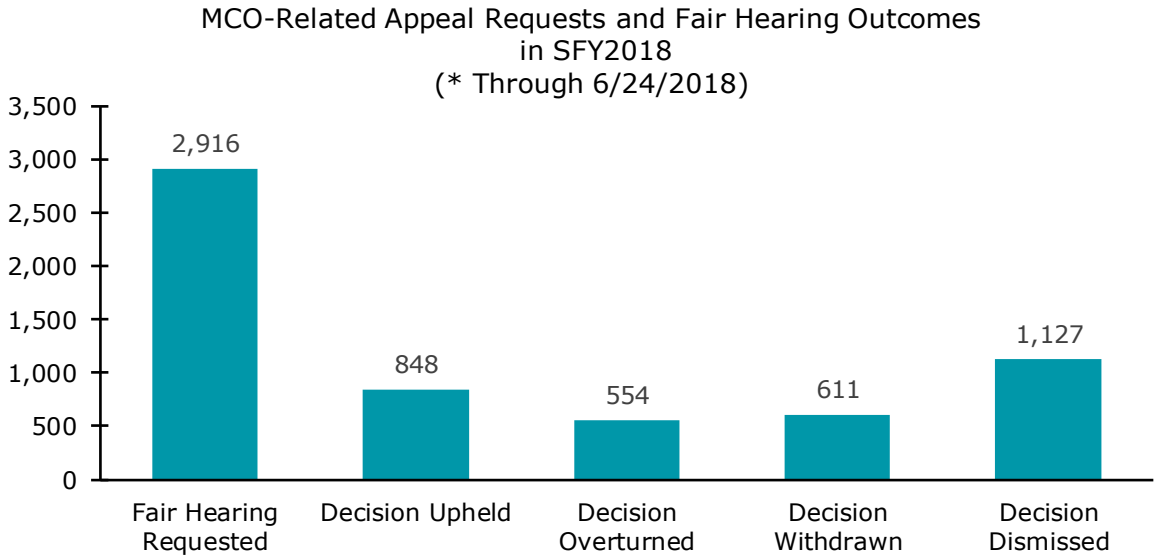


Figure 36. MCO-Related Appeal Requests and Fair Hearing Outcomes in SFY 2018.



Appendix 5.5.2 Nature of Issues Categories in HEART System

For complaints reported to MCCO and entered into the HEART system, the following categories are used to describe the nature(s) of the issue. Complaint data from the HHSC Office of the Ombudsman data is excluded from this appendix.

Figure 37. Categories describing the Nature of Issues Reported to HHSC.

Category	Nature of Issue and Related HEART Code
MEMBER SERVICES	A136-RX 72 HOUR
MEMBER SERVICES	A137-RX FORMULARY
MEMBER SERVICES	A138-ANE ABUSE, NEGLECT AND EXPLOITATION
MEMBER SERVICES	A139-PRENATAL UNDER-21/RISK APPROPRIATE CARE
MEMBER SERVICES	A140-UTILIZATION REVIEW REFERRALS
MEMBER SERVICES	A141-ELECTRONIC VISIT VERIFICATION
MEMBER SERVICES	A142-THERAPY
MEMBER SERVICES	A143-CREDENTIALING
MEMBER SERVICES	A145-OPEN RECORDS REQUEST
MEMBER SERVICES	A146-THERAPY-DENIAL FOR PRIOR AUTHORIZATION
MEMBER SERVICES	A147-THERAPY-AVAILABILITY OF SERVICES
MEMBER SERVICES	A14-HOME HEALTH
MEMBER SERVICES	A152-THERAPY-RATE
MEMBER SERVICES	A153-THERAPY-DENIAL OF AUTHORIZATION [PROVIDER]
MEMBER SERVICES	A154-THERAPY-DENIAL OF PAYMENT [PROVIDER]
MEMBER SERVICES	A156-THERAPY-PAYMENT DISPUTE [PROVIDER]
MEMBER SERVICES	A15-IDENTIFICATION CARD ISSUE
MEMBER SERVICES	A16-MCO/HMO FRAUD
MEMBER SERVICES	A17-MEDICAID POLICY
MEMBER SERVICES	A20-OUT OF NETWORK REFERRAL
MEMBER SERVICES	A21-PROVIDER FRAUD

Category	Nature of Issue and Related HEART Code
MEMBER SERVICES	A23-REP NOT RESPONDING/FOLLOWING UP
MEMBER SERVICES	A25-THSTEPS MEDICAL
MEMBER SERVICES	A26-95 DAY FILING DEADLINE
MEMBER SERVICES	A27-BALANCE BILLING
ACCESSIBILITY/ AVAILABILITY	A01.1-MEMBER CLAIM/BILLING ISSUE
ACCESSIBILITY/ AVAILABILITY	A01-ACCESS TO CARE
ACCESSIBILITY/ AVAILABILITY	A02-BENEFIT ISSUES
ACCESSIBILITY/ AVAILABILITY	A04-MEMBER FRAUD
ACCESSIBILITY/ AVAILABILITY	A05-COORDINATION OF BENEFITS
ACCESSIBILITY/ AVAILABILITY	A06-CUSTOMER SERVICE
ACCESSIBILITY/ AVAILABILITY	A09-DURABLE MEDICAL EQUIPMENT (DME)
ACCESSIBILITY/ AVAILABILITY	A101-OTHER (COMPLAINTS PROCEDURE)
ACCESSIBILITY/ AVAILABILITY	A104-DENIAL OR NON-PAYMENT FOR EMERGENCY CARE
ACCESSIBILITY/ AVAILABILITY	A106-MEMBER ENROLLMENT ISSUES
ACCESSIBILITY/ AVAILABILITY	A108-INCORRECT ENROLLEE INFO/ELIG
ACCESSIBILITY/ AVAILABILITY	A110-MCO REQUESTED DISENROLLMENT
ACCESSIBILITY/ AVAILABILITY	A113.1-MEMBER DOES NOT WANT TO ENROLL
ACCESSIBILITY/ AVAILABILITY	A113-MEMBER REQUESTED DISENROLLMENT
ACCESSIBILITY/ AVAILABILITY	A114-NEW PCP ASSIGNMENT

Category	Nature of Issue and Related HEART Code
ACCESSIBILITY/ AVAILABILITY	A115-RE-ENROLLMENT
COMPLAINTS PROCEDURE	A116-INTERNAL SYSTEMS ISSUES
COMPLAINTS PROCEDURE	A117-MEMBER TERMINATION
COMPLAINTS PROCEDURE	A118-OTHER (ENROLLMENT ISSUES)
COMPLAINTS PROCEDURE	A119-ATTITUDE INAPPROPRIATE
COMPLAINTS PROCEDURE	A11-HEALTH INFO: MISCELLANEOUS
COMPLAINTS PROCEDURE	A120-LACK OF INFO FROM COMPLAINANT
COMPLAINTS PROCEDURE	A121-MISCOMMUNICATION
COMPLAINTS PROCEDURE	A122-OTHER (MISCELLANEOUS COMPLAINTS)
COMPLAINTS PROCEDURE	A123-TMHP BILLING ISSUE
COMPLAINTS PROCEDURE	A124-VAS ISSUES
ENROLLMENT ISSUES	A125-HOME DELIVERED MEALS
ENROLLMENT ISSUES	A126-HOME MODIFICATIONS
ENROLLMENT ISSUES	A127-REDUCTION/CANCELLATION OF SERVICES
ENROLLMENT ISSUES	A128-SERVICE COORDINATOR
ENROLLMENT ISSUES	A129-SYSTEM/RATE PROBLEM
ENROLLMENT ISSUES	A130-SYSTEM CONFIGURATION
ENROLLMENT ISSUES	A131-PROCEDURE CODES/CPT/MODIFIERS
ENROLLMENT ISSUES	A132-CLAIM RECOUPMENT
ENROLLMENT ISSUES	A133-LOSS OF ELIGIBILITY
ENROLLMENT ISSUES	A134-ORTHODONTIA
ENROLLMENT ISSUES	A135-RX DME
MISCELLANEOUS COMPLAINTS	A29-CLAIM PROCESSING TIME ISSUES
MISCELLANEOUS COMPLAINTS	A30-CLEAN CLAIMS INTEREST UNPAID
MISCELLANEOUS COMPLAINTS	A32-DELAYS (CLAIMS HANDLING)
MISCELLANEOUS COMPLAINTS	A33-DENIAL OF CLAIM

Category	Nature of Issue and Related HEART Code
MISCELLANEOUS COMPLAINTS	A34-DENIAL/DELAY OF PAYMENT
MISCELLANEOUS COMPLAINTS	A36-MCO / PROVIDER CONTRACT - OTHER
PROVIDER CONTRACT	A37-MCO RETALIATION
PROVIDER CONTRACT	A38-NETWORK DENIAL/TERMED PROVIDER
PROVIDER CONTRACT	A39-PAYMENT DISPUTE
PROVIDER CONTRACT	A40-PHYSICIAN REQUESTED DISENROLLMENT
PROVIDER CONTRACT	A41-PRIOR AUTH/PRE-CERTIFICATION ISSUES
PROVIDER CONTRACT	A42-PROVIDER CODING ERROR
PROVIDER CONTRACT	A43-PROVIDER ENROLLMENT ISSUES
PROVIDER CONTRACT	A44-PROVIDER NOT ENROLLED
PROVIDER CONTRACT	A45-RECOUPMENT OF CLAIMS PAYMENT
PROVIDER CONTRACT	A46-TELEPHONE WAIT TIME FOR CALLS
PROVIDER CONTRACT	A48-OTHER (PROVIDER CONTRACT)
PROVIDER CONTRACT	A49-ACCESSIBILITY - OTHER
PROVIDER CONTRACT	A50-CONTINUITY OF CARE
PROVIDER CONTRACT	A53-INEFFECTIVE COMMUNICATION/GUIDANCE
PROVIDER CONTRACT	A55-PCP OR REFERRING PHYSICIAN ISSUES
PROVIDER CONTRACT	A56-PCP SELECTION OR TURNOVER
PROVIDER CONTRACT	A57-PROVIDER ABUSE OR NEGLECT
PROVIDER CONTRACT	A59-QUALITY OF CARE
PROVIDER CONTRACT	A61-QUALITY OF MEDICAL RECORDS
PROVIDER CONTRACT	A62-QUALITY OF PHYSICIAN/PROVIDER CREDENTIALING
PROVIDER CONTRACT	A65-OTHER (QUALITY OF CARE)
PROVIDER CONTRACT	A66-24 HOUR COVERAGE PROVIDER ACCESSIBILITY
PROVIDER CONTRACT	A67-APPOINTMENT AVAILABILITY
PROVIDER CONTRACT	A69-CIVIL RIGHTS ACT NONCOMPLIANCE
PROVIDER CONTRACT	A70-DELAY OF MEDICALLY NECESSARY TREATMENT
PROVIDER CONTRACT	A71-DELAY OF REFERRAL OR AUTHORIZATION

Category	Nature of Issue and Related HEART Code
PROVIDER CONTRACT	A72-EMERGENCY CARE ACCESS
PROVIDER CONTRACT	A73-IN NETWORK: SPECIALTY CARE/PROVIDER ACCESS
PROVIDER CONTRACT	A74-INABILITY TO ACCESS TREATMENT
QUALITY OF CARE/SERVICE	A75-OUT OF NETWORK: PHYSICIANS/SVCS ACCESS
QUALITY OF CARE/SERVICE	A76-PCP SELECTION
QUALITY OF CARE/SERVICE	A78-TRAVEL TIME/APPT. AVAILABILITY/DISTANCE
QUALITY OF CARE/SERVICE	A79-URGENT CARE ACCESSIBILITY
QUALITY OF CARE/SERVICE	A81-OTHER (ACCESSIBILITY/AVAILABILITY)
QUALITY OF CARE/SERVICE	A82-CONTINUATION OF SERVICES/HOSPITAL
QUALITY OF CARE/SERVICE	A83-DENIAL OF AUTHORIZATION OF CARE
QUALITY OF CARE/SERVICE	A84-DENIAL/NON-PAYMENT MN DME/SUPPLIES
QUALITY OF CARE/SERVICE	A85-DENIAL/NON-PAYMENT MN RX
UTILIZATION REVIEW/MANAGEMENT	A86-DENIAL/NON-PAYMT MN TX (nonemergency)
UTILIZATION REVIEW/MANAGEMENT	A87-DIAGNOSIS RELATED GROUPING (DRG)
UTILIZATION REVIEW/MANAGEMENT	A88-HOSPITAL ADMISSION OR DISCHARGE
UTILIZATION REVIEW/MANAGEMENT	A89-MEDICAL NECESSITY
UTILIZATION REVIEW/MANAGEMENT	A90-PRE-AUTH/PRE-CERT ISSUES
UTILIZATION REVIEW/MANAGEMENT	A91-OTHER (UR/MANAGEMENT)

Category	Nature of Issue and Related HEART Code
UTILIZATION REVIEW/MANAGEMENT	A92-CONFIDENTIALITY OF MEDICAL INFO/HIPAA
UTILIZATION REVIEW/MANAGEMENT	A93-ENROLLMENT/CANCELATION/RENEWAL OF ENROLLEE
UTILIZATION REVIEW/MANAGEMENT	A94-EXPERIMENTAL/INVESTIGATION PROCEDURES
UTILIZATION REVIEW/MANAGEMENT	A95-HEALTH COVERAGE/COPAY/LIMITS
UTILIZATION REVIEW/MANAGEMENT	A96-MCO APPEALS PROCESS
UTILIZATION REVIEW/MANAGEMENT	A97-MCO COMPLAINT PROCEDURE
UTILIZATION REVIEW/MANAGEMENT	A98-RX COVERAGE/COPAY/LIMITS
UTILIZATION REVIEW/MANAGEMENT	A99-TELEPHONE ACCESS

Appendix 5.5.3 Medicare Grievance Categories for Reporting

For Medicare Part C and Part D, CMS requires Medicare health plans to use predefined categories described in this section to report grievances to CMS. CMS collects and reports publicly the total number of grievances and the number of grievances in which timely notification was given for those defined categories.

- A grievance is defined in Chapter 13 of the Medicare Managed Care Manual as "Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration period. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care."
- Part D Sponsors are required to notify enrollees of their decision no later than 30 days after receiving their grievance. An extension up to 14 days is allowed if the enrollee requests it, or if the Part D Sponsor needs additional information and documents that this extension is in the interest of the enrollee. An expedited grievance that involves refusal by a Part D Sponsor to process an expedited coverage determination or redetermination requires a response from the Part D Sponsor within 24 hours.

Medicare health plans report grievance data (total number of grievances, and the number of grievances in which timely notification was given) at the contract level and by category, as seen in **Figure 38**.[77] Timely notification of

[77] *Medicare Part C reporting requirements are available at https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html and Medicare Part D reporting Requirements are available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight.html.*

grievances means the member was notified according to the following timelines:

- For standard grievances: no later than 30 calendar days after receipt of grievance.
- For standard grievances with an extension taken: no later than 44 calendar days after receipt of grievance.
- For expedited grievances: no later than 24 hours after receipt of grievance.

Figure 38. Grievance Categories Reported by Medicare health plans.

Grievance Categories
• Total Grievances
• Number of Expedited Grievances
• Enrollment/Disenrollment Grievances
• Plan/Benefit Package Grievances
• Access Grievances
• Marketing Grievances
• Customer Service Grievances
• Organization Determination and Reconsideration Process Grievances/Coverage Determination and Redetermination Process Grievances
• Quality of Care Grievances
• Grievances Related to "CMS Issues" **
• Other Grievances

** The category, *Grievances Related to "CMS Issues"*, involves grievances that primarily involve complaints concerning CMS's policies, processes, or operations; the grievance is not directed against the health plan or providers. The new grievance category is meant to identify those grievances that are due to CMS issues and are related to issues outside of the Plan's direct control. This same type of categorization is used in the Complaint Tracking Module (CTM) and allows CMS to exclude those grievances that are outside of the Plan's direct control from the total number of grievances filed against the contract.

Appendix 5.5.4 Medicare 2018 Part C and D Star Ratings Technical Notes

CMS created the Part C and D Star Ratings to provide quality and performance information to Medicare enrollees to assist them in choosing their health and drug services during the annual fall open enrollment period. The Star Ratings Program is consistent with CMS's Quality Strategy of optimizing health outcomes by improving quality and transforming the health care system. The data collected for the Part C and D Star Ratings comes from a variety of different data sources for different domains. One of the domains for Part C and Part D is Member Complaints and Changes in the Health Plan's Performance (HD4 for Part C and HD2 for Part D), which contains four separate related measures as described in **Figure 39** below.[78]

Figure 39. Measures collected and reported for the Domain Area: Member Complaints and Changes in the Health Plan's Performance.

Measures in Domain: Member Complaints and Changes in the Health Plan's Performance	Description	Metric
Complaints about the Health Plan (C28)	How many complaints Medicare received about the health plan.	Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).
Members Choosing to Leave the Plan (C29)	Percentage of plan members who chose to leave the plan.	The percentage of members who chose to leave the contract comes from disenrollment reason codes in Medicare's enrollment system. The percentage is calculated as the number of members who chose to leave the contract between January 1, 2016–December 31, 2016 (numerator) divided by all members enrolled in the contract at any time during 2016 (denominator).

[78] *Medicare 2018 Part C and D Star Ratings Technical Notes updated on May 10, 2018 and available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.*

Measures in Domain: Member Complaints and Changes in the Health Plan's Performance	Description	Metric
Beneficiary Access and Performance Problems (C30)	Each year, Medicare checks each plan to see if there are problems with the plan. For example, Medicare checks whether: Members are having problems getting services, and Plans are following all of Medicare's rules. Medicare gives the plan a lower score (on a 0 to 100 scale) if there are problems. The score combines how serious the problems are, how many are there, and how directly they affect members. A higher score is better because it means Medicare found less serious or fewer problems or they affected fewer members directly.	This measure is based on CMS's sanctions and civil money penalties, as well as Compliance Activity Module (this includes: notices of noncompliance, warning letters {with or without business plan}, and ad hoc CAPs and the CAP severity).
Health Plan Quality Improvement (C31)	This shows how much the health plan's performance improved or declined from one year to the next year.	The numerator is the net improvement, which is the number of significantly improved measures, minus the number of significantly declined measures. The denominator is the number of measures eligible for the improvement measure (i.e., the measures that were included in the 2017 and 2018 Star Ratings for this contract and had no specification changes).

Another domain relates to Health Plan Customer Service that has three measures as described in **Figure 40** below.

Figure 40. Measures collected and reported for the Domain Area: Health Plan Customer Service.

Measure in Domain: Health Plan Customer Service	Description	Metric
Plan Makes Timely Decisions about Appeals (C32)	Percentage of plan members who got a timely response when they made an appeal request to the health plan about a decision to refuse payment or coverage.	Percentage of appeals timely processed by the plan (numerator) out of all the plan's appeals decided by the Independent Review Entity (IRE) (includes upheld, overturned, and partially overturned appeals) (denominator). This is calculated as: ([Number of Timely Appeals] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]) * 100.
Reviewing Appeals Decisions (C33)	The rating shows how often an independent reviewer thought the health plan's decision to deny an appeal was fair. This includes appeals made by plan members and OON providers. (This rating is not based on how often the plan denies appeals, but rather how fair the plan is when they do deny an appeal.)	Percentage of appeals where a plan's decision was "upheld" by the IRE (numerator) out of all the plan's appeals (upheld, overturned, and partially overturned appeals only) that the IRE reviewed (denominator). This is calculated as: ([Appeals Upheld] / ([Appeals Upheld] + [Appeals Overturned] + [Appeals Partially Overturned]))* 100.

Measure in Domain: Health Plan Customer Service	Description	Metric
Call Center – Foreign Language Interpreter and TTY Availability (C34)	Percentage of time that TTY services and foreign language interpreter were available when needed by prospective members who called the health plan's prospective enrollee customer service phone number.	The calculation of this measure is the number of successful contacts with the interpreter and TTY divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with an interpreter and beginning the first of three survey questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) Successful contact with a TTY service is defined as establishing contact with and confirming that the TTY operator can answer questions about the plan's Medicare Part C benefit.

Appendix 5.7.1 Contract Amendment Process Maps

The UMCC amendment process is closely followed and is performed in a secured online environment with a single point of control for all edits. MCS Policy and Program Staff, the Deputy Associate Commissioners (DACs), a MCS Director-level position/appointee, and the Office of Chief Counsel must approve changes. Changes are logged on a change-tracking log, in a redline version of the contract, vetted for internal and external review, finalized, submitted for routing and execution, submitted to CMS 45 days prior to the effective date, and posted to the HHSC website on or before the effective date of the contract amendment.

MCS is moving from a twice-a-year amendment cycle to a once-a-year amendment cycle for nonemergency, non-rate-related contract changes to allow staff to engage in a more detailed amendment writing process. While the following information details the process as is, the to-be process will be similar with additional time for each phase that includes increased opportunities for contract language development and review. MCS will implement the once-a-year cycle beginning with the amendment effective September 1, 2019.

Figure 41 below provides a high-level summary of the five phases of the contract amendment process. Further detail of each phase is provided in separate process flow charts and step tables for each phase that follow the summary figure in **Figure 41**.

Figure 41. Contract Amendment Process.

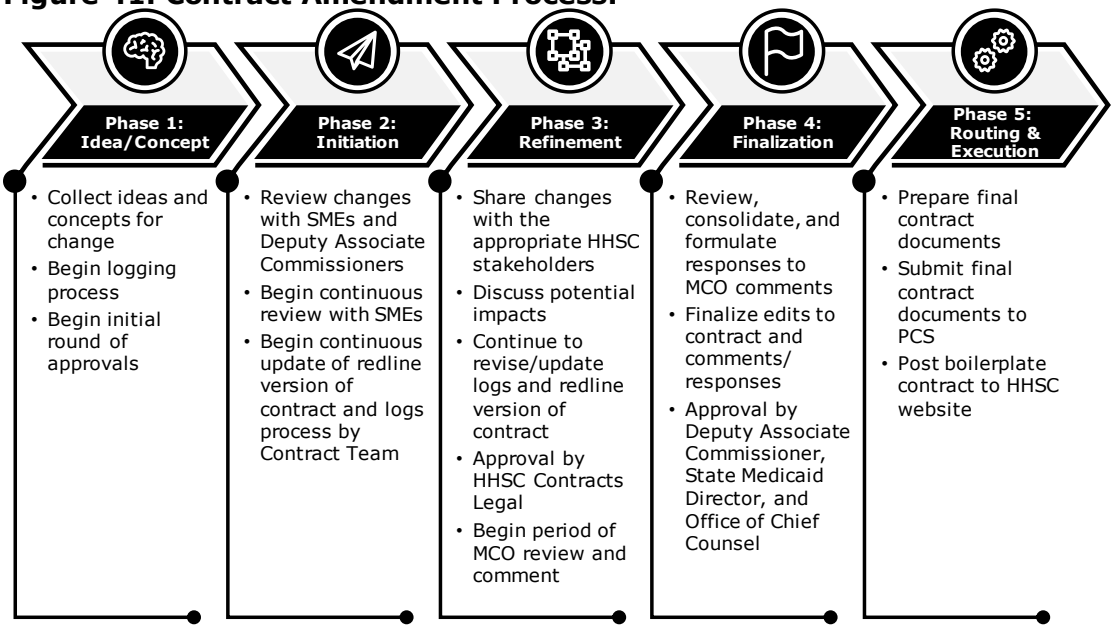


Figure 42. Key for Shapes Used in Process Flow Charts.

Figure 43. Contract Amendment Process Phase 1 Process Flow Chart.

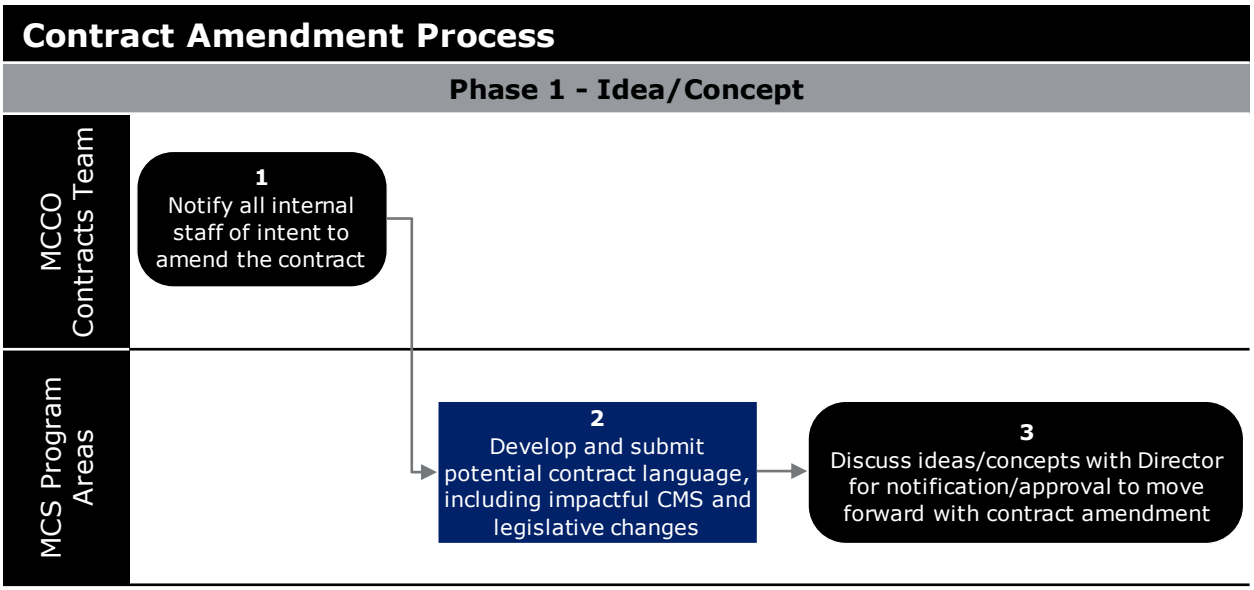


Figure 44. Contract Amendment Process Phase 1 Step Table.

Step	Task for Contract Amendment Process: Phase 1 – Idea/Concept	Completed by
1	Notify all internal staff of intent to amend the contract	MCCO Contracts Team
2	Develop and submit potential contract language, including impactful CMS and legislative changes	Applicable MCS Program Areas with proposed contract amendments
3	Discuss ideas/concepts with Director for notification/approval to move forward with contract amendment	Applicable MCS Program Areas with proposed contract amendments

Figure 45. Contract Amendment Process Phase 2 Process Flow Chart.

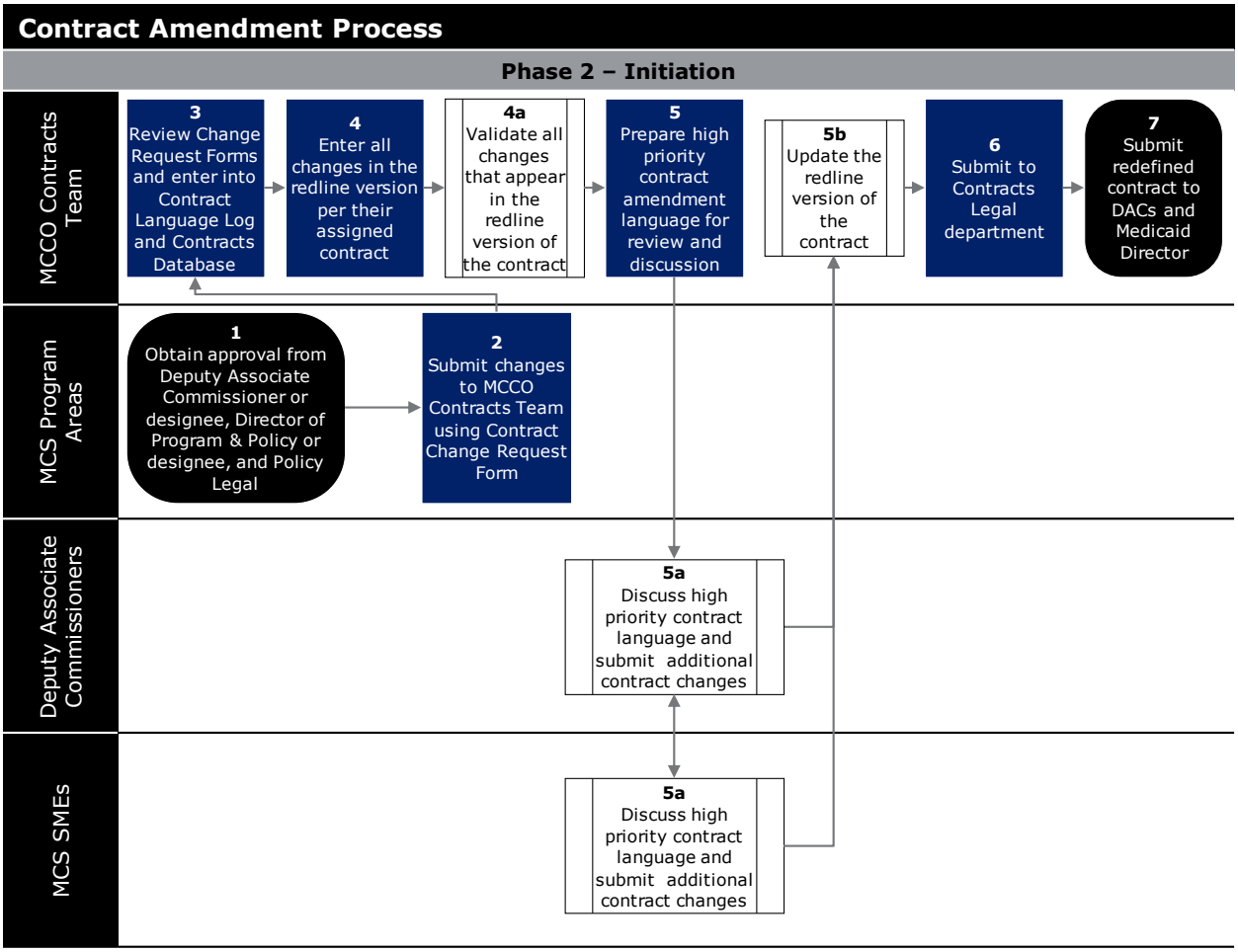


Figure 46. Contract Amendment Process Phase 2 Step Table.

Step	Task for Contract Amendment Process: Phase 2 – Initiation	Completed by
1	Obtain approval from DAC or designee, Director of Policy and Program or designee, and Policy Legal	All MCS Program Areas
2	Submit approved proposed changes to MCCO Contracts using the Contract Change Request Form no later than six months prior to the effective date of the contract amendment	All MCS Program Areas
3	Review change forms to ensure approvals and log all forms into the Contract Language Log (high-level description of contract changes) and the Contracts Database	MCCO Contracts Team
4	Enter all changes in the redline version per their assigned contract	MCCO Contracts Team (Contract Managers)
4a	Validate all changes that appear in the redline version of the contract	MCCO Contracts Team (Contract Managers)
5	Prepare high-priority contract amendment language (report as requested) to Managed Care Steering Committee and/or MCO Leadership for review, questions, and/or discussion	MCCO Contracts Team
5a	Discuss high-priority contract amendment language and timeline and submit any additional contract changes via legislation, executive-level requests, and/or audits	DACs; MCS Subject Matter Experts (SMEs)
5b	Update the redline version of the contract; create spreadsheet of high-priority changes	MCCO Contracts Team
6	Submit to Contracts Legal department for preliminary review of contract changes	MCCO Contracts Team
7	Present redline version of the contract to DACs and State Medicaid Director, making note of any priority items	MCCO Contracts Team

Figure 47. Contract Amendment Process Phase 3 Process Flow Chart.

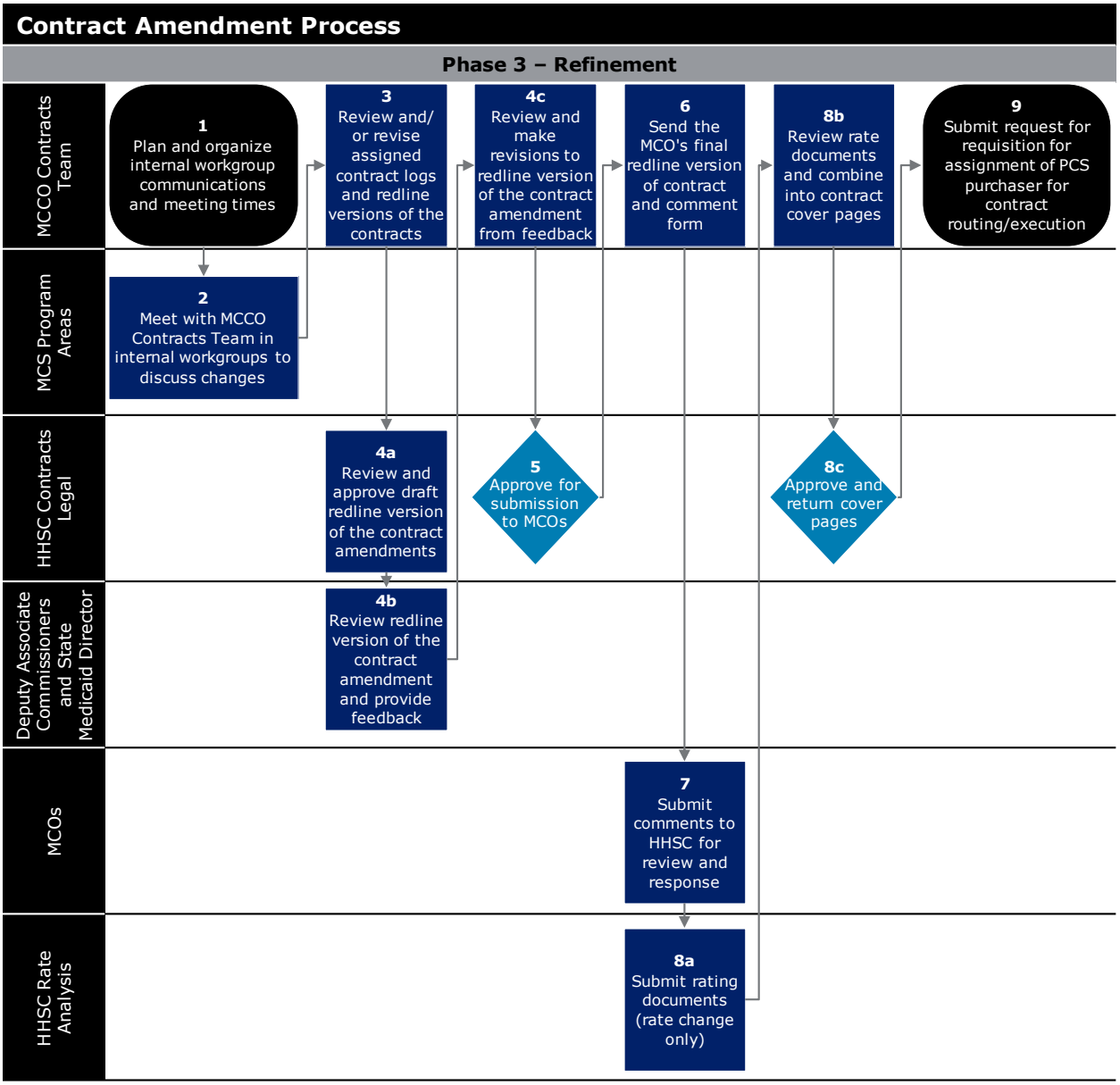


Figure 48. Contract Amendment Process Phase 3 Step Table.

Step	Task for Contract Amendment Process: Phase 3 – Refinement	Completed by
1	Plan and organize internal workgroup communications and meeting times	MCCO Contracts Team
2	Meet and discuss proposed changes in internal workgroups; the workgroups are utilized to determine and discuss potential impacts on all affected areas; resolve issues within language	MCS Program Areas, MCCO Contracts Team
3	Review and/or revise assigned contract logs and redline version of the contract to validate all changes are current and accurate; work with Office of Chief Counsel to revise any outstanding language in redline version of contract	MCCO Contracts Team
4a	Review and approve draft redline version of the contract amendment to submit to the MCOs	HHSC Contracts Legal
4b	Review redline version of the contract amendment and provide feedback to MCCO Contracts Team	DACs and State Medicaid Director
4c	Review redline version of the contract amendment; note any revisions discussed during the DAC meeting; make all revisions to the redline version of the contract and notify Contracts Legal of additional revisions	MCCO Contracts Team
5	Approve for submission to MCOs for review	HHSC Contracts Legal
6	Send the MCOs the final redline version of the contract and the comment form for review, comment, and/or approval	MCCO Contracts Team
7	Submit comments to HHSC for review/response; each MCO sends HHSC a change log with their comments	MCOs
8a	Submit rating documents if rate change occurring	HHSC Rate Analysis
8b	Review rate documents and combine into the contract cover pages; forward cover pages to Contracts Legal for review/approval	MCCO Contracts Team
8c	Approve and return cover pages, including edits and/or comments	HHSC Contracts Legal
9	Submit request for requisition for assignment of Procurement and Contracting Services (PCS) purchaser for contract routing/execution	MCCO Contracts Team

Figure 49. Contract Amendment Process Phase 4 Process Flow Chart.

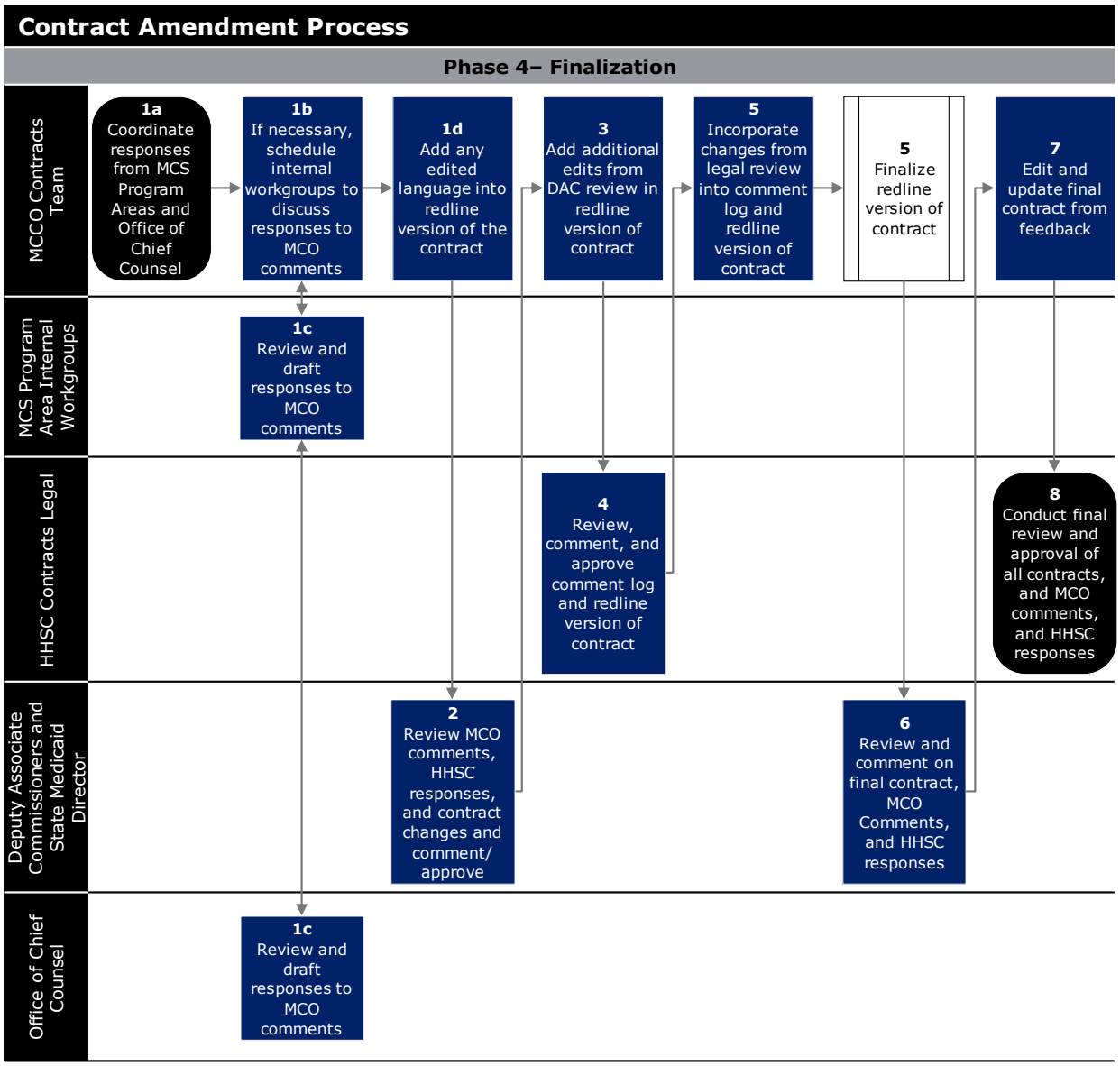


Figure 50. Contract Amendment Process Phase 4 Step Table.

Step	Task for Contract Amendment Process: Phase 4 – Finalization	Completed by
1a	Coordinate responses, comments, and edits from MCS Program Areas and Office of Chief Counsel	MCCO Contracts Team
1b	If necessary, schedule internal workgroups to meet for discussion/edits to responses to MCO comments	MCCO Contracts Team
1c	Review and draft responses to the MCO comments in the comment log; include all edited contract language as it should appear inside of the contract	MCS Program Area Internal Workgroups; Office of Chief Counsel
1d	Add any edited language into the redline version of the contract agreed upon during the workgroup meeting	MCCO Contracts Team
2	Review MCO comments, HHSC responses, and contract changes and comment, edit, and/or approve; consult with SMEs and Program Areas as needed	DACs and State Medicaid Director
3	Add any additional edits resulting from the DAC review in contract in redline version; validate MCO comments and responses in comment log	MCCO Contracts Team
4	Review, provide comments, and approve comment log and redline version of contracts	HHSC Contracts Legal
5	Incorporate changes from legal review into comment log and redline version of contract; finalize redline version of contract	MCCO Contracts Team
6	Review and comment on final contract and MCO Comments and HHSC Responses	DACs and State Medicaid Director
7	Edit and update the final contract with any edits as a result of the DAC/State Medicaid Director review	MCCO Contracts Team
8	Conduct final review and approval of all contracts MCO comments log and HHSC responses	HHSC Contracts Legal

Figure 51. Contract Amendment Process Phase 5 Process Flow Chart.

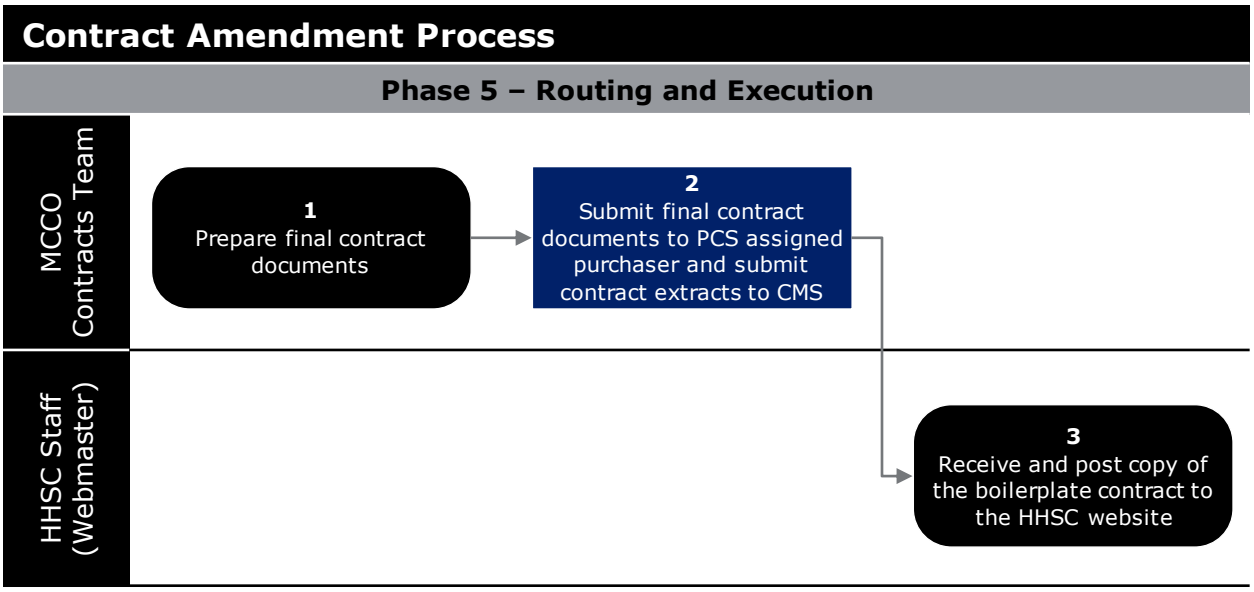


Figure 52. Contract Amendment Process Phase 5 Step Table.

Step	Task for Contract Amendment Process: Phase 5 – Routing and Execution	Completed by
1	Prepare final contract documents (i.e., final redline version of the contract, comment/response log, and final (clean) contract documents)	MCCO Contracts Team
2	Submit final contract documents to PCS-assigned purchaser for routing/execution; submit contract extracts to CMS for review/approval	MCCO Contracts Team
3	Receive and post copy of the boilerplate contract to the HHSC website on or shortly after the effective date of the contract	HHSC Staff (Webmaster)

Appendix 5.7.2 Procurement Process Maps

Figure 53 provides a high-level summary of the five phases of the procurement process for a new managed care contract. The total major procurement cycle averages about three years, with the first phase (i.e., planning and development) accounting for about 40 percent of the entire cycle and the last phase (i.e., readiness) accounting for about 30 percent of the entire cycle. Further detail of each phase is provided in separate process flow charts and step tables for each phase that follow the summary **Figure 53**.

Figure 53. Procurement Process.

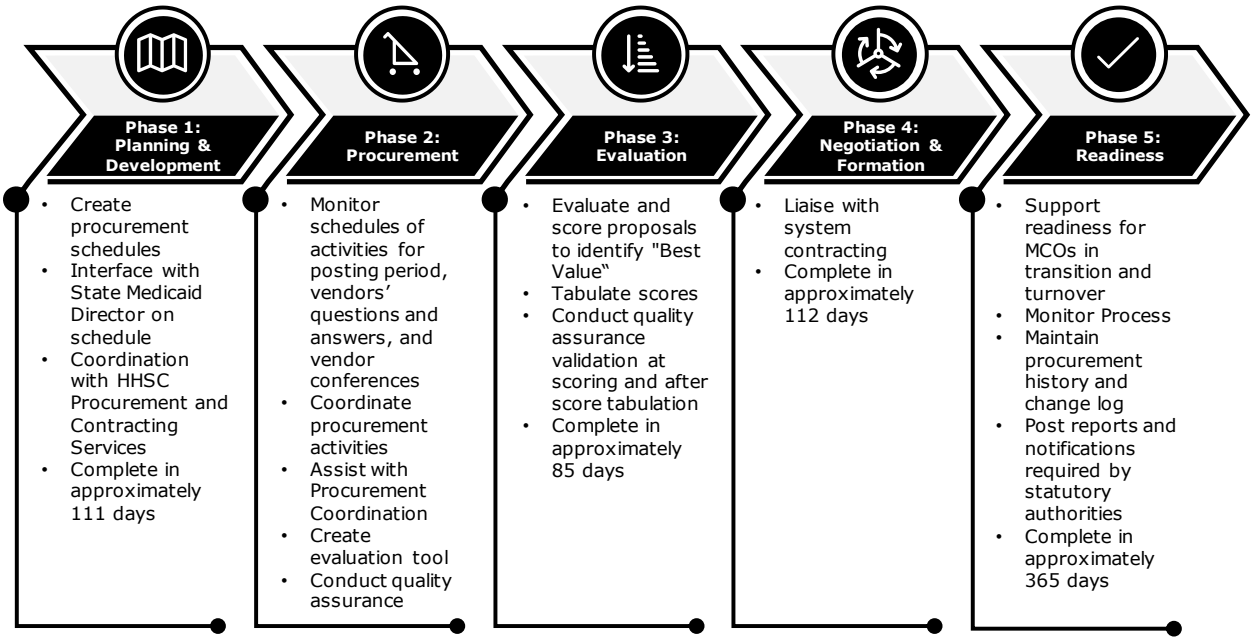


Figure 54. Process Flow Chart Key.

Figure 55. Procurement Process Phase 1 Process Flow Chart.

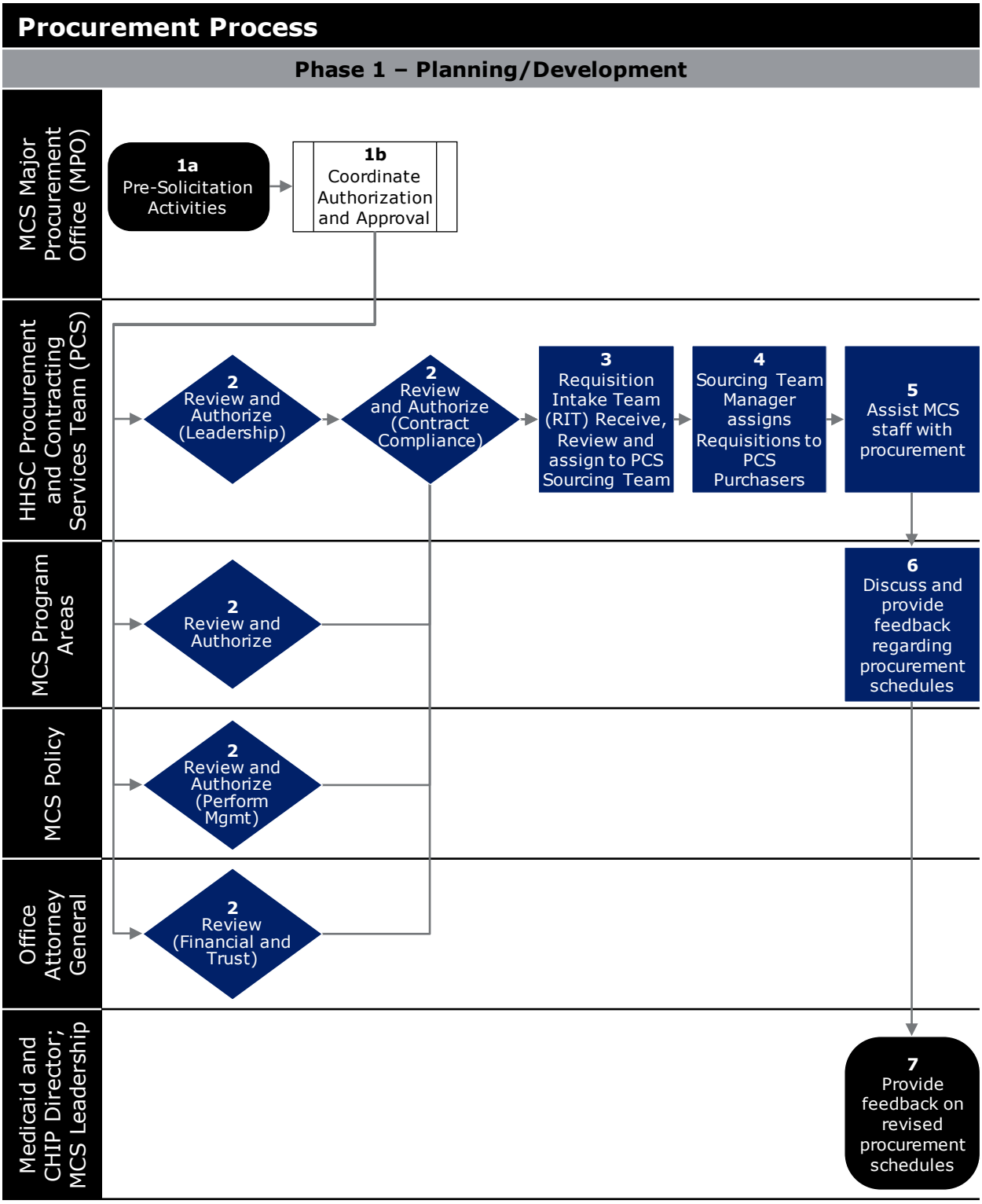


Figure 56. Procurement Process Phase 1 Step Table.

Step	Task for Procurement Process: Phase 1 – Planning/Development	Completed by
1a	Plan and develop solicitation in consultation with HHSC SME staff; review prior procurements for recommendations; develop procurement schedule; begin to collect requirements	MPO
1b	Coordinate authorization of presolicitation materials	MPO
2	Review and authorize draft MPO presolicitation materials	PCS; MCS Program Areas (including MCS MCCO and MCS Policy)
3	Receive, review, and assign requisition to PCS Sourcing Team	PCS Requisition Intake Team
4	Assign requisition to PCS Purchaser	PCS Sourcing Team Manager
5	Assist MCS staff with procurement (e.g., review and determine purchasing method, lead procurement kickoff meetings, train evaluation team, lead vendor conference, maintain procurement records)	PCS Purchaser
6	Discuss and provide feedback regarding procurement schedules	MCS Program Areas
7	Provide feedback on revised procurement schedules	Medicaid and CHIP Director; MCS Leadership

Figure 57. Procurement Process Phases 2 and 3 Process Flow Chart.

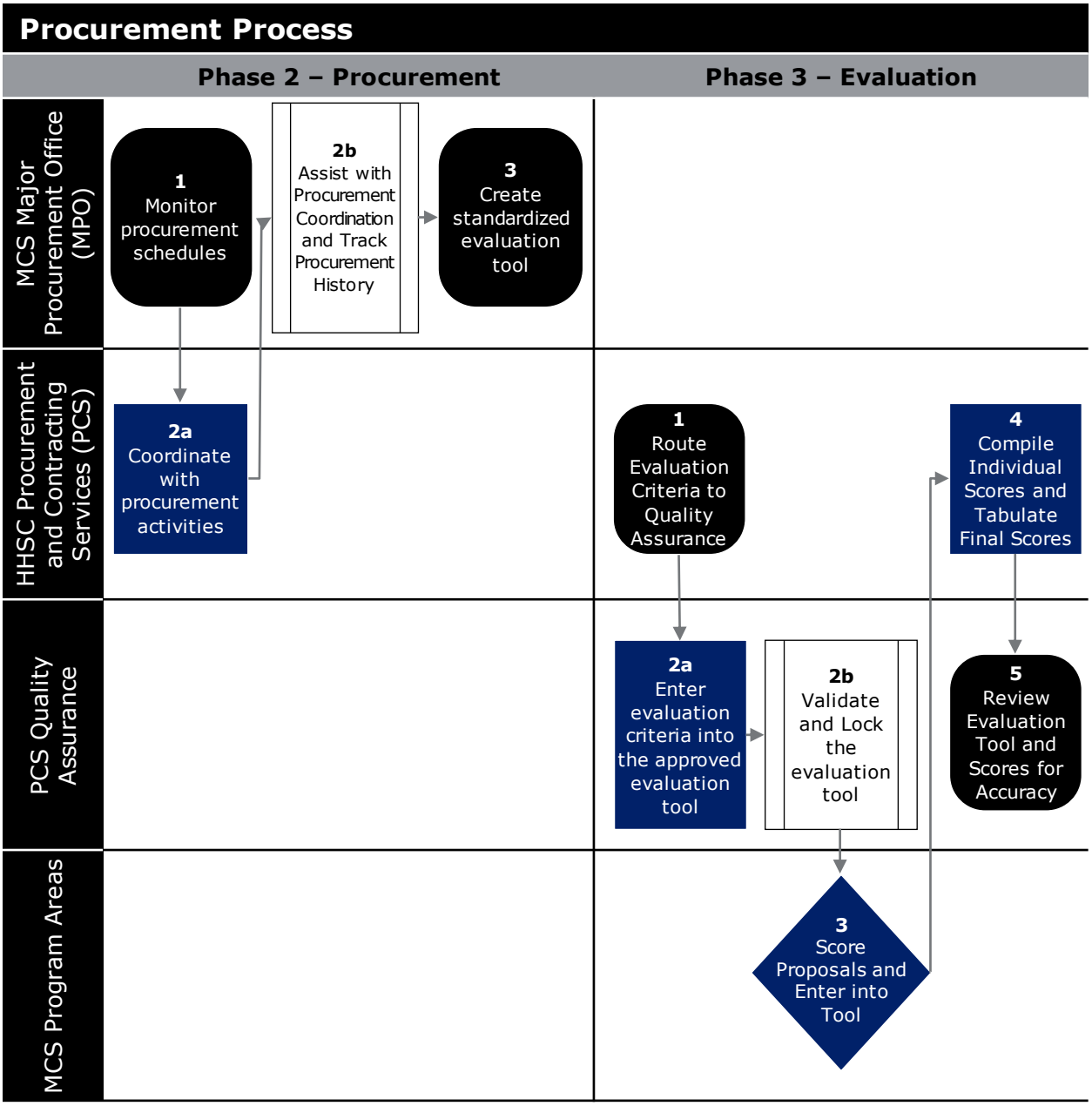


Figure 58. Procurement Process Phase 2 Step Table.

Step	Task for Procurement Process: Phase 2 – Procurement	Completed by
1	Monitor procurement schedules (e.g., posting period, vendors' questions and answers, vendor conference)	MPO
2a	Coordinate with procurement activities	PCS
2b	Assist with Procurement Coordination and track procurement history	MPO
3	Create standardized evaluation tool	MPO

Figure 59. Procurement Process Phase 3 Step Table.

Step	Task for Procurement Process: Phase 3 – Evaluation*	Completed by
1	Route evaluation criteria to quality assurance	PCS
2a	Enter evaluation criteria into the approved evaluation tool	PCS Quality Assurance
2b	Validate the evaluation tool for accurate performance and lock it	PCS Quality Assurance
3	Score the proposals and enter the scores into the evaluation tool	MCS Program Areas
4	Compile individual evaluator scores and tabulate final scores to identify "Best Value"	PCS
5	Review completed by two QA reviewers who review the evaluation tool and the scores to ensure that all calculations are correct and outliers have been addressed	PCS Quality Assurance

**Includes HHSC information that was presented at the April 18, 2018 Texas House of Representatives Committee on Appropriations (http://tlchouse.granicus.com/MediaPlayer.php?view_id=40andclip_id=15069)*

Figure 60. Procurement Process Phase 4 Process Flow Chart.

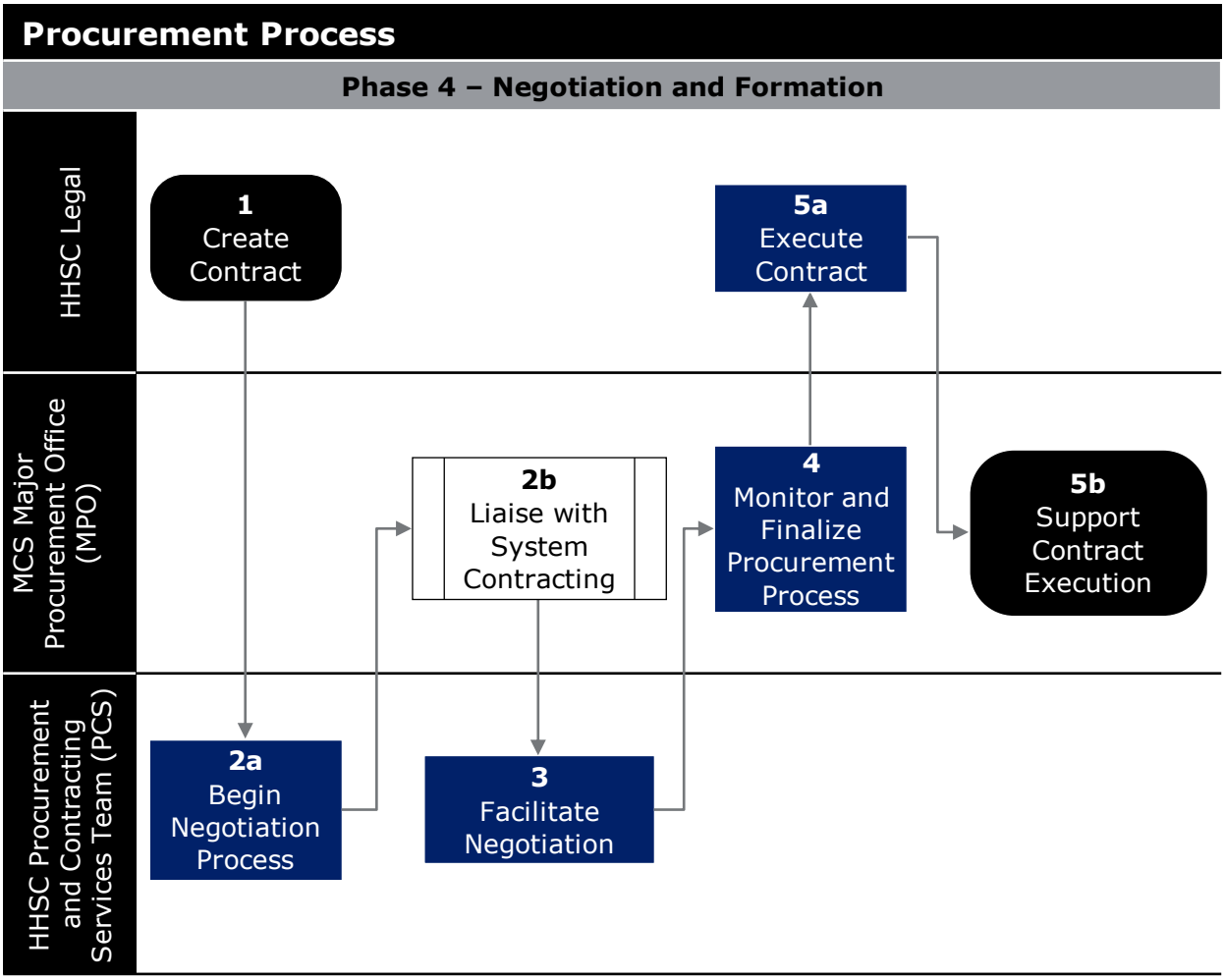


Figure 61. Procurement Process Phase 4 Step Table.

Step	Task for Procurement Process: Phase 4 – Negotiation and Formation	Completed by
1	Create contract and begin execution	HHSC Legal
2a	Begin negotiation process	PCS
2b	Liaise with system contracting	MPO
3	Facilitate negotiations as appropriate	PCS
4	Monitor and finalize procurement process (e.g., maintain procurement history, change log with contract, consult SMEs)	MPO
5a	Execute contract	HHSC Legal
5b	Support HHSC Legal during contract execution	MPO

Figure 62. Procurement Process Phase 5 Process Flow Chart.

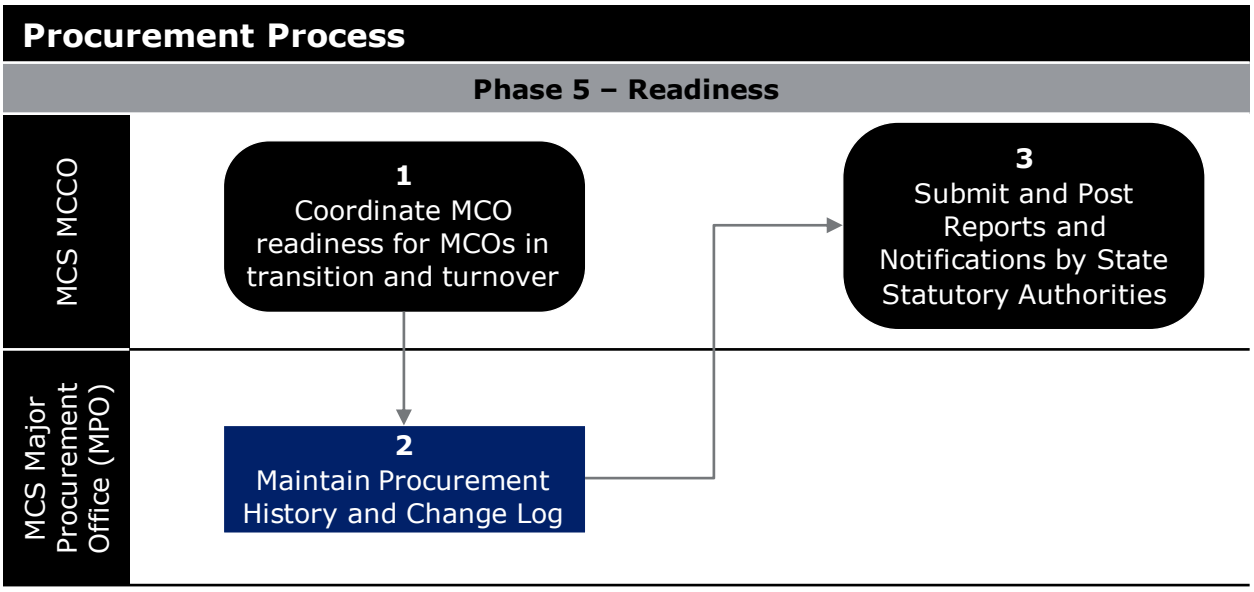


Figure 63. Procurement Process Phase 5 Step Table.

Step	Task for Procurement Process: Phase 5 – Readiness	Completed by
1	Coordinate MCO readiness for MCOs in transition and turnover	MCCO
2	Maintain procurement history and change log	MPO
3	Submit and post reports and notifications that are required by the Legislature, Legislative Budget Board (LBB), Comptroller of Public Accounts (CPA) rules, or other statutory authorities	MCCO

Appendix 5.7.3 Procurement and Contract Amendment Other-State Survey Questions

Other states were surveyed to collect information on Medicaid Managed Care procurements and contract amendment, including Arizona, California, Florida, New York, Ohio, Pennsylvania, and Wisconsin. The results are in the following **Section 5.7 Contract Amendments and Procurements.**

Below are the survey questions asked to other states.

Managed Care Organization (MCO) Procurement

1. How many unique contracts with MCOs (and/or program contracts) does the State manage? If contracts across a program are consistent across each MCO, other than basic information (e.g., MCO name), please count as one (1) unique contract for the entire program. However, if contracts vary more significantly for each MCO within a program, please count each MCO contract as unique.
2. How many total contracts with MCOs (and/or program contracts) does the State manage? For example, if Medicaid program A has a contract with 10 MCOs and Medicaid program B has a contract with five MCOs, then the State manages 15 contracts in total.
3. How long, in months, is the contract planning and development process before posting the request for proposals or soliciting MCOs?
4. Once executed, what is the typical life, in years, of a MCO contract (base contract years only)?

MCO Contract Amendment

1. How often does the State amend a contract in a typical *year*?
2. Are there limitations on the number of contract amendments that can be made in a year?
3. If Yes to the question above, how many?
4. What different types of amendments are completed?
5. If amendments are related to capitation rates – How long, in months, is the typical contract amendment process from initiation to completion?
6. If amendments are related to contract language – How long, in months, is the typical contract amendment process from initiation to completion?

Appendix 5.9.1 HHSC Rate Development Activities

Figure 64 below is the SFY 2018 Rate Development Timeline showing the lengthy timeline to develop, analyze, and attest newly developed premium rates for MCOs/DMOs. HHSC begins efforts in November, in order to have new rates effective the following September. In SFY2017, rates were updated in the interim for certain programs.

SFY2018 Managed Care Rate Development Activities as of June 9, 2017

Figure 64. SFY 2018 Managed Care Rate Development Revised Agency Activities.

Activity Description
First set of activities tentatively occurring in November
FRAC completes validation of SFY 2016 Fourth Quarter FSRs.
FRAC sends SFY 2016 Fourth Quarter FSRs to the actuaries (HHSC Actuarial Analysis and the Actuarial Vendor).
MCOs complete submissions of all SFY 2016 encounter data files for dates of service September 1, 2015 through August 31, 2016 for all programs to TMHP.
Second set of activities tentatively occurring in December
The actuaries issue Supplemental Data Request to MCOs.
FRAC sends SFY 2016 TPR Reports to the actuaries.
HHSC MCS Operations Management submits monthly eligibility (enrollment) files to the EQRO.
TMHP sends the FINAL monthly encounter data extract file for SFY 2016 to the EQRO.
HHSC System Forecasting submits SFY 2016 Recipient Month Data to the actuaries.
FRAC sends the Encounter Data Reconciliation Report to the actuaries.
Third set of activities tentatively occurring in January
The EQRO completes comparison of SFY 2016 Fourth Quarter FSRs to encounter data.
FRAC sends SFY 2016 90-Day and First Quarter SFY 2017 FSRs to the actuaries.
MCOs submit Supplemental Data request information to the actuaries.
EQRO completes initial review of encounter data and submits results to the actuaries.
Fourth set of activities tentatively occurring in February
The actuaries collect or confirm benefit, fee schedule, policy, contractual, and other Medicaid changes or information with various HHSC departments and staff. (This effort is recurring and ongoing throughout the year.)
HHSC submits request to MCOs to provide information on changes to Medicaid benefits or contract changes.
The actuaries submit requests to MCOs for updated claims lags for dates of service September 1, 2015 through February 28, 2017.

Activity Description
EQRO submits certified SFY 2016 encounter data sets for all programs to the actuaries.
Fifth set of activities tentatively occurring in March
EQRO develops acuity factors and submits results to the actuaries.
The actuaries submit compiled experience data for review to MCOs.
Sixth set of activities tentatively occurring in April
FRAC sends Second Quarter SFY 2017 FSRs to the actuaries.
Seventh set of activities tentatively occurring in May
The actuaries meet with HHSC Executive Commissioner to review rate development and propose preliminary SFY 2018 rates.
The actuaries send preliminary SFY 2018 rates to MCOs with request for comments.
EQRO submits Final SFY 2016 Encounter Data Certification Reports to the actuaries.
The actuaries present preliminary SFY 2018 rates to MCOs in a capitation workgroup meeting.
Eighth set of activities tentatively occurring in June
The actuaries meet with HHSC Executive Commissioner to propose and seek approval of final SFY 2018 rates.
The actuaries send final SFY 2018 rates to MCOs.
The actuaries present final SFY 2018 rates to MCOs in a capitation workgroup meeting.
Ninth set of activities occurring in July
HHSC submits request for approval of SFY 2018 rates to the LBB, Office of the Governor, and SAO.
HHSC submits SFY 2018 actuarial reports and actuarial certifications to CMS.
Tenth set of activities occurring in September
September 1, 2018 - Effective Date of Rates.

Appendix 5.9.2 Agreed-Upon Procedures

Below are the agreed-upon procedures (AUPs) for SFY 2015 applied by independent auditors to the Financial Statistical Reports (FSRs) provided by each MCO/DMO. The AUP engagement is solely to assist HHSC in assessing compliance with applicable the Federal Acquisition Regulation and contractual provisions outlined in the contract between certain MCOs and HHSC relating to the completion and submittal of the FSRs for the relevant programs. AUP engagements are conducted in accordance with standards established by the American Institute of Certified Public Accountants and Generally Accepted Government Auditing Standards issued by the Comptroller General of the United States. As of May 2018, all the 2015 AUP engagements have not been completed.

EXHIBIT A

Notes:

Quantitative for all FSR other than administrative expenses, than the larger of $3,000.00, or 0.5 percent of the FSR caption being tested are disclosed in this report. Quantitative exceptions for Administrative Expense FSR captions greater than the larger of $1,000.00 or 0.5 percent of the FSR administrative expense caption being tested are disclosed in this all administrative expense exception arising from audit sampling with an absolute value greater than 00.00 and/or administrative expense exceptions with an absolute value of greater than $500.00 are also disclosed in this report. Qualitative exceptions or claims pricing errors occurring in one or less instance out of a population of 40 or larger, or two or less instances out of a population of 60 or larger are not disclosed in this report. Exceptions considered qualitatively significant, regardless of the dollar value or number of occurrences, are disclosed in this report.

Procedures:

1. Obtain copies of the MCO’s 2014 FSR attestation reports and review MCO management responses to identify corrective actions that were to be implemented. Through inquiry of MCO management, determine the nature, timing, and extent of efforts to remediate the cause of prior year recommendations. Document whether such efforts were consistent with the management response provided in the prior year report
2. Obtain and review the HHSC reconciliations of MCO membership, medical premium revenue, pharmacy premium revenue, and DSPs presented in Part 1 of the Medical Expenses FSR(s). If reconciling items remain unexplained at the time of testing, through inquiry of MCO management,

determine the cause of such reconciling item(s) and whether MCO management has remediated the underlying cause(s) of the reconciling item(s) identified if applicable

3. For investment income reported in Part 1 of Medical Expense FSR(s), perform the following:
   a. Obtain from the MCO a reconciliation to the MCO's general ledger (G/L) and/or investment income allocation worksheet(s) from other entities or operating divisions, as well as to each Medical Expense FSR explain and report any significant variances.
   b. Through inquiry of MCO management determine and document whether the MCO uses a method to allocate investment income from other entities or operating divisions. If the MCO uses an allocation to report investment income, obtain the allocation schedules from the MCO. To test for accuracy, perform recalculations of three months selected haphazardly to determine if allocations are made in accordance with the methodology.
   c. Determine the completeness of investment income and compliance with provisions of the FSR instructions. Consider audited financial statements, tax returns, TDI reports, procedures on other FSR line items, and other resources as applicable to determine completeness.
4. For other revenue reported in Part 1 of the Medical Expense FSR(s):
   a. Agree to the MCO's general ledger and/or source allocation worksheet. Explain and report any material variances.
   b. Determine the completeness of other revenue. Consider audited financial statements, tax returns, TDI reports, procedures on other FSR line items, and other resources, as applicable.
5. For medical expenses represented by FFS claims presented in Part 1 and Part 4 of the Medical Expense FSR(s);
   a. Obtain from the MCO the claims lag report by program/SDA.
      i. Reconcile the MCO's claims lag report(s) to paid claims in the FSR(s) for each program/SDA.
      ii. Obtain from the MCO the detailed listing of claims and reconcile the claims detail to the claims lag report(s).
      iii. From the reconciliation in 5a(ii) above, identify variance(s) greater than 1 percent, investigate cause(s) of such variance(s), and determine whether cause(s) of such variance(s) have been remediated by management, if applicable.

6. For medical expenses represented by FFS claims presented in Part 4 of the Medical Expense FSR(s)
    a. Select a sample of claims from the detailed listing of claims obtained in 5a (ii) above. Sample size and selection methodology will be discussed with and agreed upon by HHSC prior to commencing this procedure.
    b. For the claims selected in 6a above, ensure the following:
        i. Provider is not listed on the excluded provider list from the Health and Human Services Commission Office of Inspector General (OIG list), the List of Excluded Individuals/Entities or the Excluded Parties List System.
        ii. Member and provider were eligible at the date of service.
        iii. Information in the claim database agrees with the related Explanation of Payment or Remittance Advice.
        iv. Amount of claim payment is accurate under terms of the applicable executed contract (if one exists) and underlying fee schedule.
        v. The claim was paid in a timely manner and any associated interest was calculated, paid, and reported in accordance with the UMCM.
        vi. Payment is supported by valid evidence of cash disbursement.
        vii. Ensure applicable contract is properly executed.
        viii. Claim is recorded in the proper fiscal year.
    c. In the existence of claims pricing errors, if the error(s) appear to be systemic and readily quantifiable, determine the extent of similar errors. Otherwise, consult with HHSC to determine the nature, timing, and extent if expanded testing.
7. For medical expenses represented by Capitated Services: PCPs and Hospitals included in Part 1, Part 4, and Part 5 of the Medical Expense FSR(s):
    a. Obtain from the MCO a capitation payment register and a reconciliation to the Capitated Services: PCPs and Hospitals, and Capitated Services: BH, Vision reported in Part 5 the FSR(s). Investigate any material reconciling items, and determine underlying cause(s) and whether management has remediated such cause(s).

b. Select a judgmental sample of 25 members included in capitation payments, obtain the relevant executed provider contract and evidence of the selected payments, and ensure that:

   i. The current month and retroactive capitation amounts for each enrollee listed are properly summarized by incurred months, and that the sum of the capitation amount agrees with the check amount.

   ii. The capitation was calculated properly based on the member's risk group and the provider's contracted rate.

   iii. The member receiving the service was for service during the month the capitation was paid.

c. Ensure that providers receiving capitation payments for contracted services do not also receive FFS payments for the same members and services.

8. For medical expenses represented by Capitated Services: BH, Vision, etc., included in Part 1 of the Medical FSR(s):

   a. Obtain and review the HHSC recalculations and reconciliations of Capitated Services: Vision, etc., If reconciling items remain unexplained at the time of testing, perform the following:

      i. Obtain the relevant executed contract for each material from the MCO. Recalculate and reconcile to the amounts reported in the FSR(s). Determine whether the capitation was calculated properly based on membership, the member's risk group, and the provider's contracted rate. Investigate any significant reconciling items, and determine underlying cause(s) and whether management has remediated such cause(s).

      ii. Obtain from the MCO a reconciliation of the Capitated Services: BH, Vision, etc., on the FSR(s) to the MCO's G/L detail or capitation check register.

      iii. Determine whether administrative and medical expenses related to the delegated network have been properly classified in the FSR(s).

   b. Ensure that providers receiving capitation payments for contracted services do not also have FFS payments for the same members and services.

9. For medical expenses represented by reinsurance expense and recoveries presented in Part 5 of the Medical Expense FSR(s):

a. Obtain the HHSC reconciliations of reinsurance expense Part 5 of the FSR(s) If reconciling items remain unexplained at the time of testing, perform the following:

   i. Obtain the contract between the MCO and its reinsurance provider(s). Recalculate based on membership and rates, and compare to the reinsurance expense reported in the FSR(s). If reconciling items investigate determine the cause(s) of such items and determine whether has remediated the cause(s).

   ii. Reconcile the reinsurance expense, recoveries, and refunds to the MCO's G/L detail or capitation check register.

b. Obtain from the reinsurer a detailed listing, by claim, of the reinsurance recovery payments made to the MCO and compare to recoveries and refunds reported in the FSR.

c. Obtain from the MCO a reconciliation of the reinsurance recoveries reported by the reinsurer, obtained in 9b above, to those recoveries and refunds reported in the FSR(s), if necessary. Determine whether recoveries presented in the FSR are reported in the SFY in which the claim(s) were incurred.

10. For VAS presented in Part 5 of the Medical Expense FSR(s) and Part 1 of the Administrative Expense FSR:

    a. Obtain a listing of approved VAS from HHSC and reconcile to VAS reported in the FSR(s).

    b. Ensure VAS are properly classified between administrative and medical expense, and that VAS are not included in total medical expense or total administrative expense in the FSR.

11. For other medical expense presented in Part 5 of the Medical expense FSR(s), including, but not limited to, TPR and incentives:

    a. Obtain from the MCO a listing of other medical expenses by type and a reconciliation to other medical expense reported in the FSR(s).

    b. Determine the appropriateness of classification and whether the other medical expenses are valid and allowable.

    c. Inquire of MCO management to determine if TPRs are reported on an incurred basis and if administrative expenses related to TPRs are reported in administrative expenses.

    d. If the policy is to report TPRs on an incurred basis, obtain a detailed listing of recoveries by claim and test a haphazard sample of 25 recoveries for adherence with the policy.

12. For pharmacy expenses presented in Part 6 of the Medical Expense FSR(s):
    a. Obtain from the MCO the claim detail supporting the Pharmacy Expense – Risk Group Reporting in their FSR(s) for each program/SDA.
        i. Reconcile the MCO's claims lag report(s) to paid claims in the FSR(s) for each program/SDA.
        ii. Reconcile the claims detail to the claims lag reports(s).
        iii. Identify material variance(s) and investigate cause(s) of such variance(s) and determine whether the causes of such variance(s) has been remediated by management, if applicable.
    b. Select a sample of claims form the detailed listing discussed in 12a above. Sample size and selection methodology will be discussed with and agreed upon by HHSC prior to commencing this procedure.
    c. For the claims selected in 12b above, ensure the following
        i. Member and provider were eligible on the date of service.
        ii. Pharmacy claim information agrees with underlying claims data in the pharmacy claims database and related Explanation of Benefit or Remittance Advice.
        iii. Amount of claim payment is accurate under terms of the applicable executed contract and underlying fee schedule.
        iv. The amount of the claim paid reported in the pharmacy claim detail agrees with the amount paid to the MCO's PBM;
        v. The amount paid by the PBM to the pharmacy equals the amount paid by the MCO to the PBM.
        vi. Payment is supported by valid evidence of cash disbursement.
        vii. Claim was correctly classified by Risk Group.
        viii. PA was obtained, if required by HHSC or the MCO.
        ix. Claim was paid in a timely manner, according to the requirements in the UMCM.
    d. In the existence of claims pricing errors, if the error(s) appears to be systemic and readily quantifiable, determine the extent of similar errors. Otherwise, consult with HHSC to determine the nature, timing, and extent of expanded testing.

e. Obtain the executed PBM contract with the MCO and identify arrangements or payment structures that would qualify as improper rebates or spread pricing, i.e., situations in which the MCO reimburses the PBM for amounts different from what the PBM pays the pharmacy.

f. If transaction fees paid by pharmacies, improper rebates or spread pricing are identified, investigate to determine the extent of such items, and determine whether management has remediated the issue.

13. For "specified in-house service" (direct) administrative expenses presented in Line 18 of Part 1 of the Administrative Expense FSR:

    a. Obtain a listing of all G/L account codes that are included in Part 1 of the Administrative Expense FSR for SFY 2015. Determine which account codes allocate expenses to the ESR and which are charged directly to the FSR.

    b. Scan account codes and detail listing looking for potentially unallowable items.

    c. Obtain from the MCO a reconciliation of the FSR(s) to the MCO's G/L and/or other detailed transaction records, and select an appropriate sample for test work. Sample size and selection methodology will be discussed with and agreed upon by HHSC prior to commencing this procedure.

    d. For the detail items selected in 13c above:

        i. Determine that sufficient evidence exists to support the charge as an SFY 2015 administrative expense.
        ii. Ensure the expenses are allowable, based on the support obtained and Cost Principles for Expenses in Chapter 6.1 of the UMCM (UMCM Cost Principles).
        iii. Ensure that payment occurred as reported.
        iv. Note any discrepancies identified in the testing. For accounts that appear to include some unallowable expenses, which were identified during testing and could indicate systemic errors, consult with HHSC to determine the nature, timing, and extent of expanded testing. Calculate the total unallowable expenses identified in these accounts based on the items tested.

14. For "outsourced services (noncapitated arrangements)" administrative expenses presented in Line 19 Part 1 of the Administrative Expenses FSR:
    a. If "outsourced services (noncapitated arrangements)" administrative expenses are based on a contractual rate that can be recalculated without necessary information from the provider's invoice, obtain the relevant executed contracts for material provider, and recalculate and reconcile to amounts reported in the FSR(s) for accuracy.
    b. If "outsourced services (noncapitated arrangements)" administrative expenses are not based on a contractual rate, from the detailed listing of administrative expenses that are included on the Administrative Expense FSR, select an appropriate sample for test work. Sample size and selection methodology will be discussed with and agreed upon by HHSC prior to commencing this procedure.
    c. For the detail items selected in 14b above:
        i. Determine that sufficient evidence exists to support the charge as an SFY 2015 administrative expense.
        ii. Ensure the expenses are allowable, based on the support obtained and UMCM Cost Principles.
        iii. Ensure that payment occurred as reported
        iv. Ensure that payments comply with the applicable contract and rates.
15. For "outsourced services (capitated arrangements)" administrative expenses presented in Line 20 Part 1 of the Administrative Expense FSR:
    a. If "outsourced services (capitated arrangements)" administrative expenses are based on a contractual rate, obtain the relevant executed contracts for material providers and recalculate and reconcile to amounts reported in the FSR for accuracy.
    b. If "outsourced services (capitated arrangements)" administrative expenses are not based on a contractual rate:
        i. From the detailed listing of reimbursed administrative expenses that are included on the Administrative Expense FSR, select an appropriate sample for test work. Sample size and selection methodology will be discussed with HHSC prior to commencing this procedure.
        ii. If administrative expenses are not based on a detailed listing of reimbursed transactions, recalculate the administrative portion

of the payments by subtracting the total amount of medical claims reported on the Medical Expense FSR(s) from the total payments made to the provider.

c. For the detail items selected in 15b (i) above:

   i. Determine that sufficient evidence exists to support the charge as an SFY 2015 administrative expense.
   ii. Ensure the expenses are allowable, based on the support obtained and UMCM Cost Principles.
   iii. Ensure that payment occurred as reported.
   iv. Ensure that payments comply with the applicable contract and rates.

16. For "PBM Admin Fees – Fees based on $PMPM" administrative expenses presented in Line 21 Part of the Administrative Expense FSR:

    a. Recalculate "PBM Admin Fees – Fees based on $PMPM" administrative expenses presented on the contractual rate and compare to monthly balances reported in the FSR for the accuracy.
    b. Ensure, on a sample basis, that payment occurred as reported. Sample size and selection methodology will be discussed with and agreed upon by HHSC prior to commencing this procedure.

17. For "PBM Admin Fees – Fees based on transaction volume" administrative expenses presented in Line 22 Part 1 of the Administrative Expense FSR:

    a. Obtain from the MCO a reconciliation of the FSR to the MCO's G/L or other accounting records. Identify significant variance(s) and investigate cause(s) of such variance(s) and determine whether the cause(s) of such variance(s) have been remediated by management.
    b. Recalculate "PBM Admin Fees – Fees based on transaction volume" administrative expenses based on the contractual rate and compare to monthly balances reported in the FSR for accuracy.
    c. Ensure, on a sample basis, that payment occurred as reported. Sample size and selection methodology will be discussed with and agreed upon by HHSC prior to commencing this procedure.

18. For "PBM Admin Fees – Other" administrative expenses presented in Line 23 Part 1 of the Administrative Expense FSR:

    a. Obtain from the MCO a reconciliation of the administrative expenses to the MCO's G/L or other accounting records. Identify significant variance(s) and investigate cause(s) of such variance(s) and determine whether the cause(s) of such variance(s) has been remediated by management.

b. If "PBM Admin Fees – Other" administrative expenses are based on a contractual rate, obtain the relevant executed contract and recalculate and compare to monthly balances reported in the FSR for accuracy.
c. If "PBM Admin Fees – Other" administrative expenses are not based on a contractual rate, from the detailed listing of administrative expenses, select an appropriate sample for test work. Sample size and selection methodology will be discussed and agreed upon with HHSC prior to commencing this procedure.
d. For the detail items selected in 18c above:
   i. Determine that sufficient evidence exists to support the charge as an SFY 2015 administrative expense.
   ii. Ensure the expenses are allowable, based on the support obtained and UMCM Cost Principles.
   iii. Ensure that payment occurred as reported.

19. For "Corporate Allocation" administrative expenses presented in Line 24 Part 1 of the Administrative Expense FSR:

a. Obtain an understanding of the indirect cost allocation methodology utilized by other operating divisions or affiliated entities to record costs on the Administrative Expenses FSR. Ensure that the methodology is in compliance with Section V of the UMCM Cost Principles.
b. Scan general ledger account codes and detailed listing of transactions for potentially unallowable items. Utilize the results to target specific transaction codes for sample selection in 19e below, if applicable.
c. Obtain from the MCO a reconciliation of corporate allocation expenses included on the Administrative Expense FSR to the MCO's general ledger or other accounting records. Identify significant variance(s) and investigate cause(s) of such variances(s) and determine whether the cause(s) of such variance(s) have been remediated by management, if remediation is necessary.
d. If "Corporate Allocation" administrative expenses are estimated or based on a contractual rate, obtain from the MCO a cost analysis that details actual cost to the cost charged to administrative expense through the corporate allocation contract/agreement. Determine whether the estimate has been adjusted to reflect actual cost, if applicable.
e. From the detailed listing of administrative expenses, select an appropriate sample for test work. Sample size and selection methodology will be discussed with and agreed-upon by HHSC prior to commencing this procedure.
f. For the detail items selected in 19e above:

i. Determine that sufficient evidence exists to support the charge as an SFY 2015 administrative expense.
ii. Ensure the expenses are allowable based on the support obtained and UMCM Cost Principles.
iii. Payment is supported by valid evidence of cash disbursement.
iv. Note any discrepancies identified in the testing. For accounts that appear to include some unallowable expense, which were identified during testing and could indicate systemic errors, consult with HHSC to determine the nature, timing, and extent of expanded testing. Calculate the total unallowable expenses identifies in these accounts based on the items tested.

g. Ensure "Corporate Allocation" administrative expenses are based on actual expenses incurred during SFY 2015.

20. For all administrative expenses, validate that any executive compensation reported in the FSR(s), including that which has been allocated and is compliant with FAR.

    a. Verify that bonuses are paid according to bonus plan schedule.
    b. Verify that only the allowable portion of total executive compensation is reported on the Administrative Expense FSR.

21. For all administrative expense detail testing, in the existence of errors or unallowable expenses, if the errors appear to be systemic, consult with HHSC to determine the nature, timing, and extent of expanded testing.

22. Determine the existence of all types of related-party transactions between the MCO and its affiliates and other potential conflicts of interest, including, but not limited to, reinsurance arrangements, capitated services, PBM Services etc., Perform the following:

    a. Examine the transaction types included on the schedule obtained from the MCO. Ensure that the transactions are at fair market value or reported at cost. If the MCO qualifies for the fair market exception, request the contract between the related party and the MCO. Determine if the expenses reported are allowable per the UMCM/UMCC and FAR, though comparison to contracts with third parties or other relevant benchmarks.

    b. Obtain from the MCO a schedule of all payments to related parties included in the Administrative Expense FSR and pharmacy expense sections of the Medical Expense FSR(s). The schedule should include the company, relationship to the MCO, type of services provide, payment terms, and amounts paid that agrees to the FSR(s).

c. Obtain a schedule form the MCO of related-party payments included on Total Related-Party Expenses on Part 5 of the Medical Expense FSR(s). The schedule should include the company, relationship to the MCO, type of provider, type of payment, and amounts paid that agrees to the FSR(s):

   i. Test the completeness of the schedule through comparisons to any audited financial statements, reports submitted to the TDI, and the Affiliate Reports submitted to HHSC.

23. Obtain management responses from the MCO for all variances or errors noted in procedures 1 through 22 above. Reflect material variances, as defined above, as adjustments to the appropriate program/SDA FSR(s) and, if appropriate, the Administrative Expense FSR.

24. Verify that there is no IBNR included in the 334-Day FSRs. If there is IBNR, investigate the nature of the IBNR and whether it is appropriate to include on the 334-Day FSRs.

25. Obtain from the MCO a signed management representation letter that include attestations to the following:

    a. All Investment Income and Other Revenue are reported on the FSRs appropriately, completely and accurately.

    b. The PBM does not charge transaction fees to pharmacies.

    c. The PBM and MCO do not report spread pricing on the FSRs.

    d. Value-Added Services (VAS) are not included in total medical expense or total administrative expense in the FSR(s). The related-party expense detailed listings provided are complete and include payments made to all affiliates and other entities with which the MCO has an influential relationship, and payments to such entities are included on the FSR(s).

Rider 61(c): Evaluation of Medicaid and CHIP Managed Care – Managed Care Rate Setting

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1. Rider 61(c) Executive Summary

The 85th Texas Legislature commissioned Rider 61(c) to review Medicaid Managed Care rate setting processes in Texas and other states, including consideration for the reimbursement arrangements, the processes utilized to select and procure managed care organizations (MCOs), and the approach used to set capitation rates. While the Centers for Medicare & Medicaid Services (CMS) has outlined guidance in the managed care environment, methodology variations across states still exist. Therefore, the study highlights common practices across the country and opportunities for HHSC's consideration.

1.1. Managed Care Rate Setting Methodology

Capitation rate setting is the process of developing a fixed rate – typically per member per month (PMPM) that a state Medicaid Managed Care program will pay to an MCO to assume responsibility for providing covered services to members covered and enrolled in the managed care program. The review of the rate development process compared six rate setting elements across Texas and other states. The **Figure 1** below provides a high-level summary of this rate development comparison and the subsequent report summarizes additional details and considerations on each of the rate setting elements.

Figure 1. Rate Setting Comparison.

Rate Setting Element	Texas Methodology	Comparison to Other States
Base Data: *Historical data set serving as a starting point for the development of capitation rates.*	• One year of encounter claims as their base data • Adjusted with incurred but not reported (IBNR)	• One to three years of encounter claims data • Service carve-outs have the most variation across states
Claim Trends: *Claim cost trends are a series of assumptions used to project base data from the historical base period to the current rating period.*	• Medical and prescription trend rates based on historical data • Medical trends for each program applied by service delivery area and risk group • Prescription drug trends for each program applied by risk group and drug type	• Historical data is the preferred method by CMS • Historical data is a common source, but some states supplement historical experience with other data sources to leverage industry and comparable state experience, or to increase the credibility of the dataset

Rate Setting Element	Texas Methodology	Comparison to Other States
Adjustments: *States may make additional adjustments to base data in order to develop rates that best fit their programs, populations, and covered services.*	• Applies efficiency reimbursement reduction adjustment • Implemented additional incentive programs to improve quality and effectiveness of care	• Incorporate efficiency adjustments in a similar manner • Some states make adjustments for incentive programs and withholds
Nonmedical Expenses: *Nonmedical expenses must include expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital.*	• Administrative load development utilizes hybrid of percentage of projected benefit costs and fixed per member per month (PMPM) amount, with varying values across each program • Risk margin of 1.5 percent of premium for STAR, STAR Health, and CHIP programs and 1.75 percent for STAR+PLUS and STAR Kids	• Other states utilize a percentage of projected benefit costs, fixed PMPM amount, or hybrid method • Other states typically have risk margins between one and two percent, but some do not include an explicit risk margin, but instead include them in the administrative load
Risk Mitigation: *Various techniques are used to appropriately mitigate the acuity differences across various populations.*	• Prospectively applies risk adjustment to recognize cost differences between MCOs based on the health of their members • Does not include any other risk-sharing mechanisms	• The risk-adjustment methodology used in Texas's rate development process is a similar approach utilized by many other states
Rate Detail: *States have the flexibility to develop capitation rates at the community level, such as on a statewide or regional basis, or at a more granular level specific to each MCO.*	• Certifies specific point estimates by rate cohort and service delivery area for all programs • Develops capitation rates for 13 managed care service delivery areas or regions and broken down by one to eight risk groups	• Many states are now adjusting their approaches to comply with the new managed care regulations requiring certifying specific point estimates • Other states have similar numbers of rate cells as Texas

1. **Base Data:** Base data is the historical data set that serves as a starting point for the development of capitation rates in determining an estimate of future claims experience. The approach utilized by Texas and its

consulting actuary, Rudd and Wisdom, to select and develop the base data is consistent with most of the states that were reviewed. Key similarities between Texas's approach and those utilized by other states include referencing different data sources to verify the most complete and accurate data is used to set the managed care capitation rates and utilizing a one-year period for base data. The base data component with the most variation in methodology across the states was the service carve-outs, which are often driven by state-specific program policy rather than an actuarial rate setting determination.

2. **Claim Cost Trends:** Claim cost trends are a series of assumptions used to project base data from the historical base period to the current rating period. Texas's trend rate assumption development is similar to other states. The use of state-specific historical data is a method preferred by CMS and an approach which Texas has been using for many years for the more mature managed care programs. Additionally, the application of medical trends by risk group and service delivery area is a useful method in capturing the difference in claims experience across populations and geographic regions.
3. **Adjustments:** States may make additional adjustments to base data in order to develop rates that best fit their programs, populations, and covered services. Many states incorporate incentive arrangements, efficiency adjustments, and quality adjustments to reward their contracted MCOs for providing quality services to members while maintaining costs. Texas currently incorporates incentive arrangements, efficiency adjustments, and quality programs in a similar manner as the other states reviewed. Analysis should continue to be performed to review the impact of these adjustments, arrangements, and programs on reducing the rate of growth for total Medicaid health care expenditures and increasing the quality of the provided services.
4. **Nonmedical Expenses:** CMS Medicaid Managed Care rate setting guidance states that "the development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital." The approach utilized by Texas to develop nonmedical expense loads is consistent with the other states reviewed. As outlined in the Rider 61(d) report, when reviewing Medical Loss Ratio (MLR) results in Texas in comparison to other states, the Texas program is at approximately 90 percent, which is above the minimum 85 percent threshold and is in line with other states. Texas should continue to monitor the administrative expense experience and

adjust its assumptions and approach as necessary. One consideration is in the development of the fixed and variable components of the administrative load. Texas could consider performing a deeper analysis on which costs from the Financial Status Report (FSR) should be considered fixed versus variable costs and modify their current fixed and variable assumptions accordingly.

5. **Risk Mitigation:** States use various techniques to appropriately mitigate the acuity differences across the populations within their rate setting methodology. Risk adjustments can be applied prospectively or retrospectively, both in a budget neutral manner. The annual update of Chronic Illness and Disability Payment System (CDPS+Rx) risk scores used in the Texas's rate development process is a similar risk-adjustment approach utilized by many other states. Other common risk-sharing methods used by other states to stabilize premium payments to MCOs against unexpected high costs include high-cost risk pools, risk corridors, and reinsurance. One consideration is to determine if additional risk-adjustment approaches could be incorporated into the rate development process for more specific conditions. For example, some states are beginning to consider social determinants of health within the development of capitation rates. States will likely continue to implement additional adjustments to more accurately price the populations in their programs. However, there are considerations regarding how these adjustments should be applied so that MCOs continue to be incented to help reduce the negative impact of such variables for their populations and the adjustments are required to be budget neutral.
6. **Rate Detail:** States have the flexibility to develop capitation rates at the community level, such as on a statewide or regional basis, or at a more granular level specific to each MCO. Since Texas has been certifying specific rates for each rate cell rather than rate ranges, it is ahead of many states which are now adjusting their approaches to comply with the new managed care regulations. The Texas-selected number of rate cells is similar to the selections seen across other states, but should continue to be monitored for credibility or deviations in actual versus expected claims experience.

For each of the six rate development elements, the report provides a detailed description of the methodology and data sources utilized to develop the capitation rates for Texas, followed by comparisons to methods used in other states.

1.2. MCO Selection

Within Medicaid Managed Care programs, states contract with MCOs and providers to deliver services to their members. In the past, states contracted with any MCO that met the state's requirements ("any willing provider"). More recently, states have started creating more rigorous selection processes, including evaluating MCOs based on additional components such as the services they provide, adequacy of their provider networks, and administrative costs and claims costs, and then deciding on whether to contract with the MCO. The process of a state deciding with whom it will contract is referred to as competitive bidding.

There are typically four types of MCO selection processes that states use to determine their contracted MCOs. For the purposes of this analysis, the four types of MCO selection processes have been defined as: "Any-willing-provider," competitive bidding with technical component, competitive bidding with nonmedical cost component only, and competitive bidding with full cost component. Competitive bidding with a technical component is the simplest form of competitive bidding, which allows states to be selective with whom they contract, but the state still has full control over the development of the rates. Texas currently chooses to contract with MCOs based on competitive bidding with a technical component.

Even when states follow one of these processes, there may be additional situations that can guide the selection process, such as a desire by the state to have more than one MCO in each region or service area, the distribution of members across regions of the state, and health care delivery models.

The review of MCO selection across other states identified five considerations when reviewing the states utilizing competitive bidding processes:

1. **Number of MCOs:** Some states use competitive bidding to reduce the number of MCOs in the state or to incentivize competition by guaranteeing a certain number of MCOs within each region of the state.
2. **Published Rate Range:** Within a state's request for proposal (RFP) process, they can elect to publish a rate range for MCOs to reference and also provide MCOs with enough data and information to develop the rates on their own. If a rate range is published, a majority of the state's actuarial analysis needs to be completed before procurement, creating a larger gap between procurement, MCO selection, and rating period effective dates.
3. **Adjustments to Submitted Bids:** Often in procurements utilizing competitive bidding with a cost component, the submitted MCO bids may

require an adjustment after submission due to program changes or other experiences that occur prior to the effective date of the contract, but after the bids were accepted. Most states calculate these adjustments internally and then apply the adjustments to the MCO-submitted bids. In other instances, certain factors may be published with the RFP, so that the MCOs can incorporate them into their bid development.

4. **Procurement and Ongoing Administrative Costs:** There are additional procurement costs involved with releasing and scoring an RFP, including the time to develop and evaluate the RFP, as well as the ongoing implications of maintaining more rates than States have in the past, due to MCO-specific rates.
5. **Cost Savings**: While cost savings are likely to have some impact on the reasoning for states to shift to a competitive bidding model, there are no known studies to support cost savings. Although, through the RFP process, states may choose to offer MCOs with the lowest bid a greater portion of assigned members, otherwise known as auto-assigned lives, which can motivate MCOs to achieve larger membership at a lower cost to the state.

1.3. Reimbursement Arrangements

Texas's reimbursement arrangements are similar to other states that have carved the majority of their Medicaid members into managed care. The State of Texas should consider analyzing whether it should continue to transfer in additional populations, while balancing considerations on cost effectiveness, quality of care, and access to care.

2. Introduction

According to the General Appropriations Act for the 2018-19 Biennium, Senate Bill No. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, **Rider 61, Subsection (c))**:

"Out of funds appropriated above, HHSC shall conduct a study of Medicaid Managed Care rate setting processes and methodologies in other states."

States' Medicaid Managed Care programs use varying approaches to select MCOs and establish capitation rates. Based on this language in the Act, the report analyzes methods used to select participating MCOs and the methodologies used to establish managed care capitation rates. Based on discussions with HHSC, the focus of funding mechanisms was based on reimbursement arrangements such as self-funded, fully-funded, and hybrid reimbursement models, and the study will review these arrangements. The findings include the current rate setting methods, reported results, and lessons learned from the states reviewed in the study.

2.1. Background and Purpose

While new CMS managed care regulations have laid the foundation for managed care rate setting principles, there is still variation in rate setting approaches across the country. The rate setting assessment of the current Texas managed care rate development process provides insight into how the rate development process conforms to federal guidelines, differs from other states' methodologies, and aligns with the overarching Texas Medicaid program. Furthermore, the study on rate setting allows consideration for how Texas can account for better predictability in costs, helping support future benefit and budget initiatives.

Within Medicaid Managed Care programs, states contract with MCOs and providers to deliver services to their members. The MCO selection study reviewed the various processes that states are currently utilizing to award contracts to MCOs. This information can be utilized by HHSC as it reviews other potential models for selecting MCOs.

Some states have pursued alternate options to fund their Medicaid programs outside of traditional fee-for-service (FFS) and at-risk MCO capitation models. For example, states are pursuing service carve-outs and value-based care (VBC) reimbursement mechanisms as methods to incentivize new member and certain provider behaviors. An assessment of the current inventory of reimbursement arrangements used in other states

was conducted, accounting for insured, self-insured, and hybrid funding models.

Pursuant to Rider 61(c), this review focuses on managed care rate setting processes in Texas and other states, including consideration of the reimbursement arrangements, the processes utilized to select and procure MCOs, and the approach used to set capitation rates. While CMS has outlined guidance in the managed care environment, methodology variations across states still exist. Therefore, the study also highlights different methodologies used across the country and opportunities for HHSC's consideration.

2.2. Approach

The overall approach to accomplish the goals of Rider 61(c) involved two primary tasks: gathering and reviewing available information, and summarizing and comparing the methodologies of rate setting, MCO selection, and reimbursement arrangements. An outline of the steps taken to complete the report is as follows:

2.2.1. Review of Managed Care Rate Setting Methodologies

1. **Gather Information:** HHSC provided historical rate setting certifications for all Medicaid Managed Care programs in Texas. Rate setting certifications for other states that were selected for comparison were gathered by conducting research for publicly-available documentation. When rate development documentation for the identified states was not publicly-available, state relationships and rate setting experience in these states was leveraged to support the data collection process. In addition, the CMS Medicaid Managed Care Final Rule (42 CFR 438), and the applicable Actuarial Standards of Practice (ASOPs) on Medicaid rate development were referenced.
2. **Compare Rate Setting Methodologies:** Rate setting experience across the country, knowledge of the current Texas MCO environment, and prior experience in program evaluation support was leveraged to summarize and document procedures for developing, adjusting, and applying the various components of capitation rates, highlighting potential areas of opportunity for Texas.

2.2.2. Study of MCO Selection Processes

1. **Gather Information:** Publicly-available MCO procurement information for states identified as comparable to Texas was collected. In addition, responses from the "Managed Care Pricing Models" Request for Information (RFI) released by HHSC to the current participating Texas Medicaid MCOs and other state Medicaid programs were reviewed.
2. **Summarize MCO Selection Processes:** Data from MCO selection processes, including competitive bid arrangements, variation in the selection process by Medicaid population, contracting requirements, and competition requirements, were consolidated and documented.

2.2.3. Research Reimbursement Arrangements Utilized

1. **Gather Information:** Data for reimbursement arrangements was collected utilizing client relationships, subscription services, and publicly-available information.
2. **Document other states' reimbursement arrangements:** Inventory of reimbursement arrangements used in other states, accounting for insured, self-insured, and hybrid reimbursement arrangements, was documented.

2.3. Data Sources

The rate setting study relied on data provided by HHSC, as well as publicly-available data. From the data provided by HHSC, some of these data sources were developed by HHSC, while others were prepared or created by third parties and delivered to HHSC.

As part of the study, the data received was reviewed for reasonableness, but an audit of the data was not performed. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be impacted by those issues. In certain cases, the data is audited or reviewed by other sources, and the results and any conclusions from those reviews were considered in determining whether the data was reasonable for use in this report.

A summary of key data items received from HHSC or located via publicly available sources and used in the study performed under Rider 61(c) is as follows. Additional detail on data sources can be found in the **Appendix.**

Figure 2. Data Sources.

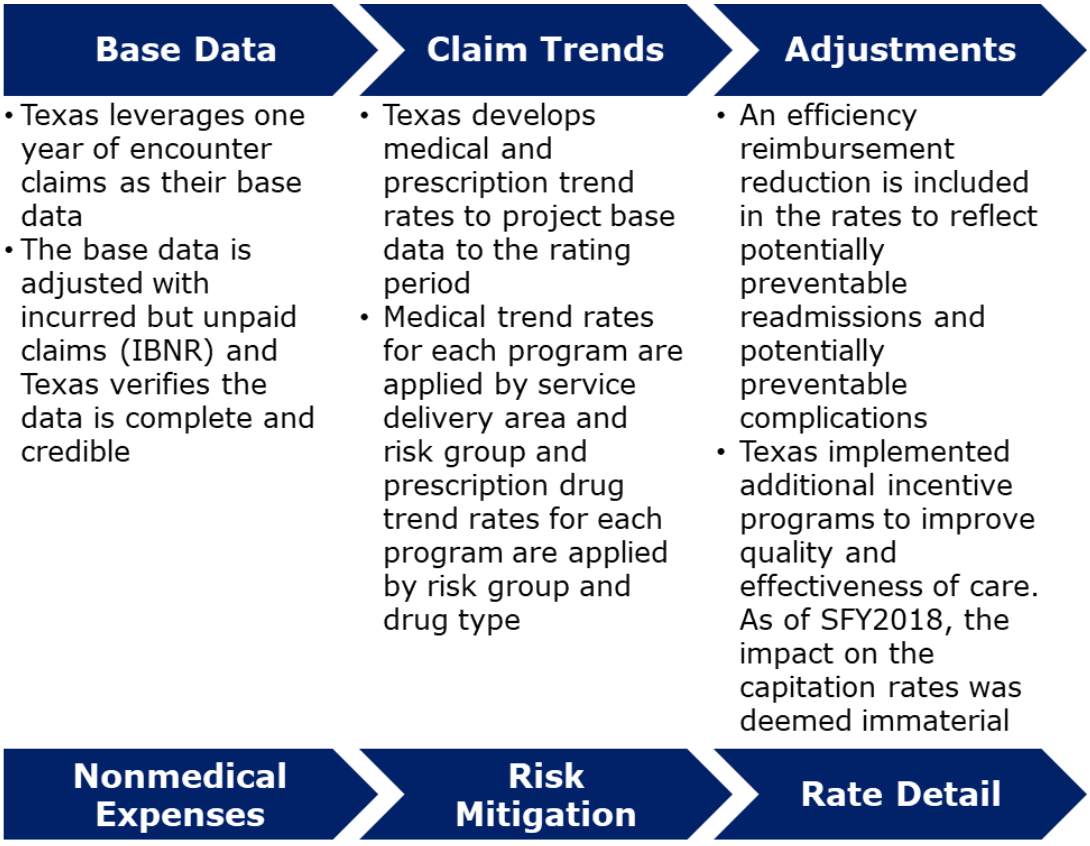
Report Section	Data Sources	Description
Rate Development	Actuarial Rate Setting Certifications	Publicly available actuarial rate setting certifications for Texas and other states were researched and utilized for the analysis.
Rate Development	CMS 2017-2018 Medicaid Managed Care Rate Development Guide and Actuarial Standards of Practice (ASOP) No. 49	Standard rate setting guidance documents were utilized to document recommended rate setting methodology.
MCO Selection	Responses from the Texas RFI on Managed Care Pricing Models	RFI responses from Amerigroup, AmeriHealth, BCBS of Texas, UnitedHealthcare, and WellCare were reviewed and utilized for the analysis.
MCO Selection	Medicaid.gov	Medicaid Managed Care summaries by state from Medicaid.gov
MCO Selection	MCO selection research	Various publicly available sources
Reimbursement Arrangements	Reimbursement arrangement research	Various publicly available sources
Summary of Opportunities	All analyses of data sources used above	

3. Rate Development

3.1. Texas Rate Setting Overview

HHSC hired Rudd and Wisdom, Inc. as their actuary to assist in the development of the SFY2018 capitation rates for the Texas Medicaid Managed Care programs. The figure below provides an overview of the steps taken to develop their capitation rates.

Figure 3. Texas Rate Setting Overview.



3.2. Base Data

Base data is the historical data set that serves as a starting point for the development of capitation rates in determining an estimate of future claims experience. This section reviews the components of base data for Texas's capitation rate development across its managed care programs, as well as components of base data utilized by other states.

3.2.1. Data Sources Used

Actuaries determine the appropriate base data by using historical data that is relevant to the given Medicaid population and program in which the capitation rates are being developed. Managed care encounter data, financial reports, subcapitation payment information, and provider settlement payment reports are all examples of reasonable MCO data sources.

3.2.1.1. Actuarial/CMS Guidance

When possible, CMS encourages states and their actuaries to utilize the most recent three years of validated managed care encounter data when developing the capitation rates. Encounter data records are the detailed records of services delivered to Medicaid members and are submitted by the managed care organizations. Alternative data sources may need to be used if the managed care program is new or if there were recent changes to carved-out services. In these instances, FFS data, summary claims data reports, and experience from other states would be examples of reasonable data sources for rate setting. In specific cases where the population is new to managed care, data sources for similar populations should be identified and appropriate adjustments should be made.

3.2.1.2. Texas

Because of Texas's long history with managed care and overall quality of the managed care encounter data, the rate development for the majority of their programs is based primarily on managed care encounter data. However, there are exceptions for less mature programs such as the Adoption Assistance and Permanency Care Assistance for the STAR program, Medicaid Breast and Cervical Cancer Program for STAR+PLUS members, and members in the STAR Health program on hospice care. Additionally, since the STAR Kids program was implemented in November 2016, historical FFS data was referenced. When determining the appropriate base data for rate setting, HHSC and its consulting actuary compared three sources of claims data to verify consistency: encounter data, MCO summary reports, and

FSRs. Encounter data provides claims detail at the most granular level, including claim-level provider, procedure, and diagnosis information. MCO summary reports provide further detail on subcapitated expenses, claim lag data, and other medical expenses. FSR data provides high-level information of claims data, subcapitated expenses, reinsurance expenses, and administrative expenses. By examining each of these sources with various levels of detail, the State's actuary along with HHSC and the External Quality Review Organization (EQRO) determined that data sources for all programs for the SFY2018 capitation rates are complete and credible.

3.2.1.3. Other States

States that are new to managed care or those that have new programs in managed care, similar to the STAR Kids program in Texas, tend to use FFS claims data or raw claims data reports in combination *with* their encounter data until the encounter data for the new managed care population is credible, accurate, and complete. For example, Kentucky analyzed its encounter data, but determined it was incomplete and referenced MCO-submitted claims data for rate setting purposes. Nevada and Pennsylvania are working toward transitioning completely to encounter data, but for now, they still reference their FFS and MCO-submitted claims data. South Carolina primarily uses encounter data; however, it references FFS claims data for certain risk groups with limited experience.

Of the 18 states reviewed, the data sources utilized across each state's most common or most populated Medicaid programs were distributed as follows:

- Nine states primarily use encounter data, including Texas
- Two states primarily use FFS data
- Four states use a combination of encounter data and FFS data
- Two states use detailed claims data

Figure 4. States' Primary Source of Base Data.

State	Managed Care Encounter Data	FFS Claims Data	Health Plan Financial Data	Other Medicaid Program Data
Texas	✓		✓	MCO summary reports, including claim lag data and subcapitated expenses
Colorado	✓			
Florida	✓	✓	✓	
Georgia	✓			
Illinois		✓		
Kentucky			✓	MCO-submitted claims data, eligibility data, and nonsystem payments (nonclaims)
Mississippi	✓	✓	✓	
Nevada			✓	Detailed claims data and eligibility data
New Hampshire		✓		Eligibility data
New Mexico	✓		✓	Experience data
New York	✓		✓	
Oregon	✓			Subcapitated expenditures and supplemental payments
Pennsylvania	✓	✓	✓	
South Carolina	✓			
Tennessee	✓			Claims data, aggregate data by rate cell, and capitated payments and recoveries
Virginia	✓			Subcapitated vendor payments and eligibility data
Washington	✓	✓	✓	
Wisconsin	✓		✓	

3.2.2. Service Carve-outs

States can determine the range of services they offer under managed care. Often, the decision to carve-out or exclude services from their managed care capitation rates is driven by program policy; however, in some instances, the decision may be made from a rate setting perspective. For example, some states may choose to carve-out services from the capitation rates due to volatility of claims or limited credibility of data. Examples of services that are commonly carved-out include behavioral health and dental services, as well as high-cost specialty drug services. Typically, when services are carved-out of the managed care capitation rate, the service will then be covered on a FFS or contractual basis. Another method some states use is to include these types of services in the capitated rate, but reconcile the amount included in the capitation payment to the actual costs at the end of the fiscal year.

3.2.2.1. Actuarial/CMS Guidance

CMS allows states to determine which services are carved-out of managed care. States should ensure the base data excludes any services that are carved-out of managed care when developing capitation rates.

3.2.2.2. Texas

Within Texas's managed care capitation rates, antiviral drugs used for the treatment of Hepatitis C and the drug Orkambi, used to treat cystic fibrosis, were carved-out across most programs for SFY2018 and were not covered under the capitation rates. While these drugs were carved out for SFY2018, the specific drugs that are carved out of the capitation rates often vary year by year as determined during rate development. Texas also has several other service carve-outs that are program-specific, such as hospice services.

3.2.2.3. Other States

With the recent emergence of high-cost specialty drugs that are often used to treat rare diseases for a small subset of the Medicaid population, states, and their actuaries are reviewing alternate payment methods, such as high-cost drug pools, value-based drug rebates to lower the net price at the NDC level, or reimbursement on a per-treatment basis due to the overall volatility and lack of credible experience. A more recent example of this type of carve-out is for hemophilia treatment. Mississippi, along with other states, excludes the treatment for this disease from its managed care program, resulting in these services being covered by the Medicaid FFS system. Gene therapy treatment is a new emerging procedure, which is a high-cost

service, often performed in a hospital setting. This type of treatment is challenging from a rate setting perspective as it is not common and only certain subsets of hospitals are equipped to provide the service, which can cause challenges when developing regional or statewide rating assumptions.

Rate setting approaches for these types of services are still being monitored, but it is anticipated that states and their actuaries will continue to develop alternate reimbursement procedures or reconciliation processes in the interim, until more credible data is established.

3.2.3. Base Data Time Period

Base data is the historical data set that serves as a starting point for the development of capitation rates in determining an estimate of future claims experience. This section reviews the time periods and the number of years utilized for base data by Texas and other states.

3.2.3.1. Actuarial/CMS Guidance

Rate setting guidance provided by CMS specifies that the base data used for developing capitation rates should be based on data that is not older than the three most recent and complete years prior to the rating period. Alternate base periods and number of years can be selected for various populations and programs depending on population, or the credibility of the data available, and states and their actuaries may request to use other data under special circumstances.

3.2.3.2. Texas

Like the majority of other states reviewed, Texas elected to reference a one-year period for base data experience, varying the time periods of the data between medical and prescription drug data. The base period selected for the medical component of the SFY2018 capitation rates was SFY2016. Due to the faster claims payment runout for prescription drug claims, more recent calendar year (CY) 2016 data was selected as the base data for the prescription drug component of the capitation rates. This approach was consistent across all programs, with the exception of the Texas Dual Eligible Integrated Care Demonstration Project which used SFY2016 for both medical and prescription drug capitation rates.

3.2.3.3. Other States

While the base data selection often varied across states depending on the program and population, most other states reviewed use a one-year period

for base data experience or aggregated two years of data in certain circumstances. For example, of Nevada's two MCOs, one had complete encounters and subcapitated arrangements in CY2015 but not for CY2016. However, the Nevada and their actuary determined the more recent time period was still reliable, so they chose to use both years of data.

Utilizing a one-year period for base data experience results in simplifying further adjustments needed in the rate setting process. For example, using a one-year period for base data typically makes the process of applying trend rates and various data adjustments less complicated, since only one year of experience needs to be considered when making the adjustments rather than having to account for how those adjustments may vary across multiple years of base data. However, it is important to note that while many states and actuaries elect one to two years of data for the base data period, often additional periods of data are often analyzed when developing trends as discussed further in **Section 3.3 Trends.**

Figure 5. Summary of Years of Data Used by Other States.

State	One Year	Two Years	More than Two Years
Texas	✓		
Colorado	✓		
Florida	✓		
Georgia	✓		
Illinois		✓	
Kentucky	✓		
Mississippi	✓		
Nevada		✓	
New Hampshire		✓	
New Mexico	✓		
New York		✓	
Oregon	✓		
Pennsylvania	✓		
South Carolina	✓		
Tennessee			✓
Virginia		✓	
Washington	✓		
Wisconsin		✓	

3.2.4. Data Blending Methods

When states select base period data of more than one year, they often blend the various years of data based on the reliability and accuracy each year, with considerations that the most recent data is typically more closely aligned to the rating period.

Common data blending methods include applying equal weights to each year of data (such as a 50/50 percent blend), utilizing member months from the experience periods to calculate weights for each year of data, and applying more credibility weight to the most recent year of data. Another consideration when blending multiple periods of data or data sources is the volatility of each data period. For example, states and their actuaries may determine both periods of data are fully credible, but may apply credibility weightings in a nonequal manner to attempt to smooth or normalize volatility in the data. This approach is more common in instances when services or populations have shifted across the base period or when claims expenditure costs have abnormally increased or decreased abnormally during a certain time period.

3.2.4.1. Actuarial/CMS Guidance

While actuarial guidance states that base data may span more than one year, no specific guidance is provided regarding data blending methods across multiple years of base data is provided.

3.2.4.2. Texas

Texas did not utilize data blending in its managed care capitation rate development, as it used a one-year period for its base data selection.

3.2.4.3. Other States

Across the states that were reviewed, examples of each common data blending method were utilized. For example, Illinois chose to blend each base year period with equal weight. Nevada chose to weight each year differently based on the three populations covered: Temporary Assistance for Needy Families (TANF)/CHIP, Check-up (Children under Nevada's Children's Health Insurance Program (CHIP) expansion), and Expansion. For the first two populations, Nevada weighted CY2016 as 55 percent and CY2015 as 45 percent, placing more reliability on the more recent time period, while still using a full 24-month period of data. However, Nevada chose to weigh the expansion population as 100 percent on CY2016 because of market fluctuations over CY2015. Wisconsin blended projected claims by

categories and regions, weighing the two encounter data years based on member month volume in each period.

3.2.5. Base Data Adjustments

States must validate their base data for completeness, accuracy, and consistency across data sources and make adjustments as necessary to ensure that complete and accurate base data is used for capitation rate development.

3.2.5.1. Actuarial/CMS Guidance

Actuarial guidance recommends that actuaries consider base data adjustments to account for data issues or changes such as:

- Missing data
- Incomplete data
- Population shifting
- Funding or service carve-outs
- Retroactive eligibility
- Data smoothing

3.2.5.2. Texas

Texas's base period data includes an adjustment for incomplete data to estimate IBNR claims, which were incurred through August 31, 2016, with payments made through January 2017, or more recent, depending on the program. IBNR adjustments are an estimate of the services that have occurred, but have not yet been reported in the data. The completed data is also reviewed by each MCO to understand any MCO-specific variations in the data. For the SFY2018 rate setting process, Texas and its consulting actuary determined no additional base data adjustments were necessary. As noted in **Section 3.4 Adjustments**, additional adjustments were incorporated in the rate setting process to reflect program, benefit, and policy changes.

3.2.5.3. Other States

Like Texas, most states apply completion factors to their base data through IBNR data adjustments. Once this adjustment has been included, states and their actuaries review the data further to determine if additional adjustments need to be made to assure accuracy and credibility of the data. Other common adjustments include those to more appropriately align encounter

data with MCO-submitted financial reports, and adjustments to smooth the data for high-cost claims outliers that are not anticipated to occur in the future.

Some states deemed that additional base data adjustments beyond IBNR adjustments were necessary. Colorado conducted data smoothing by reviewing the volume of claims and total expenditures longitudinally. They used moving averages of previous months to ensure that any gaps or spikes in the data were identified and smoothed. Virginia adjusted for credibility by data smoothing across program categories, member ages, and regions for smaller rate cells that were not considered credible on their own. By referencing financial reports, Oregon identified two necessary adjustments to their base data, including a reconciliation adjustment and a claims underreporting adjustment. The reconciliation adjustment updated the raw encounter data for specific costs known to be missing and removed the impact of subcapitated encounters. The underreported adjustment accounted for costs that were underreported in the encounter data.

3.2.6. Base Data Findings/Conclusions

The approach utilized by Texas and its consulting actuary to select and develop the base data is consistent with most states that were reviewed. Key similarities between Texas's approach and the approaches utilized by other states include:

- **Data Quality:** Texas references three different data sources to verify the most complete and accurate data is used to set the managed care capitation rates. The credibility and completeness of the underlying base data is of utmost importance in the rate development process. Texas's approach of reviewing multiple data sources to verify encounter data completeness is a leading practice.
- **One-Year Base Period:** Like the majority of states that were reviewed, Texas utilizes a one-year period for base data. This method simplifies further adjustments in the rate setting process, as blending across multiple years is not needed.

The base data components with the most variation in methodology across the states that were reviewed were the service carve-outs. As noted earlier, variation on base data carve-outs is expected, as many are state-specific or are policy-driven decisions. However, Texas should continue to consider the claims experience, especially high-cost prescription drugs, to determine if further changes to the approach are appropriate in light of emerging drugs. As carving-out certain services into FFS may increase administrative

complexities, Texas may want to consider certain services such as high-cost prescription drug treatments within the capitation rates, but implementing risk corridors or other risk-neutral pools within the rate development process in order to keep the services within managed care.

3.3. Claim Trends

Claim trends are a series of assumptions used to project base data from the historical base period to the current rating period. Trend assumptions should be developed from actual experience of the Medicaid population or from a similar population, and include consideration of other factors that may affect projected claim cost trends through the rating period. The assumptions account for various changes, including within the population, benefits, price and utilization, and other adjustments. The assumptions should not include adjustments captured elsewhere in the capitation rate development.

3.3.1. Trend Development Sources

States typically use a combination of sources to develop their claims trends. These sources commonly include historical trends from Medicaid population experience, as well as external trend projections and influences, including trend projections from the CMS National Health Expenditures (NHE) report.

3.3.1.1. Actuarial/CMS Guidance

CMS guidance states that trend assumptions must be developed primarily from actual experience of the Medicaid population or from a similar population. Trend assumptions may also include consideration of other factors that may affect projected benefit cost trends through the rating period.

3.3.1.2. Texas

Texas references the MCOs' claims experience data to develop the medical trend rate assumptions. Utilization and unit cost data are analyzed by risk group, summarized at the service delivery area and on a statewide basis. The emerging program results are combined with the past three years of historical trend information when developing each program's final aggregate medical trend assumption. The medical trends for each program vary by risk group and service delivery area.

Similarly, for prescription drug trends, Texas summarizes historical utilization and unit cost data by risk group and reviews on a statewide basis. Adjustments are incorporated to reflect the impact of high-cost drugs and drugs currently carved-out of the capitation rates, such as Hepatitis C treatments. The projected trends are developed based on a multiyear average of historical results and emerging experience. The assumptions are developed on a statewide basis by risk group for each program.

3.3.1.3. Other States

While historical data is a common source for trend rates, and a preferred method by CMS as outlined in the managed care regulations, other states also supplement historical experience with other data sources. For example, Kentucky uses projected trends submitted by the MCOs, and several states reference CMS's NHE projections in addition to their own data.

A summary of the various sources used by comparable states is as follows:

Figure 6. Trend Development Sources.

State	Historical Data/ Trends	Other States Data/ Trends	CMS NHE Projections	Other
Texas	✓			
Colorado	✓	✓		External influences
Florida			✓	
Georgia	✓			MCO expected trends
Illinois	✓		✓	
Kentucky	✓	✓	✓	MCO predicted trends, pharmacy benefit management (PBM) trends, and Hepatitis C treatment trends
Mississippi	✓	✓		
Nevada	✓		✓	
Oregon	✓			Financial data and supplemental information by MCO
Pennsylvania	✓	✓	✓	Market changes, financial reports, and CPI report
South Carolina	✓		✓	Express Scripts trend reports
Tennessee	✓			
Virginia	✓			
Washington	✓	✓		
Wisconsin	✓			2015 Actuarial Report on the Financial Outlook for Medicaid

3.3.2. Trend Rate Detail

PMPM trends are used to project claims costs to the rating period based on the expected change in PMPM claims cost from the previous periods. Change in utilization captures changes in how frequently services are being used

such that the amount or duration along with changes in services provided. Unit cost not only adjusts for pure price change but can also incorporate changes in MCOs' contracts with providers, program changes, or payment models. States may elect to apply unit cost and utilization trends separately, apply combined unit cost and utilization trends in the form of a PMPM trend, or leverage a hybrid approach applying unit cost and utilization trends for certain services and a PMPM approach for other services.

3.3.2.1. Actuarial/CMS Guidance

CMS guidance states that trend rates may be developed utilizing an aggregate PMPM trend rate or a combination of unit cost and utilization trend rates.

3.3.2.2. Texas

Texas applies trend assumptions that combine the impact of inflation and utilization. For both cost and utilization trends, Texas analyzes the trends by program, risk group, and service category to determine a combined aggregate medical trend rate. Texas's focus for this analysis is on utilization changes, as unit cost changes are primarily driven by provider reimbursement changes. Additional detail on provider reimbursement, program, benefit, and population changes can be found in Section 3.4 Adjustments.

3.3.2.3. Other States

The application of trends varies across states, as many states elect to apply unit cost and utilization trends separately, or at times they may utilize a hybrid approach and leverage unit cost and utilization trends for certain services and a PMPM approach for other services. A PMPM approach considers both unit cost and utilization trends; however, the trends are applied after the unit cost and utilization trends have been combined.

Figure 7. Trend Rate Detail.

State	Unit Cost/Utilization	PMPM
Texas	✓	✓ (for Medical)
Colorado	✓	✓
Florida	✓	✓ (for Pharmacy)
Georgia	✓	
Illinois		✓
Kentucky	✓	✓
Mississippi	✓	
Nevada	✓	✓ (for Pharmacy)
New Hampshire	✓	
Oregon	✓	✓
Pennsylvania	✓	
South Carolina	✓	✓ (for Pharmacy)
Tennessee	✓	
Virginia	✓	
Washington	✓	✓
Wisconsin	✓	

3.3.3. Calculation of Trend Rates

States typically develop separate trend rates for medical and pharmacy services; however, when calculating the rates, states develop trend rates by different cohorts, such as by service category, region, or risk group. Additionally, some states develop trend rates on a PMPM basis, while other states develop both utilization trend rates and unit cost trend rates to develop the aggregate trend rate. Managed care guidance developed by CMS requests that the actuarial certifications include a breakdown of unit cost and utilization trends; however, the overall development and application of the trends is subject to actuarial judgment.

3.3.3.1. Actuarial/CMS Guidance

Actuarial guidance states that multiple elements should be considered when establishing trends in utilization, unit cost, or in total. Utilization trends may

be affected by demographic, benefit, and policy or program changes while unit cost trends may be affected by reimbursement schedules, FFS schedules, and provider contracting. The trend rates should not include adjustments applied within the capitation rate development.

3.3.3.2. Calculation of Medical Trend Rates

Medical trend rates can be developed through a variety of methodologies. Some states choose to create their own methodology, while other states utilize industry tools. States typically utilize various regression models to combine and project years of data forward to the projection period, calculating the trend rates needed to arrive at the projections. It is also common for states to make adjustments to trends based on the available data, such as combining smaller populations into larger cohorts.

3.3.3.2.1. Texas

Texas reviewed its MCOs' claims experience by service delivery area and risk group to develop the trend factors used to adjust the base period two years forward, SFY2017 and SFY2018, to the projection rating period. The SFY2017 trend rates were developed based on the actual estimated trends by service delivery area and projected trends weighted from the past four years. These were applied by service delivery area and risk group. The SFY2018 trend rates were developed on a statewide basis by averaging the annual trends from the previous four fiscal years. These trends were applied statewide by risk group. The trend rates for each fiscal year were applied separately.

3.3.3.2.2. Other States

Nevada used a Relative Value Unit tool to convert utilization to a relative value unit (RVU), allowing for a more direct comparison of intensity and required resources among services. The experience was then summarized by utilization (RVUs), cost per RVU, and PMPM amounts. Finally, a regression model was applied to each of these categories grouped by population and service category and trend rates were chosen based on a comparison of the trend rates from the regression analysis to the calculated trend rates from the previous period.

As an alternative to industry tools, states often review results using various methods of linear regression. Results can be reviewed on a monthly, quarterly, or annual basis, with credibility assumptions applied to various scenarios. For programs with larger or more stable populations, the medical experience can be analyzed in greater detail at the service category level,

with final trend assumptions being developed by service category when deemed credible.

3.3.3.3. Calculation of Pharmacy Trend Rates

States consider a variety of components when developing their pharmacy rates, including drug types and brand versus generic costs, as well as brand patent loss timing. Due to large variety among prescription drug cost and utilization, it is common for states to adjust their trends based on anomalies within their experience data or remove outlier drugs from their projections.

3.3.3.3.1. Texas

For pharmacy trend rates, Texas reviewed recent pharmacy claims data by program and developed average utilization and cost per service statistics by risk group and drug type (brand, generic, and specialty) for each of the five most recent 12-month periods. The periods were weighted based on the most recent time frame to the projection period. The final trend rate assumptions were developed by applying the utilization and cost trend by individual drug type to actual experience during the 12-month period and combining the results into a single trend assumption for each risk group. These rates project the base data period to the projection rate period. In SFY2018 Hepatitis C and Orkambi were not included in the trend analysis since these drugs are carved-out of the capitation rates. In addition, Tamiflu is not included in the trend analysis due to large variations in flu season from year to year. Makena was also excluded due to an increase in utilization from the US Food and Drug Administration expanding the patent on the drug.

3.3.3.3.2. Other States

South Carolina developed a tool to study and project pharmacy trend information. The tool summarizes claims by month, drug type (brand, generic, specialty brand, and specialty generic), covered population, and therapeutic class. South Carolina also considered variables such as brand patent loss, changes in cost per script, changes in utilization, and recently released high-cost drugs and developed the rates by population and service category. Like Texas, South Carolina adjusted its rates for anomalies such as the impact of Spinraza and Exondys-51, which are not reflected in their experience data, as well as an increase to certain populations for the higher utilization of Makena.

Although states often review medical and pharmacy trend rates at more granular levels, they may ultimately apply the trend rates to the base data at more aggregate levels. The figure below summarizes the level of detail at which states applied their trends:

Figure 8. Application of Trends.

State	Medical Service Category for Medical	Region for Medical	Population/ Risk Group for Medical	Drug Type for Pharmacy	Pharmacy Service Category	Risk Group for Pharmacy
Texas		✓	✓	✓		✓
Colorado	✓	✓	✓			
Georgia	✓					✓
Illinois	✓					
Mississippi	✓		✓			✓
New Hampshire	✓		✓			
Oregon	✓		✓			
Pennsylvania	✓		✓			
South Carolina	✓		✓		✓	✓
Tennessee	✓		✓			
Virginia	✓		✓			
Washington	✓		✓			
Wisconsin	✓					

3.3.4. Claim Cost Trends Findings/Conclusions

Texas's trend rate assumption development is similar to other states. The use of historical data is a method preferred by CMS and an approach which Texas has been using for many years for the more mature managed care programs. Additionally, the application of medical trends by risk group and service delivery area is a useful method in capturing the difference in claims experience across populations and geographic regions.

Texas should continue to closely monitor emerging program experience and perform deeper trend analyses as necessary. For medical services, Texas could consider developing trend assumptions at a more granular service category level, building off their current process which already incorporates a review of the trend results by service category when determining the final aggregate trends. While the credibility of the results at the risk group level would need to be considered, an analysis of service category detail may help more effectively identify emerging program changes, which can be incorporated into the capitation rates. For the prescription drug assumptions, as new high-cost drugs continue to hit the market, a deeper analysis by drug type may allow Texas to incorporate trend adjustments for influences such as generic dispensing rates and lower-cost brand alternatives.

An additional consideration is to revisit the amount of historical data that is utilized in the trend development. Currently, Texas utilizes three to four years of historical trend data when developing the projected trend assumptions. Given the trend assumptions utilized in rate development are applied prospectively, Texas should monitor how trends have evolved over time and whether program results from three to four years back are an appropriate indicator of future program performance. As the program evolves, more credibility could be applied to the emerging program experience and validated with external industry trend sources.

3.4. Adjustments

States may make additional adjustments to base data in order to develop rates that best fit their programs, populations, and covered services. These adjustments may be made to reflect retroactive changes that occurred during the base period, interim period adjustments that reflect changes that occurred between the base period and rating period, and prospective adjustments to reflect changes that are expected to occur during the rating period. Typically, these adjustments vary across states due to differences among programs and covered services. For example, as states introduce new benefits or expand Medicaid Managed Care to new populations, several adjustments may be necessary to align the base data with services and populations that will be covered in the rating period. In Texas, similar adjustments have been made historically as the STAR and STAR+PLUS programs have expanded.

In addition to adjustments to reflect changes to the Medicaid program, population, or covered services, states are often incorporating adjustments to promote greater efficiency or increased quality within their Medicaid programs. These adjustments include those for efficiency or managed care savings, reimbursement incentives, and payment withhold arrangements. The application of these adjustments can be compared across states and are the focus of this section.

3.4.1. Efficiency Adjustments

Efficiency adjustments are based on the expectation that managed care programs and the MCOs continue to improve value of care for the total cost, typically leading to an assumed reduction of claim costs built into the capitation rates. The adjustment reflects the difference between base experience and expected levels of cost and utilization as the managed care program continues to mature. States can develop their own methodology to calculate this adjustment or leverage developed algorithms.

When managed care programs are new, explicit savings are often assumed within their capitation rate development for the expected efficiency that the managed care program will produce in comparison to FFS. These adjustments are often applied directly as a managed care savings adjustment and can vary between one and 20 percent depending on the assumed impact the managed care transition will have on the underlying program. Texas has utilized similar explicit managed care savings adjustments historically as managed care expanded, for example, as STAR+PLUS was introduced, explicit acute and Long Term Services and

Supports savings assumptions were incorporated into the capitation rate development.

3.4.1.1. Actuarial/CMS Guidance

Actuarial guidance states that managed care adjustments may be applied to the base data. These adjustments are typically based on the assumption that the program will move from the level of managed care seen in the underlying base data to a different level of managed care during the rating period. The adjustments may be to utilization, unit cost, or both and the changes reflected in the adjustments should be attainable in the rating period.

3.4.1.2. Texas

As the programs evolve and mature, states need to look elsewhere for savings. Commonly, states look for efficiencies within their program such as analyzing potentially preventable events to drive further savings adjustments within the rate development process. Texas's current efforts for savings include efficiency reimbursement reductions within the rate setting process to reflect potential savings as a result of reducing potentially preventable readmissions and potentially preventable complications. Since the implementation of these adjustments in May 2013 or March 2014 across all programs except the Dual Demonstration program, the resulting impact of each adjustment is based upon actual MCO experience and applied as percentage reduction between one and 2.5 percent. Texas also includes other data adjustments when analyzing whether provider payments in the data are reasonable. For example, expenses of known related parties are analyzed to ensure the payments are in line with payments to nonrelated parties, and adjustments are made as needed.

3.4.1.3. Other States

Similarly, South Carolina developed efficiency factors by referencing NYU Center for Health and Public Service Research ED Algorithm and Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators. In conjunction with MCO data, they analyzed potential savings within the emergency room, as well as inpatient hospital services, pharmacy services, and delivery services. Within the emergency room classifications, they apply payment reductions of 10 percent for services identified as nonemergency, five percent for services identified as treatable with primary care, and two percent for preventable/avoidable admissions. Illinois's efficiency adjustments reference Milliman Cost Guidelines and other Milliman

proprietary data, resulting in an aggregate impact of 13.7 percent for nonmaternity capitation rates and five percent for pharmacy. Uniquely, Illinois also adjusts average reimbursement rates to reflect intensity of services due to the management of health care.

While explicit efficiency adjustments are commonly used to drive cost savings and improve the quality of care, as managed care programs continue to mature, states are challenged as the underlying adjustments are not always material. As a result, states have become more aggressive in setting efficiency targets and have also introduced additional incentive and withhold arrangements to drive additional savings and increase quality.

3.4.2. Incentive Program Adjustments

As defined in 42CFR 438.6(a), an incentive arrangement is any payment mechanism under which an MCO may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract. In most cases, states use a percentage add-on amount for their incentive arrangements; however, some states develop programs that provide reimbursement or incentives to drive more care management and efficiencies. These arrangements must be approved by CMS and deemed to be actuarially sound as part of the rate certification process.

3.4.2.1. Actuarial/CMS Guidance

Actuarial guidance states that when incentive arrangements are in place, the actuary should consider how these arrangements will affect the MCOs' costs, including claims and administration costs. The capitation rates should not reflect the value of incentives and the actuary should consider any limitations to the amount of incentive payments specified in legislative regulations or guidance.

3.4.2.2. Texas

Texas implemented the Pay-for-Quality program that provides incentives and disincentives based on managed care performance on certain quality measures. Up to three percent of the managed care premium is at risk in this program. Individual MCOs can receive a penalty, but all recouped dollars are redistributed so that there is a targeted budget neutral impact for the program. Simulations on historic data determined the average impact by MCO was less than 0.1 percent, and therefore, the program does not have a material impact on premium rate development.

Quality-based incentives are common in the rate development process as states move toward value-based reimbursement. Like Texas, Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data are common sources analyzed for quality measurement. For example, Kentucky is analyzing new HEDIS measures and Electronic Health Records to incorporate into incentive arrangements.

Texas also implemented the Network Access Improvement Program for its STAR and STAR+PLUS programs, allowing them to increase availability and effectiveness of primary care for Medicaid members. There arrangements are voluntary and developed between MCOs and hospitals. Therefore, not all MCOs participate and not all rates are affected. For participating MCOs, this adjustment impacts all risk groups excluding Dual Demonstration, Nursing Facility, Medicaid Breast and Cervical Cancer Program, and Adoption Assistance or Permanency Care Assistance, and is made on a PMPM basis. Additionally, Texas implemented the Quality Incentive Payment Program (QIPP) for nursing facilities. This program encourages nursing facilities to improve the quality and innovation of services using the CMS 5-star rating system as a measure for success. HHSC makes payouts to nursing facilities based on quality measures' comparison to the baseline.

3.4.2.3. Other States

Washington uses a safety net assessment fund as increased funding for inpatient and outpatient payments for select hospitals. This adjustment is based on expected hospital costs and is included as a PMPM load. Similarly, Mississippi developed the Mississippi Hospital Access Program (MHAP) to help ensure access to inpatient hospital services. The result is enhanced hospital reimbursement in capitation rates and an annual reimbursement for MCOs to provide to individual hospitals. Funding for MHAP is received through a broad-based hospital assessment.

3.4.3. Withhold Arrangement Adjustments

As defined in 42 CFR 438.6(a), a withhold arrangement is any payment mechanism under which a portion of a capitation rate is withheld from an MCO, and a portion of or all of the withheld amount will be paid to the MCO for meeting targets specified in the contract. Like, incentive arrangements, any withhold included in the capitation rates must be deemed actuarially sound.

3.4.3.1. Actuarial/CMS Guidance

Actuarial guidance states that when withhold arrangements are in place, the actuary should consider how these arrangements will affect the MCO costs, including claims and administration costs. Alternative to incentive payments, the capitation rates should reflect the value of the portion of the withholds for targets that the MCOs can reasonably achieve.

3.4.3.2. Texas

Texas currently included a withhold for the Dual Demonstration program where a portion of premium is withheld upfront for contract specific quality thresholds.

3.4.3.3. Other States

Other states develop withholds, typically ranging from one to 2.5 percent to pay their MCOs for their performance. Withholds are utilized when reviewing performance measures such as potentially preventable events, in addition to quality-based performance. South Carolina has a quality withhold measure, which evaluates quality based on performance in diabetes care, women's health, and pediatric preventative care. Illinois returns the withhold payments to MCOs based on meeting quality and/or reporting measure improvements.

3.4.4. Uncommon and Unique Adjustments

In addition to incentive and withhold arrangements to drive efficiencies, cost savings, and increased quality, states also use various other adjustments to personalize capitation rates for their programs. A detailed analysis of prescription drug experience and related adjustments has been an area of increased focus lately across states. As higher-cost drugs, such as those for Hepatitis C treatment, have come off patent or had new lower-cost options enter the marketplace, states have analyzed how quickly MCOs have adopted the lower-cost options. States are incorporating adjustments in instances where they believe higher utilization of lower-cost or generic options can be achieved.

3.4.5. Adjustments Findings/Conclusions

Texas currently incorporates incentive arrangements, efficiency adjustments, and quality adjustments in a similar manner as other states reviewed. Analysis should continue to be performed to review the impact of these adjustments, arrangements, and programs on reducing the rate of growth

for total Medicaid health care expenditures and increasing the quality of the provided services.

Additionally, Texas should continue to closely monitor the emerging prescription drug claims experience as there may be opportunity for additional adjustments if there are variances in managed care performance in utilizing lower-cost alternatives. A deeper analysis on drug utilization, particularly across higher-cost treatments and emerging drugs entering the market can be performed to determine if additional cost savings can be achieved. A withhold or incentive arrangement could be put into place to encourage MCO participation, in addition to explicit efficiency adjustments.

3.5. Nonmedical Expenses

CMS Medicaid Managed Care rate setting guidance states that "the development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital." When determining nonmedical expenses, actuaries should account for characteristics and functions of the MCOs and the Medicaid program, including overall size of the MCO, age and length of time participating in Medicaid, organizational structure, and demographic mix of enrollees.

This section will cover several components of nonmedical expense development, including:

1. Rate Administrative Load
2. Rate Risk Margin
3. MLR Targets and Claw-Back Provisions

3.5.1. Rate Administrative Load

The administrative load is a positive adjustment made to capitation rates based on a program's projected administration costs.

3.5.1.1. Actuarial/CMS Guidance

CMS guidance allows the load to be applied as a percentage of capitation rates or projected benefit costs, as PMPM costs, or as a hybrid of the two.

3.5.1.2. Texas

Texas's administrative load development utilizes a hybrid of a percentage of projected benefit costs and a fixed PMPM amount, with varying values across each program. The administrative load development process utilizes detailed administrative expense information submitted by each MCO through the FSRs, which are subject to audit. The State's FSRs and overall administrative expenses were further reviewed within the Rider 61(d) report. To develop the administrative load, the FSR data from the three most recent fiscal years is used to determine an average administration expense amount. The total amount is then separated into fixed (percentage of capitation rates) and variable (PMPM) components. The fixed and variable components currently do not account for different administrative expense categories, rather they are developed in aggregate to cover all administration costs. This approach

allows the State to assign higher administrative expense loads to the higher cost programs.

In SFY2018, Texas's STAR program included $8.00 PMPM (approximately four percent of total revenue), plus 5.75 percent of gross premium for medical and $1.80 PMPM for pharmacy. CHIP included $8.00 PMPM (approximately six percent of total revenue) for the non-Perinate program and $12.50 PMPM (approximately three percent of total revenue) for the Perinate program, plus 5.75 percent of gross premium, while STAR+PLUS allocated $18.00 PMPM (approximately one percent of total revenue), plus 5.75 percent gross premium for medical and $1.80 PMPM for pharmacy. As discussed further in the **Rider 61(d) Report Section**, Texas has established an experience rebate profit-sharing mechanism, which requires MCOs to return a portion of net income if it exceeds three percent of revenue. The administrative expense component of the profit-sharing mechanism is capped at the predetermined amounts incorporated into the capitation rates. For example, if an MCO's total administrative expenses for the STAR program exceeds $8.00 PMPM, plus 5.75 percent of gross medial premium plus $1.80 PMPM, expenses will be capped at this amount for the MCO in the experience rebate profit-sharing calculation.

3.5.1.3. Other States

Across other states, Washington applies a percentage ranging from 6.5 to 10.0 percent of premium depending on the population. Nevada also uses a percentage of premium, which averaged to approximately nine percent. However, Nevada utilizes bids submitted from MCOs, rather than their own review of administrative expenses. Virginia's administrative load development included a PMPM amount of $23.87 based on revenue and administrative cost data provided by the MCOs. Similar to Texas, Mississippi uses a hybrid rate administrative load to account for fixed and variable administrative costs: $4.92 PMPM, plus 6.25 percent of revenue. These amounts are determined based on Mississippi's review of MCO-reported administrative costs and national benchmarks and industry reports.

Figure 9. Application of Administrative Load.

State	Percentage	PMPM	Hybrid	Not Included
Texas			✓	
Colorado				✓
Florida	✓			
Georgia	✓			
Illinois	✓			
Kentucky		✓		
Mississippi			✓	
Nevada	✓			
New Hampshire	✓			
New Mexico	✓			
Oregon	✓			
Pennsylvania	✓			
South Carolina	✓			
Tennessee	✓			
Virginia		✓		
Washington	✓			
Wisconsin		✓		

3.5.2. Rate Risk Margin

Rate risk margin is another positive adjustment incorporated into rate development on a percentage of premium basis to support underwriting gain, capital reserves, and risk-based capital requirements. Based on the states observed, risk margins ranged from one to two percent. The amount allocated to the risk margin typically depends on the stability of the population. Risk margins for populations that are more mature or stable will typically be lower, while risk margins for populations that are new to managed care or less stable will typically be higher.

3.5.2.1. Actuarial/CMS Guidance

Actuarial guidance states that the actuary should include a provision for underwriting gain. This provision is typically developed as a percentage of the premium rate, to provide for a margin and the cost of capital.

3.5.2.2. Texas

Texas included a risk margin of 1.5 percent of premium among its STAR, CHIP, and STAR Health programs and 1.75 percent for STAR+PLUS and STAR Kids, which is consistent with the values reported among other states.

3.5.2.3. Other States

Some states include their risk margin within their rate administrative load amount or accepted margin amounts submitted through bids; however, for purposes of transparency, states typically separate amounts for rate administrative load and risk margin for larger programs. As an example, Nevada's risk margin was based upon the MCO-submitted bids. The MCOs submitted admin loads ranging from 10.0 to 10.5 percent, and therefore, the state considered these as nine percent administrative costs and the remaining one to 1.5 percent for the risk margin.

Figure 10. Risk Margin Percentage by State.

State	Risk Margin
Texas	1.5% for STAR, STAR Health, and CHIP; 1.75% for STAR+PLUS and STAR Kids
Colorado	1.0%
Florida	2.0%
Georgia	Included within Admin
Illinois	Included within Admin
Kentucky	1.0%
Mississippi	2.0%
Nevada	1%–1.5%
New Hampshire	Included within Admin
Oregon	1.5%
Pennsylvania	Included within Admin
South Carolina	1.0%
Virginia	1.5%
Washington	1.5%
Wisconsin	1.6%

3.5.3. MLR Targets and Claw-Back Provisions

CMS implemented a new requirement for states to calculate and report MLR for contracts beginning on or after July 1, 2019.

3.5.3.1. Actuarial/CMS Guidance

CMS guidance states that the capitation rates must be developed in a manner targeting MLR greater than or equal to 85 percent. There are no required provisions for MCOs to return profit in excess of the MLR, but states are able to implement claw-back provisions as they prefer.

3.5.3.2. Texas

Because this is a new requirement, Texas did not yet report on its MLR in the most recent rate setting certification. However, as discussed in the Rider 61(d) report, based on FSR reporting, current aggregate MLR results for SFY2016 and SFY2017 are approximately 90 percent before adjusting for the experience rebates, above the minimum required 85 percent rating thresholds as prescribed by CMS.

3.5.3.3. Other States

Like Texas's current experience rebate risk-sharing mechanisms, some states have implemented minimum MLR thresholds in excess of 85 percent with required payment provisions from the MCOs if actual results fall below the stated targets. For example, New Hampshire's minimum requirement is 89 percent and South Carolina's is 86 percent.

3.5.4. Nonmedical Expenses Findings/Conclusions

The approach utilized by Texas to develop nonmedical expense loads is consistent with the states reviewed. As outlined in the **Rider 61(d) Report Section**, when reviewing MLR results in Texas in comparison to other states, the Texas program is at approximately 90 percent, which is above the minimum 85 percent threshold and is in line with other states. Additionally, the experience rebate profit-sharing mechanism is a useful approach for cost containment and one that is not very common across the states other than those states who have begun to implement targeted MLR thresholds with claw-back provisions.

Texas should continue to monitor the administrative expense experience and adjust its assumptions and approach as necessary. One consideration is in the development of the fixed and variable components of the administrative load. Currently, the actual MCO administrative costs are not separated into

specific fixed and variable components during rate development. Texas could consider performing a deeper analysis on which costs from the FSR should be considered fixed versus variable costs and modify their current fixed and variable assumptions accordingly. The state could look to tie administrative costs to inflation indices (such as the Consumer Price Index) rather than the underlying medical trend assumptions in an effort to contain costs.

A second consideration, as discussed in the Rider 61(d) report, is to consider revisiting the various profit-sharing thresholds within the experience rebate calculation. For instance, the state currently has a claw-back of 20 percent on profits between three and five percent. Increasing that percentage or getting to 100 percent at a lower level of net income (currently in excess of 12 percent) could provide an increased incentive for MCOs to moderate expenditures.

Adjustments to the profit-sharing thresholds within the experience rebate calculation should consider the impact the experience rebate contractual provision has on MCO medical expenditures. The experience rebate allows MCOs to retain some profits, some of which may currently be reinvested within the Texas Medicaid and CHIP programs. Texas MCO investments around value-based purchasing, quality improvement programs, or other innovative quality and efficiency reforms may result in a reduction in overall program expenditures and improved member access and quality of services. Therefore, the potential short-term impact of an adjustment to the experience rebate thresholds needs to be considered against the potential longer-term impacts the profit-sharing mechanism has on the Texas Medicaid and CHIP programs.

3.6. Risk Mitigation

States use various techniques to appropriately mitigate the acuity differences across the populations within their rate setting methodology. Most states develop rates separately by region and/or risk group to reflect cost differentials from a demographic and geographic perspective. Utilizing an acuity risk adjustment is another common risk mitigation strategy used by states. Risk adjustment accounts for the health status of enrollees by either predicting the relative risk of the population or evaluating the experience retrospectively. States may also utilize risk-sharing mechanisms, including reinsurance, risk corridors, or stop-loss limits.

3.6.1. Risk Adjustment

States risk adjust by assigning relative risk factors to each member of their Medicaid program based on their health status, allowing them to better predict the costs of services for the defined population. Risk adjustment is not required, but many states choose to apply it to some or all of their managed care populations. Generally, larger, more typical Medicaid Managed Care populations are risk adjusted, while smaller populations with higher costs or more volatility may not be risk adjusted. For example, long-term care, behavioral health, or specialized substance abuse programs may not be assigned a risk factor. While there are several tools and different types of software available, some states develop their own methodologies to calculate risk factors.

3.6.1.1. Actuarial/CMS Guidance

CMS guidance allows states to apply the risk adjustment, prospectively or retrospectively, in a budget neutral manner. A prospective risk adjustment uses historical data to project risk scores for the current rating period. A retrospective risk adjustment is calculated by looking at the experience during the rating period and adjusting for the emerging results. With the retrospective method, MCOs do not know what they will be receiving as the total payment until after the period has ended. Therefore, most states choose to apply the adjustment prospectively, unless a population or benefit update creates risks that may vary from the historical data.

3.6.1.2. Texas

Texas established a risk-adjustment methodology for STAR, CHIP, STAR+PLUS, and STAR Kids in order to recognize cost differences between MCOs based on the health of their members. The analysis was performed by

University of Florida's Institute for Child Health Policy using the CDPS+Rx software. The risk adjustment was applied to each MCO and risk group for acute care and pharmacy portion of premiums. The CDPS+Rx package groups the International Classification of Disease codes found in health care encounter data into a series of diagnosis categories and the National Drug Codes (NDC) into a series of pharmacy categories. Texas applies the risk adjustment prospectively and updates the rates each year.

3.6.1.3. Other States

Most other states also use the CDPS+Rx software to develop their risk-adjustment factors and 3M's Clinical Risk Group (CRG) software is also becoming more common. The CDPS+Rx model is a hybrid version of the CDPS and MRX models. The CDPS model is utilized to indicate what major categories' members are assigned based on medical diagnosis and the MRX model assigns members into different therapeutic categories based on pharmacy NDC. The CRG risk-adjustment model is a component within a suite of tools developed by 3M that are utilized for various health care initiatives by state governments, health plans, and providers. The model is capable of utilizing both medical and pharmacy data along with functional health status and employs a categorical approach, which differs from regression style models in that every member gets assigned to only a single risk group that indicates the full scope of their health status or burden of illness.

Like Texas, most states update their acuity risk-adjustment analysis for each rating period. However, Kentucky calculates risk scores semiannually. Alternatively, Illinois proposed an adjustment on an interim basis to be applied retrospectively to the entire population, but only if the data supports a revision.

Nevada chose to implement a retrospective risk adjustment at the end of each rating period due to a new MCO entering its managed care program. The state will continue to use this method until enrollment stabilizes among all MCOs.

Figure 11. Risk Adjustment Examples.

State	Software	Update Frequency	Model Type
Texas	CDPS+Rx	Annual	Prospective
Kentucky	CDPS+Rx	Semiannual	Concurrent
Mississippi	CDPS+Rx	Annual	Prospective
Nevada	N/A	Annual	Retrospective
New Hampshire	CDPS+Rx	N/A	Concurrent
New York	CRG	Annual	Prospective
Oregon	CDPS+Rx	Annual	Prospective
Pennsylvania	CDPS+Rx	Annual	Prospective
South Carolina	CDPS+Rx	Annual	Prospective
Virginia	CDPS	Annual	Prospective
Wisconsin	CDPS+Rx	Annual	Prospective

3.6.2. Other Risk-sharing Mechanisms

States use risk-sharing mechanisms to stabilize premium payments to MCOs from unexpected high costs and to share the risk of higher-cost populations. These mechanisms include reinsurance, risk corridors, high-cost risk pools, and stop-loss limits. Some states may also implement population or service carve-outs to reduce risk, as discussed further in **Section 3.2 Base Data.**

3.6.2.1. Actuarial/CMS Guidance

While CMS allows states to utilize risk-sharing mechanisms at their own discretion, states must consider the effect of these risk-sharing arrangements when developing the capitation rates. Guidance states that the actuary should consider how payments related to risk-sharing arrangements have been reported in the base period data, how these payments are to be estimated in the future, and how these payments will be reflected in the capitation rates.

3.6.2.2. Texas

Texas does not include any risk-sharing mechanisms within their capitation rate setting methodology other than their service carve-outs. Antiviral drugs used for the treatment of Hepatitis C and the drug Orkambi were carved-out across most programs for SFY2018 and were not covered under the

capitated arrangement. While these drugs were carved out for SFY2018, the specific drugs that are carved out of the capitation rates often vary year by year as determined during rate development. Other notable examples of Texas carve-outs include long-term care services for the intellectual or development disabilities (IDD) risk group for the STAR+PLUS program, Medicaid cost-sharing and wraparound services for Dual Eligible members in the STAR+PLUS program, and Federally Qualified Health Center (FQHC) wrap payments for all programs.

In addition to service carve-outs, Texas allows MCOs to carry losses forward for two years when determining experience rebates to provide relief from paying the experience rebate on future years' profits.

3.6.2.3. Other States

Commonly, states use risk-sharing mechanisms to protect against high-cost pharmacy drugs. Nevada is in the process of developing a risk corridor for high-cost drugs, which will reduce the risk for MCOs who incur larger amounts of high-cost pharmacy costs.

Virginia implemented a pharmacy reinsurance adjustment that is applied to all population groups after base rate development to protect MCOs from unexpected pharmacy costs. The program reinsures 90 percent of drug costs above $175,000 per member per year. The program does not cover 100 percent of costs to incentivize MCOs to appropriately use the treatment of drugs.

New Hampshire developed a risk corridor program to protect against uncertainty in annual profit or loss for qualified MCOs. In addition, they applied a risk corridor for the New Hampshire Health Protection program using a target MLR of 89 percent. The settlements will be based on MCO encounter data.

Pennsylvania funded a high-cost risk pool for individuals with more than $80,000 in total medical expenses – 80 percent of the expenses above this threshold are included in the pool and 20 percent remain in the capitation rates. The amounts are withheld from the capitation rates and later distributed to the MCOs on a quarterly basis.

3.6.3. Risk Mitigation Findings/Conclusions

The annual update of CDPS+Rx risk scores used in the Texas's rate development process is a similar risk-adjustment approach utilized by many other states. Texas should continue to closely monitor the emerging program experience by MCO and service delivery area, to confirm the acuity

risk adjustment is appropriately reflecting the demographic and geographic differences in membership enrollment within the MCOs across the State.

One consideration is to determine if additional risk-adjustment approaches could be incorporated into the rate-development process for more specific conditions. For example, some states, such as Massachusetts, are beginning to consider social determinants of health within the development of capitation rates. These states have begun reviewing the impact of various variables, such as homelessness, crime rates, and education levels on a population's health care costs. Another risk-adjustment capability for consideration is longitudinal risk adjustment at the member level. These risk adjustments allow states to reference multiple years of FFS or encounter data, as well as initial member assessments to build longitudinal cost models to more accurately determine expectations for future years. Other states choose to utilize different risk models for different populations. States will likely continue to implement additional adjustments to more accurately price the populations in their programs. However, there are considerations regarding how these adjustments should be applied so that MCOs continue to be incentivized to help reduce the negative impact of such variables for their populations.

A second consideration is to continue to analyze the high-cost drug expenditures and modify the current service carve-outs, as deemed necessary. However, new emerging treatments, such as gene therapy treatments or hemophilia treatments, which are high cost and have low occurrences, may suit well for a new service carve-out or high-risk drug pool to better mitigate the volatility of the claims experience across all the MCOs.

3.7. Rate Detail

This section compares the rate detail utilized in Texas to other states. Specifically, it compares states that utilize a community rating method versus developing rates specific to an MCO. It also analyzes how specific the rate cells and cohorts are developed, including those with broader population categories versus those with rate cells varying by more detailed age bands.

3.7.1. Community Rates versus MCO-Specific Rates

States have the flexibility to develop capitation rates at the community level, such as on a statewide or regional basis, or at a more granular level specific to each MCO.

3.7.1.1. Actuarial/CMS Guidance

While CMS requires that states certify all rate cells and all regions, CMS allows states to determine whether they develop rates at the community level or specific to each MCO.

3.7.1.2. Texas

Texas utilizes a community rating methodology in the development of the capitation rates for the STAR+PLUS and STAR Kids programs. For the STAR and CHIP programs, Texas utilizes an adjusted community rating methodology, which, with the exception of maternity services, utilizes a blend of the risk-adjusted community rates by service delivery area and MCO-specific rates. The final rates are determined as the minimum of the risk-adjusted community rate and 108 percent of the MCO-specific rate. Across all programs, specific point estimates by rate cohort and service delivery area are certified, rather than a rate range.

Previously, states could certify a range of capitation rates and each MCO's contracted rates could be at any point within the certified range; however, per 42 CFR 438.4(b), beginning for rating periods on or after July 1, 2018, capitation rates must be specific payments for each rate cell under the contract. Therefore, states' actuaries must develop and certify a specific rate for each rate cell rather than a rate range. States may then increase or decrease the capitation rate for each rate cell by up to 1.5 percent without a revised certification.

Although the updated rule regarding specific capitation rates for each rate cell versus a rate range began for rating period on or after July 1, 2018, Texas has been certifying specific rates for each rate cell for a number of

years. Additionally, in line with many other states, Texas utilizes a community rating methodology.

3.7.1.3. Other States

In some instances, states may elect to use a combination of community rates and MCO-specific rates. Most states today leverage a community rating process, developing state-wide or regional rates and then incorporating MCO-specific risk adjustments. However, states, such as New Mexico, that utilize a competitive bidding process incorporating a cost component when procuring MCOs are more likely to develop MCO-specific rates. States should always consider the credibility of the rate cells as they are determining whether to rate on a community basis or an MCO-specific basis.

Figure 12. Regional- versus MCO-Specific Capitation Rates.

State	Regional Rates	MCO Specific
Texas	✓	
Colorado	✓	
Florida	✓	
Georgia	✓	
Illinois	✓	
Kentucky	✓	
Mississippi	✓	
Nevada	✓	✓
New Hampshire		✓
New Mexico		✓
New York	✓	
Oregon	✓	
Pennsylvania	✓	
South Carolina		✓
Tennessee	✓	
Virginia	✓	
Washington	✓	
Wisconsin	✓	

3.7.2. Rate Cohorts

As discussed in the above section, when developing capitation rates, states can create community- or MCO-specific rates. The rates are then broken down further by risk groups or rate cells in order to develop more specific rates for the assigned population. States must assure the rate cells are credible; therefore, the level of granularity of rate cells can vary depending on the state's population.

3.7.2.1. Actuarial/CMS Guidance

Similar to community rates versus MCO-specific rates, CMS allows states to determine the level of detail included in their rate cells; however, they do require that states certify all rate cells and regions.

3.7.2.2. Texas

Texas developed capitation rates for 13 managed care service delivery areas or regions. Additionally, rates were broken down by eight risk groups or rate cells for both the STAR and the STAR+PLUS programs and rates were broken down by seven risk groups or rate cells for both the STAR Kids and CHIP programs. The Dual Demonstration included three risk groups and the STAR Health program assigned rates in aggregate as a statewide rate.

3.7.2.3. Other States

For other states, the number of risk groups or rate cells utilized ranged from four to 28. States with fewer rate cells have broader population categories, such as TANF or individuals with disabilities. Those with more rate cells typically have age and gender breakdowns of the broader populations or rate cells for specific courses of treatment, such as individuals receiving home and community-based services.

3.7.3. Maternity Supplemental Payments

Maternity cases can incur unexpected high claim costs within various risk groups and the distribution of these cases can vary across MCOs depending on their underlying enrollment. Most states adjust for these situations by making additional fixed payments to the MCOs commonly referred to as supplemental payments or "kick" payments. These payments are typically made for each maternity case upon delivery and may vary based on the severity of the case, often differentiating for low-birth weight or premature delivery cases.

3.7.3.1. Actuarial/CMS Guidance

Actuarial guidance states that the actuary should identify any special payments to providers and include these payments in development of the capitation rates in a manner that reflects the payment policy for these special payments in the rating period.

3.7.3.2. Texas

Like most states, Texas pays a delivery supplemental payment (DSP) by risk group for each delivery to the corresponding MCO. The amount is developed based on the average delivery cost in the area. To achieve cost neutrality in the rate development, the state projects total costs, including deliveries, and then subtracts the projected cost of maternity expenses. The subtracted amount corresponds with the DSPs and the remaining costs are used to develop the premium rates.

3.7.3.3. Other States

Examples of other maternity supplemental payments include the State of Washington, which has a low-birth-weight payment that is made to MCOs for expenses related to newborns with low-birth weight. Payments are based on encounter data and the case must fall under a list of approved APR-DRG codes, incur more than $75,000 in claims paid by the MCO, and be for a member under the Family/State Children's Health Insurance Program. Georgia implemented supplemental payments for deliveries and for high-cost neonatal incentive care unit (NICU) cases. For the delivery payment, the payment amount is developed using only the delivery claims and not predelivery or postdelivery claims. For the NICU payment, half of the claims from qualifying NICU babies were used to develop the payment amount and half were left in the zero to two months and three to 11 months low-income Medicaid rate cells and were used to develop the premium rates for those rate cells. Oregon developed MCO-specific maternity supplemental case rates. These were broken up by region, vaginal and cesarean deliveries, and in-state versus out-of-state cases. MCO-specific adjustments were made based on each component.

3.7.4. Rate Detail Findings/Conclusions

Since Texas has been certifying specific rates for each rate cell rather than rate ranges, they are ahead of many states which are now adjusting their approaches to comply with the new managed care regulations. Texas's selected number of rate cells is similar to the selections seen across other

states, but should continue to be monitored for credibility or deviations in actual versus expected claims experience.

While Texas's approach of utilizing a community rating method by service delivery area is a common approach utilized across most states, the adjusted methodology within STAR and CHIP of blending MCO-specific experience and community averages when determining the final STAR and CHIP rates is a method not commonly seen across states. The use of the minimum of 108 percent of the MCO-specific rate and the risk-adjusted community rate allows Texas to incentivize MCOs for efficiency while limiting the ability for the most efficient MCOs to benefit excessively from the community average rates.

Texas should continue to monitor the reasonability of the 108 percent adjustment factor and determine if the factor could be raised or lowered in future years. With the introduction of additional value-based purchasing programs across the state and the implementation of additional efficiency and quality rating adjustments, some MCOs may be able to drive greater cost efficiencies as the program evolves. The state would need to review the actuarial soundness of such modifications, particularly if other cost-saving initiatives are incorporated into the rates, such as modifications to the experience rebate risk-sharing mechanism or a targeted MLR threshold.

4. Managed Care Organization Selection

Within Medicaid Managed Care programs, states contract with MCOs and providers to deliver services to their members. In the past, states contracted with any MCO that met the state's requirements ("any willing provider"). More recently, states have begun creating more rigorous selection processes, including evaluating MCOs based on additional components, such as the services they provide, adequacy of their provider networks, and administrative and claims costs, and then deciding on whether or not to contract with the MCO – a process referred to as competitive bidding.

The various processes that states are currently utilizing to award contracts to MCOs were reviewed and are documented throughout this section. In addition to researching publicly available documents, RFIs sent by HHSC to the current participating Texas Medicaid MCOs and other state Medicaid programs, specifically regarding competitive bidding with a cost component were leveraged for the analysis.

There are typically four types of MCO selection processes that states use to determine their contracted MCOs. For the purposes of this analysis, the four types of MCO selection processes have been defined as: "Any-willing-provider," competitive bidding with technical component, competitive bidding with nonmedical cost component only, and competitive bidding with full cost component. Even when states follow one of these processes, there may be additional situations that can affect the chosen MCOs, such as a desire by the state to have more than one MCO in each region or service area, the distribution of members across regions of the state, and health care delivery models.

Number of MCOs per State

The number of MCOs in a given state tends to vary widely, due to a variety of factors, including their MCO selection processes and the populations included within their program.

Competitive bidding allows states to have a say in the number of MCOs with whom they contract, whereas states that have an open selection process are not able to limit their contracted MCOs. However, competitive bidding does not necessarily indicate a state will have fewer contracted MCOs. Even when states participate in the same selection process, there is not a standard number with whom states contract. Texas participates in competitive bidding with a technical component and has 18 MCOs and two dental managed care organizations (DMOs). Maryland participates in the "any-willing-provider" model and has eight MCOs. Nevada and Arizona participate in competitive

bidding with nonmedical cost component and have three and 11 MCOs, respectively.

When states carve more populations into their managed care programs, such as long-term services and supports (LTSS) and intellectual and developmental disabilities (IDD) populations, they are more likely to have more MCOs. West Virginia and Florida both participate in competitive bidding with a full cost component and their number of MCOs are four and 17, respectively. Seven of Florida's 17 MCOs are specialty plans due to the inclusion of the long-term care population.[79] When states include more unique populations, they tend to require more MCOs due to these plans having targeted specialties or requiring the MCOs to provide more direct care to members.

Further variations occur due to other requirements that can be chosen by the state. For example, North Carolina is developing a managed care program and plans to limit the number of MCOs to a maximum of 15, with three statewide MCOs and up to 12 MCOs that will provide coverage by region. Additionally, Texas's STAR+PLUS program has a requirement of two participating MCOs per region, which may influence the total number of contracted MCOs for the program in the future.

Type of Participating MCOs

Most states tend to contract with a variety of MCOs, including national and local, for-profit and not-for-profit, and hospital based. Depending on a state's MCO selection process, it may have some influence in the types of MCOs it contracts with; however, this is typically not a state decision and occurs based on the qualifications of the MCOs as weighed against stated selection criteria.

Across Texas's 20 MCOs, there are many national and local health plans, for-profit and not-for-profit health plans, and local hospital systems. The two DMOs are national dental plans, one of which is a nonprofit organization. It is common to have a variety of participating MCOs, like in Texas, but there are some states that only contract with national, for-profit health plans. In addition to national and local health plans, other states include county-based regional support networks, usually used to manage behavioral health care.

[79] *Kaiser Family Foundation, "Medicaid & Chip Indicators," https://www.kff.org/state-category/medicaid-chip/medicaid-managed-care-market-tracker/medicaid-managed-care-state-level-data/.*

4.1. MCO Selection Processes

MCO selection processes are used by states to award contracts to their MCOs. As health care costs continue to rise and states are putting more emphasis on the level of care being provided, these processes have become an important part in determining the future of health care.

States are moving away from the "any-willing provider" model and toward competitive bidding with a technical component, as well as competitive bidding with a technical and cost component. However, as this shift occurs, there is variation in the level of competitive bidding states participate in.

4.1.1. Any-Willing-Provider Model

The "any-willing-provider" model allows states to award MCO contracts to all organizations that meet the states' requirements. With this selection process, the states do not have a choice in with whom they contract. Arkansas, Maryland, New Jersey, and Wisconsin all contract with their MCOs based on this open policy.

4.1.2. Competitive Bidding with Technical Component

Competitive bidding with a technical component is the simplest form of competitive bidding. This allows states to be selective with whom they contract, but the state still has full control over the development of the rates. Texas currently chooses to contract with MCOs based on competitive bidding with a technical component. Other states that utilize competitive bidding with a technical component include California, Delaware, Georgia, and Pennsylvania. Through this process, states release an RFP, review all responses, and award contracts to some or all respondents based on a defined evaluation process. North Carolina will be utilizing this arrangement by setting capitation rates as part of its RFP process and requiring the MCOs to accept the rate setting and risk-adjustment methodologies.

4.1.3. Competitive Bidding with Nonmedical-Only Cost Component

Competitive bidding with a nonmedical cost component is an additional form of competitive bidding where states request the competing MCOs to submit nonmedical cost components in their proposals. The nonmedical cost component includes the administrative load or underwriting gain. These submitted costs are factored into the evaluation of each MCO by an amount defined by the state. The state can then choose to incorporate the submitted

nonmedical cost component within its capitation rates or conduct negotiations with MCOs to determine the final amounts. Nevada's cost component includes only administrative services and Arizona's includes administrative services and underwriting gain.

4.1.4. Competitive Bidding with Full Cost Component

Competitive bidding with full cost component requires MCOs to submit a full capitation rate cost component within their bids. These amounts are usually included within the final capitation rates or adjusted with factors, such as acuity and other program adjustments. Some states may request that MCOs submit full cost components for certain programs, regions, or populations. States that participate in the full competitive bidding process include Florida, Illinois, Indiana, Kansas, and Tennessee. Indiana requires a full cost component, but only for specific populations. Several states participated in full competitive bidding in the past, but no longer participate, including District of Columbia, New Mexico, Washington, and West Virginia.

The **Figure 13** below summarizes the states that were evaluated and which MCO selection process they currently use. In order to gather more data on competitive bidding, states who used competitive bidding in the past were also referenced.[80,81]

[80] *The District of Columbia and Wisconsin utilizes competitive bidding with technical component in one region only.*

[81] *Nevada, New Mexico, Washington, and West Virginia completed competitive bidding in the past.*

Figure 13. MCO Selection Process by State.

State	"Any-Willing-Provider"	Competitive Bidding with Technical Component	Competitive Bidding with Nonmedical-Only Cost Component	Competitive Bidding with Full Cost Component
Texas		✓		
Arkansas	✓			
Arizona			✓	
California		✓		
Delaware		✓		
District of Columbia				✓
Florida				✓
Georgia		✓		
Illinois				✓
Indiana				✓
Kansas				✓
Maryland	✓			
Nevada			✓	
New Jersey	✓			
New Mexico				✓
New York		✓		
Pennsylvania		✓		
Tennessee				✓
Washington				✓
West Virginia				✓
Wisconsin	✓	✓		

4.2. Competitive Bidding with Cost Component

Through competitive bidding with a cost component, MCOs develop and propose the cost factors of the entire capitation rate or a few components of it. States are then able to decide how the cost components should be considered in the rate development process to best fit their program and enrolled members and how they will be adjusted throughout contract years. Throughout the decision-making process, the final determined amounts stay in compliance with managed care regulations on actuarial soundness and the application of actuarial standards of practice.

4.3. Evaluation of Cost Component

4.3.1. Cost Bid Components

States can request that MCOs bid on multiple cost components, including administrative services, underwriting gain, and medical services. Some states require MCOs to bid all cost components combined, while others only require one or two of the components to be bid. Requiring MCOs to bid for all cost components combined is more common across states with both Kansas and Indiana utilizing this method. New Mexico requests all components to be bid separately on a PMPM basis. Arizona requests administrative services and underwriting gain in the cost proposal and Nevada requests an administrative-only cost component.

4.3.2. Development of Factors

Some states allow MCOs to develop rates in any capacity, whereas others develop a range for MCOs to stay within. When states choose to develop a range, the states generally submit a data book to the MCOs that explains the methodology used to determine the range. The data book includes a description of the data sources used, such as encounter and financial data. New Mexico and Illinois released data books for MCOs to utilize while completing proposals.

When a range is not defined by the state, MCOs look at a variety of sources to set the cost component, including previous individual MCO experience, aggregate reported MCO experience, and prior rate setting experience. Regardless of the method used to develop the rates, the final determined amounts must stay in compliance with managed care regulations on actuarial soundness and the applicable actuarial standards of practice.

4.3.3. Price Guarantees

Price guarantees ensure that the rates submitted by the MCOs in response to a proposal will be guaranteed for a specific period of time, typically this is a short-term guarantee for the initial year or years of the agreement. Within the proposal, states request MCOs to confirm that their submitted cost components do not need to change for an associated time period. The state is ultimately able to decide if this price guarantee amount is used when developing the managed care rates.

Most states utilize price guarantees for all services, including administrative services. However, Arizona only requests price guarantees for the administrative services and underwriting gain, Nevada only requests price guarantees for administrative services, and Illinois does not request price guarantees for any of the cost components.

There are a variety of ways states can use price guarantees within capitation rates. The most common is for states to provide a range within which MCOs can bid within. The District of Colombia and Washington follow this process. This is also done for Illinois and New Mexico, but the bid is not a "price guarantee" as some known adjustments will occur after procurement.

Other methods include using price guarantees to inform rate development for the initial years of contract to be used in the initial year of contract or to be used in negotiations with the state.

4.3.4. Multiyear Contracts

When states develop multiyear contracts, the price guarantees are typically only required for a portion of the contract. Most commonly, states require price guarantee for the first year only.

Arizona's administrative PMPM bid was a multiyear bid that does not change, unless updated by the state. The underwriting gain was allowed to be up to one percent, but MCOs could bid different amounts for the first three years.

Illinois calculates a midpoint rate for each region after the initial year. Through this method, an MCO receives a capitation rate equivalent to MCOs prior-year rate multiplied by the percent change in midpoint rate relative to the current year.

Indiana requires a price guarantee for the first year and the percentile of the MCOs bid within the bid range across all MCOs is used to determine capitation rates for future years.

4.3.5. Proposal Evaluation and Scoring

When developing the proposal evaluation, states assign a certain amount of points to each section of the proposal. This signifies how cost will factor into the final contract award decision. Not all states reveal the scoring criteria of their proposal, but there is variation among those who do.

The District of Colombia is on the lower end with cost making up 8.9 percent of overall proposal evaluation points, while Tennessee is on the higher end with the cost component being evaluated at 30 percent.

Illinois provides a range in their proposal within which MCOs may bid. They evaluate the score for an MCO's bid based on where they fall within the range. For example, 33 percent is awarded if a bid is at the minimum rate, while zero percent is awarded at the maximum rate. Bids that fall in between the range are scored based on linear proration of the percentages.

4.4. Rate Finalization

4.4.1. Negotiation Process

When releasing an RFP for competitive bidding with a cost component, the state must determine what negotiations regarding the rates submitted by the MCOs will be conducted or if the MCOs will be bound to the initial rates submitted in the RFP. Florida has chosen to conduct negotiations regarding the scope of services, terms and conditions, as well as the initial rate submitted in the RFP. Following negotiations, contracts are awarded to MCOs where they could agree on all terms, including final rates after negotiations.

4.4.2. Revisions

Often in procurements utilizing competitive bidding with a cost component, the submitted MCO bids may require an adjustment after submission due to program changes or other experiences that occur prior to the effective date of the contract, but after the bids are accepted. Most states calculate these adjustments internally and then apply the adjustments to the MCO-submitted bids. In other instances, certain factors may be published with the RFP, so that the MCOs can incorporate these into their bid development.

In Arizona, if the state makes changes to the program that adjust the services provided by MCOs, the state's actuaries will revise the administrative PMPM amount.

4.4.3. Acuity/Risk Adjustments

Acuity and risk adjustments are commonly used to differentiate capitation rates based on the variance in acuity and health care status of an MCO's members. When conducting competitive bidding with a full cost component, states may adjust for acuity after the MCOs have submitted their unadjusted bids or they may provide risk-adjustment information in the data book and require the MCOs to risk-adjust their bids within the RFP.

For example, the data book that Florida provides to MCOs to develop rate bids for the RFP includes aggregate population risk score information. Florida provides detail on the development of these risk scores and the MCOs are expected to make appropriate risk score adjustments to the bids that are submitted within their RFPs.

4.5. Regulations/Statutory Requirements

Although competitive bidding allows states to have more control over the MCOs that participate in their program, some regulations and statutory requirements must also be fulfilled. Some states are mandated by statute to give preferential treatment to MCOs with certain characteristics. Commonly these include local and small businesses as well as resident and veteran-owned businesses. As outlined in Section 533.004 of the Texas Government Code, Texas is required to contract with MCOs that are:

- Owned and operated by a hospital district in the region;
- Created by a nonprofit that has a contract, agreement, or other arrangement with a hospital district in that region or with a municipality in that region and under the contract, agreement, or other arrangement; assumes the obligation to provide health care to indigent patients; and leases, manages, or operates a hospital facility owned by the hospital district or municipality; or
- Created by a nonprofit corporation that has a contract, agreement, or other arrangement with a hospital district in that region under which the nonprofit corporation acts as an agent of the district and assumes the district's obligation to arrange for services under the Medicaid expansion for children.

The District of Colombia gives preferences to MCOs with these characteristics. Kansas gives up to 10 percent preference to businesses that are primarily conducted in the state and have at least 10 percent of employees who are individuals with disabilities. Additional regulations may be put in place by the state. Florida is required to contract with a provider

service network which is a network of providers who directly provide health care services without an intermediary. In the state of Illinois, a county provider is entitled to contract with any region located in whole or in part within the county.

4.6. Timeline

The timing of an MCO selection process varies by state based on the type of procurement, review time, statewide versus and individual program contracts, and length of contracts. When a state develops an RFP for MCOs, the process includes the following components:

- **RFP:** On an average, states give MCOs one to three months to submit the RFP responses or proposals. Most states, including Nevada and Kansas, allow MCOs two months to complete their proposal. States that carve-in populations, including managed long-term services and support and IDD, may offer a longer submission period. For example, Florida's statewide Medicaid Managed Care program, which provides long-term care services, allows up to three months.
- **Proposal to Contract Award:** Once the proposal has been received, states award contracts as quickly as less than one month to as long as more than five months. Tennessee has a faster review process, allowing it to award contracts within one month. Some states, such as New Mexico and West Virginia, review for two to three months, while other states may take upward of a year or longer.
- **Contract Award to Contract Start:** Once contracts have been awarded, the time until start date of the contracts vary. Some contracts start within a month, but most do not begin for many months and sometimes not for over a year. West Virginia's contract begins within a month of contract awards. Tennessee's contract does not begin until 12.5 months later. In most states, including Kansas and Indiana, contracts begin around six months after contract award.
- **Contract Length:** Many MCOs sign a one-year contract with the option to renew for a few years. West Virginia and District of Columbia both contract for one year, but have a maximum of three- and four-year extensions, respectively. Other states offer multiyear contracts that can last up to four years, plus extension periods. New Mexico and Nevada have contract lengths of four years. New Mexico extends to no more than four more years, allowing for a total of eight contracted years and Nevada offers a maximum of two additional years for a total of six contracted years.

4.7. Value-Based Purchasing

Value-based purchasing is any activity that Medicaid programs implement to hold providers and/or MCOs accountable for costs and quality of care for which they provide or pay. Value-based purchasing is Medicaid's approach to restructure financial incentives to reward providers for delivering coordinated, high-quality care. As value-based purchasing becomes more common, these elements are being incorporated into the MCO selection processes and MCOs must be willing to develop these arrangements with their providers.

A common form of value-based purchasing is through implementing alternative payment models. These models are new ways for states to pay providers that incentivize value rather than volume. Three of the most common alternative payment models include payments in support of delivery system reform, episode-based payment programs, and population-based payment models.

4.7.1. Payments in Support of Delivery System Reform

Payments in support of delivery system reform are supplemental payments made to providers on a PMPM basis for meeting expectations of infrastructure, quality measurement, and reporting. Typically, this payment model is used for patient-centered medical home (PCMH) and health home delivery services.

South Carolina implemented incentive payments through gross-level adjustments for PCMHs. Efficiency adjustments that reimburse providers for performing functions, such as reducing emergency department visits or hospital admissions, are another example of payments that support delivery system reform. See **Section 3.4.1 Efficiency Adjustments** for more information on states developing efficiency adjustments.

4.7.2. Episode-Based Payment Programs

Episode-based payment programs hold providers accountable for quality and total cost of care for specific procedures or episodes. The episodes are paid for on a FFS basis, but the goal of the payment is to increase focus on refining clinical pathways in order to produce more effective care. States may establish this arrangement through their MCOs or directly with providers. Currently, a few states have implemented episode-based payment programs and more are considering the idea. Arkansas, Ohio, and Tennessee

have all implemented episode-based payment programs. For example, one of Tennessee's implemented episodes was a perinatal episode where all prenatal, delivery, and postpartum services for the mother 40 weeks prior to delivery and 60 days post-delivery were included in the payment model.

4.7.3. Population-Based Payment Models

Population-based payment models hold providers responsible for targeted expenditures for most health care services for an established population. This model requires providers to focus on prevention in order to improve quality and manage costs. There are various risk models among this payment model, including primary care capitation and full risk capitation. Primary care capitation is a fixed amount of money paid to a practice for the entire set of services it provides to a population. Full risk capitation pays a provider a fixed amount for a set of services and, therefore, puts them at risk for any costs incurred over the set amount. Rhode Island recently implemented a pilot of this type of program; it certified four accountable entities or groups of providers to negotiate the spending and quality performance targets.

4.8. Challenges/Considerations of Competitive Bidding

Competitive bidding allows states to have more discretion in which MCOs are awarded contracts. However, there are still many things to consider when reviewing potential competitive bidding models.

4.8.1. Number of MCOs

Some states use competitive bidding to reduce the number of MCOs in the state. When states use competitive bidding to achieve this goal, they need to determine if they will publish the number of MCO slots available for award. If the number of MCO slots available is published, this may affect the competitiveness of the rates submitted. In many cases, if the MCO believes they can win a large number of members, they will bid lower rates with the assumption that administrative costs can be spread over a larger population. Alternatively, if they do not believe they will win a large number of members, often due to many available slots, they may bid less competitively due to concerns regarding the distribution of administrative costs.

An additional way to incentivize competition through competitive bidding is to guarantee a certain number of MCOs within certain zones of a state, such as requiring at least two MCOs for each particular region. Three MCOs could

be more preferred, so if one MCO drops from the program, there would still be two available for competitive purposes.

4.8.2. Published Rate Range

Another consideration for competitive bidding is whether to publish a rate range or to provide the MCOs with enough data and information to develop the rates on their own. When publishing a rate range, states may choose to publish one or both ends of the rate range. They also have discretion in how the MCOs bid within the rate range is scored and how it will impact rates in future years of a multiyear contract. Under both methods, MCOs have limited ability to propose an appropriate bid due to uncertainty of critical cost factors, as well as programmatic concerns. Additionally, lack of information when setting rates or MCOs setting low rates to attract membership may lead to risks in MCO solvency.

On the state's end, if a rate range is published, a majority of the actuarial analysis needs to be completed before procurement. This can be challenging with incorporating emerging experience and the gap between procurement, MCO selection, and rating period effective dates. Beginning in 2019, new managed care regulations require states' actuaries to certify point estimates rather than ranges. They can still develop and publish a range, but will need to review the final payment rates as those are what are ultimately certified.

4.8.3. Adjustments to Submitted Bids

Often in procurements utilizing competitive bidding with a cost component, the submitted MCO bids may require an adjustment after submission due to program changes or other emerging experience that occurred prior to the effective date of the contract, but after the bids were accepted. Most states calculate these adjustments internally and then apply the adjustments to the MCO-submitted bids. In other instances, certain factors may be published with the RFP, so that the MCOs can incorporate them into their bid development.

4.8.4. Procurement and Ongoing Administrative Costs

When exploring competitive bidding, states should also consider the procurement costs involved with releasing and scoring an RFP, as well as the ongoing implications of maintaining more rates than they have in the past. RFPs for competitive bidding require time to develop and release the RFP, determine scoring criteria for the RFP, and evaluate and score the RFP. In

addition, when cost is a component to the bid, states should consider the level of detail they will require for rate submission from the MCOs, such as statewide rates or separate rates for each region. The state will need to develop the data books, rate ranges, and other adjustments at the same level of detail the state will require for the submitted bids. They also need to factor in evaluation time to ensure the bids are reasonable and evaluate potential modifications to their rate development process to reflect MCO-specific rates.

4.8.5. Cost Savings

Another consideration for transitioning to a competitive bidding model is cost savings. While cost savings are likely to have some impact in the reasoning for states to shift to a competitive bidding model with a cost component, there are no known studies to support cost savings. However, one method states can utilize to achieve cost savings is through autoenrollment. Through the RFP process, states may choose to offer MCOs with the lowest cost bid a greater portion of the autoassigned lives. This strategy can motivate MCOs to achieve larger membership, as well as to enroll the autoassigned lives, as they have historically had lower morbidity than members who choose their own MCO. However, since autoassigned members tend to have a lower average cost than those members that directly select an MCO, the method by which states autoassign members to MCOs has an impact on the MCO's average cost. In order for the capitation rate to be actuarially sound, those rates must recognize the autoassignment methodology used by the state.

5. Reimbursement Arrangements

Medicaid is financed by both the federal and state governments, covering more than 70 million low-income and disabled Americans. States typically fund services through FFS or managed care arrangements. In line with Texas, most states have developed managed care programs, providing services to approximately 75 percent of Medicaid members through contracted MCOs. Under managed care contracts, states provide an agreed-upon payment to MCOs for the delivery of services to enrolled members throughout a contract period. The development of these payments, or capitated rates, was discussed in further detail in **Section 3 Rate Development.**

There are three primary reimbursement arrangements with varying levels of risk that states typically utilize for their Medicaid programs. The three reimbursement models are as follows:

1. Self-funded models
2. Full risk capitation models
3. Hybrid models

Given the variety of services and populations covered under Medicaid programs, states may use one or more of the reimbursement models for their programs. Even within managed care programs, some populations or services may be carved out and funded through different arrangements. In addition, more states have begun to implement programs for specific services that are not covered within their original capitated payments. These programs are funded through various models that utilize FFS payments and oftentimes other organizations or vendors. Common services that utilize other reimbursement arrangements include pharmacy, nonemergency medical transportation (NEMT), home assistance, and other specialty populations or services.

5.1. Self-Funded Models

A self-funded model is most commonly performed using FFS payments. Under a FFS arrangement, the provider receives payments from the state for each service they provide, so there is no risk in the arrangement. Self-funded models were the most common reimbursement arrangement used prior to the development of managed care programs. In addition to FFS, states may use other PMPM reimbursements which may not be at risk.

The Kaiser Family Foundation summarized Medicaid MCO enrollment as of September 2017. The study summarized Medicaid enrollment in comprehensive Medicaid MCOs and only Medicaid enrollees in MCOs that provide comprehensive services are counted. Comprehensive services include comprehensive Medicaid acute care services and, in some cases, LTSS as well. Enrollment in prepaid ambulatory health plans, prepaid inpatient health plans, and Programs of All-Inclusive Care for the Elderly is not included. From this study, there were 12 states that did not have Medicaid contracts with MCOs and, thus, utilized mostly FFS payment models only. The 12 states utilizing only FFS payment models include Alabama, Alaska, Arkansas, Connecticut, Idaho, Maine, Montana, North Carolina, Oklahoma, South Dakota, Vermont, and Wyoming.

The FFS payment model is leveraged differently across some states. For example, Maine has an accountable care organization (ACO) model that is made up of communities of providers that form an accountable community. Each of these accountable communities has a target cost of care and quality metrics and they are able to receive shared savings payments based on performance.

5.2. Full Risk Capitation Models

A full risk capitation model provides MCOs with a fixed PMPM payment for the services they deliver. This is the reimbursement method for many of the Medicaid Managed Care programs across the nation. As of September 2017, 39 states, including the District of Columbia, had Medicaid contracts that provided coverage for comprehensive services with MCOs.

States have recently begun incorporating VBC and pay-for-performance arrangements into the capitation model to transfer additional risk to the MCOs and the providers and to incentivize increased health care quality. One arrangement states are utilizing includes developing pay-for-performance programs which evaluate MCO performance based on various quality measures. States are then able to withhold a certain percentage of the capitated rates, unless the MCO meets the defined quality targets. An alternative arrangement would be providing states with shared savings payments or bonuses when certain quality thresholds are met. Based on new managed care regulations, states are now allowed to reimburse up to five percent above the capitation rates for alternative arrangements such as those mentioned above.

Texas implemented the pay-for-quality program that provides incentives and disincentives based on managed care performance on certain quality

measures. Up to three percent of the managed care premium is at risk in this program and the program was designed so that all recouped dollars are redistributed to the high-performing MCOs. Thus, there is a targeted budget neutral impact at the program level.

States that utilize withholds for their pay-for-performance programs typically withhold between one and 2.5 percent of the capitated payments made to MCOs. South Carolina has a quality program that holds back 1.5 percent of the capitated payments, unless MCOs are able to achieve targets across quality measures related to diabetes care, women's health, and pediatric preventative care. Quality-based incentives are common among states. Similar to Texas, HEDIS and CAHPS data are typically analyzed for quality measurement. For example, Kentucky is analyzing new HEDIS measures and electronic health records to incorporate into incentive arrangements.

In addition to withholding arrangements and shared savings/bonus arrangements, several other alternative payment models are being utilized in Medical managed care programs, including PCMHs, Medicaid health homes, episode of care payments, and ACOs. The following includes a summary of each of these models:

- **PCMHs:** PCMH is a model of organizing primary care so that patients receive care that is coordinated by a primary care physician, supported by information technologies for self-care management, delivered by a multidisciplinary team of allied health professionals, and adherent to evidence-based practice guidelines. Some states require that providers participating in PCMH initiatives be certified by the National Committee for Quality Assurance or another certifying body.
- **Medicaid Health Homes:** The Health Home model builds on PCMH, but goes further by requiring integration of physical and behavioral health services. It also extends care coordination beyond medical services to include social and community supports. The ACA includes incentives for states to adopt health homes by creating a new Medicaid state plan option and provides 90 percent federal matching funds for the first eight quarters of program implementation
- **Episode of Care Programs:** Episode of care (EOC) payments, also called bundled payments, provide a lump-sum payment for all health care services delivered to a patient for a particular illness, procedure, or condition (episode). In theory, EOCs can improve predictability, reduce cost variation, and provide financial incentives to improve care coordination among providers and across health care settings.

- **ACOs:** An ACO is a network of providers who are collectively responsible for managing the full continuum of care for a defined patient population. ACOs are held responsible for the quality of care provided as well as the overall cost.

5.3. Hybrid Models

A hybrid model is a combination of a full-risk capitation model and a self-funded model. Typically, under a hybrid model, some populations or services are in a Medicaid Managed Care program, while other populations or services are carved out into FFS or a special program is developed specifically for these populations or services. While most states have a majority of their populations in a managed care program, it is common for a certain services and populations to remain in FFS. Common examples of the hybrid models are summarized below.

5.3.1. Service Carve-outs

States can determine the range of services they offer under managed care. Often, the decision to carve out or exclude services from their managed care capitation rates is driven by program policy. However, in some instances, states may choose to carve out services from the capitation rates due to volatility of claims or limited credibility of data.

Most managed care programs have carved prescription drugs into their managed care covered services in recent years, including these amounts within their capitated rates. Other states have elected to carve out all pharmacy services or some of the high-cost specialty drugs, such as drugs related to Hepatitis C. Wisconsin carved-out all prescription drugs from the capitation rates and covered the services through a FFS arrangement. Mississippi, along with other states, carved-out prescription drugs related to hemophilia and in SFY2018 Texas carved-out antiviral drugs used to treat Hepatitis C. Uniquely, Tennessee carved-out prescription drugs and developed separate capitation rates for pharmacy, leveraging one PBM throughout the state, and making the services fully insured rather than FFS. The costs vary by eligibility category and demographic group, but follow the same breakouts as the state's medical capitated rates.

5.3.2. FFS Populations

States may elect to maintain certain populations within the FFS payment model, rather than moving to full-risk managed care. Populations that are commonly maintained within a self-funded model include behavioral health,

home- and community-based services, intellectual or developmental disabilities, or long-term care.

Texas has chosen to carve most of these populations into their managed care program. Within Texas's STAR+PLUS program, nursing facility care and IDD populations were historically carved out of the managed care program. However, in SFY2015, the nursing facility population and acute services for the IDD population were carved into the STAR+PLUS managed care program. Additionally, on November 1, 2016, implementation of the STAR Kids program for children with disabilities, less than 10 percent of Texas Medicaid clients, remained in FFS. Texas Medicaid programs remaining in FFS include Medicaid and state-supported program clients not enrolled in an MCO and receiving Medicaid acute care, Medicaid LTSS, Healthy Texas Women, and Children with Special Healthcare Needs.

5.3.3. Value-Based Care Component

To promote quality of care while managing costs, states develop programs for services to be reimbursed by FFS with an at-risk component. Some states, such as Maine, utilize a FFS payment model with an accountable care organizational structure with the providers, where services are reimbursed through FFS payments, but reimbursement is at risk depending on reaching certain targets.

NEMT is a program that covers the cost of transportation or travel-related expense for Medicaid enrollees to medical examinations and treatments. HHSC contracts with Managed Transportation Organizations and full-risk brokers to provide NEMT services in a full-risk, capitation model. The program was typically a FFS program, but more states are moving toward brokerage administrative services only (ASO) contracts and full-risk contracts. Within these arrangements, the broker takes over most responsibilities, such as verifying members' eligibility, determining the appropriateness of trips, and arranging the transportation. FFS models require states to have trip reimbursement systems and to develop the infrastructure to audit and monitor trips and historical trends. ASO contracts transfer oversight functions and trip logistics to brokers, but the state maintains the trip rates and reimbursement system. The state of Washington contracts with six brokers through an ASO model. Full-risk brokers are typically paid a fixed amount of PMPM and are responsible for the same functions as ASO contracts, as well as developing provider networks and compensating the providers for trip services. Mississippi and South Carolina have full-risk brokerage contracts.

In addition, other specialty populations and services are implemented with unique reimbursement arrangements. Connecticut implemented a home care program for elders to help residents remain living within their communities rather than moving into a nursing home. Participants are accessed based on their capabilities and grouped into one of five categories, which are either state-funded or Medicaid-funded. Participants among the state-funded categories are required to make a copayment equal to nine percent of the cost of their monthly care plan.

5.4. Reimbursement Arrangements Findings/ Conclusions

Texas's reimbursement arrangements are similar to other states that have carved the majority of their Medicaid members into managed care. They should consider analyzing whether they should continue to transition additional populations, while balancing considerations on cost effectiveness, quality of care, and access to care.

Rider 60 was commissioned to study the potential savings from implementing certain changes to HHSC's current method of administering prescription drug benefits for Medicaid and the CHIP. The study found that the transition in pharmacy delivery models contemplated under Rider 60 has the potential to change many aspects of members' care and well-being in the State of Texas. Based on the results of this study, there may be savings inherent in carving the pharmacy benefit out of managed care, but these savings should be assessed against the risks and other considerations posed herein.

As discussed in **Section 3.4 Adjustments**, HHSC has recently revised its MCO pay-for-quality program that creates both incentives and penalties based on MCO performance on certain quality measures. Up to three percent of the managed care premium is at risk in this program, and the program was designed so that all recouped dollars are redistributed to the high-performing MCOs. Thus, there is a net zero impact at the program level. HHSC should continue to monitor the results as the program continues to mature and emerging experience becomes available.

6. Appendices

6.1. Actuarial Certifications

Figure 14. State Actuarial Certification Sources.

State	Data Reference
Texas	**STAR:** https://rad.hhs.texas.gov/sites/rad/files/documents/managed-care/2018/2018-09-star.pdf **CHIP:** https://rad.hhs.texas.gov/sites/rad/files/documents/managed-care/2018/2018-09-chip.pdf **STAR+PLUS:** https://rad.hhs.texas.gov/sites/rad/files/documents/managed-care/2017/2017-09-star-plus.pdf **STAR Health:** https://rad.hhs.texas.gov/sites/rad/files/documents/managed-care/2018/2018-09-star-health.pdf **STAR Kids:** https://rad.hhs.texas.gov/sites/rad/files/documents/managed-care/2018/2018-09-star-kids.pdf **Dual Demonstration:** https://rad.hhs.texas.gov/sites/rad/files/documents/managed-care/2017/2017-09-dualdemo.pdf
Colorado	https://www.colorado.gov/pacific/sites/default/files/Appendix%20BB%20Draft%20Behavioral%20Health%20Capitation%20Rates.pdf
Florida	**MMA:** https://ahca.myflorida.com/medicaid/recent_presentations/House_Health_Care_Appropriations_Subcommittee_Managed_Care_Rate_Setting_2017-01-11.pdf **SMMC:** http://edr.state.fl.us/Content/conferences/medicaid/archives/170809medicaidmanagedcareratesettingpresentation.pdf
Georgia	http://dch.georgia.gov/sites/dch.georgia.gov/files/GF_Rate_Certification_FY14_06182014_Procurement.pdf
Illinois	https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/ManagedCare.aspx
Kentucky	http://www.bidnet.com/bneattachments?/350636411.pdf
Mississippi	https://medicaid.ms.gov/wp-content/uploads/2017/02/RFP-20170203_Appendix-C_MississippiCAN-Capitation-Rate-Development-Report.pdf
Nevada	http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/Rates/20170929%20Nevada%20Capitation%20Rate%20Certification%20CY%202018.pdf

State	Data Reference
New Hampshire	https://www.dhhs.nh.gov/ombp/medicaid/
New Mexico	https://www.nmlegis.gov/Entity/LFC/Documents/Health_Notes/Health%20Notes%20-%20Medicaid%20managed%20care%20rates.pdf
New York	https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/nhtd-tbi/2016-11-16_overview.htm
Oregon	https://www.oregon.gov/OHA/HPA/ANALYTICS/OHPRates/Oregon%20CY17%20Capitation%20Rate%20Certification%202016-10-10.pdf
Pennsylvania	http://www.emarketplace.state.pa.us/FileDownload.aspx?file=RFP%2006-15/Solicitation_3.pdf
South Carolina	https://msp.scdhhs.gov/managedcare//sites/default/files/10%20-%20SFY%202017%20South%20Carolina%20Medicaid%20Managed%20Care%20Certification%20-%20FINAL....pdf
Tennessee	https://www.tn.gov/content/dam/tn/tenncare/documents2/actuarial17.pdf
Virginia	https://virginiamanagedcare.com/
Washington	https://www.hca.wa.gov/assets/program/2eshb-2376-mc-cap-rates.pdf
Wisconsin	https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Reimbursement_and_Capitation/pdf/2017_WI_SSI_Rate_Report.pdf.spage

6.2. Other Data Sources

Figure 15. Other Data Sources.

Report Section	Data Source	Description
Rate Setting	Medicaid Managed Care Final Rule	https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html
Rate Setting	ASOP 49	http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/
Rate Setting	CMS Medicaid Managed Care Rate Development Guide	https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/2018-medicaid-rate-guide.pdf
MCO Selection	Texas RFI	Information received through RFI responses, based on MCOs understanding on states procurement processes, provided by HHSC
MCO Selection	Milliman "Fixed Offer or Competitive Bid?"	http://www.milliman.com/uploadedFiles/insight/2015/fixed-offer-competitive-bid.pdf
MCO Selection	Kff.org	https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/
Funding Mechanisms	NEMT 2015	http://www.hauseactuarial.com/newsletter/2015_NEMT_Report_20160113.pdf
Funding Mechanisms	Kff.org	https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/
Summary of Opportunities	All analyses of data sources used above	

6.3. Comparable State Program Descriptions

Figure 16. Comparable State Program Descriptions.

State	Program	Medicaid Only Enrollment	Population
Texas	STAR	2,985,219	Provides health care to most of the state's Medicaid population: • Family/children on the TANF • Pregnant women • Limited income • Newborns
Colorado	Medicaid Behavioral Health Managed Care Capitation Rates	1,217,893	Health First Colorado members who are US citizen or legal permanent residents for minimum five years with a behavioral health diagnosis that is covered by the program
Florida	SMMC - MMA and LTC	3,039,243	Provides health care to most Florida Medicaid members
Georgia	Georgia Families	1,316,171	Provides health care to most but not all Medicaid and PeachCare for Kids members: • Parent/caretaker with children • Pregnant women • Children under 19 • Newborns • Women eligible due to breast and cervical cancer • Refugees
Illinois	Family Health Population	1,846,736	• Children • Parents • Affordable Care Act adults
Kentucky	Kentucky's Medicaid MCO Program	1,197,048	• Low-income adults • Children • Aged • Disabled children and adults • Foster care children • Medicare-Medicaid Eligible member

State	Program	Medicaid Only Enrollment	Population
Mississippi	Mississippi Coordinated Access Network (MississippiCAN)	499,365	• Supplemental Security Income (SSI) • Department of Human Services foster care children • Disabled child living at home • Working disabled • Breast/cervical cancer • Pregnant women and infants • Family/children on the Temporary Assistance for Needy Families (TANF) • Newborns
Nevada	Nevada Medicaid Managed Care Mandatory Health Maintenance Program	401,434	• Low-income adults • Children • Adults and children with behavioral health needs only
New Hampshire	MCO Capitation Rate Development for the Alternative Benefit Plan NH Health Protection Program	5,061	Expansion population Medically frail population
New Mexico	Centennial Care	642,757	Provides health care to most New Mexico Medicaid members
New York	Medicaid Managed Care	4,444,585	• Low-income adults • Children • Foster care children
Oregon	Oregon Health Plan	896,927	• Low-income adults • Children • Pregnant women
Pennsylvania	Health Choices Physical Health	2,205,108	• Adults • Children • Pregnant women • Women with breast and/or cervical cancer • Lawfully present immigrants
South Carolina	Medicaid Managed Care Program	742,134	• Low-income adults • Children • Disabled children and adults

State	Program	Medicaid Only Enrollment	Population
Tennessee	TennCare Program	3,695,999	• Low-income pregnant women • Parents or caretakers of a minor child • Children • Individuals who are elderly or have a disability
Virginia	Virginia Medicaid Medallion 3.0 Program	759,579	• Children • Pregnant women • Care taker parents • Aged, blind, disabled • Acute care for waiver recipients
Washington	Apple Health Programs	1,348,504	• Individual adults ages 19 to 65 • Parents/caretakers • Pregnant women • Children • Non-citizens • Aged, blind, or disabled • Foster care • LTSS
Wisconsin	SSI Managed Care	23,693	Provides health care services for those who receive the following: • Medicaid SSI • SSI-related Medicaid because of a disability

Rider 61(d): Evaluation of Medicaid and CHIP Managed Care – Managed Care Administrative Expenditure Audit

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1. Rider 61(d) Executive Summary

The 85th Texas Legislature asked the Texas Health and Human Services Commission (HHSC) to conduct an analysis of Managed Care Organization (MCO) administrative costs, including a survey to understand the nature and scale of administrative expenditures and resources of the State of Texas's Medicaid and Children's Health Insurance Program (CHIP) MCOs, to help identify potential savings and efficiencies that may be achieved.

1.1. Approach and Methodology

The evaluation of Texas MCOs' administrative expenditures involved three main tasks:

1. **Gather and review existing data** — This task included examining national administrative expense trends, including new federal Medicaid Managed Care regulations, and analyzing Texas Medicaid and CHIP MCO Financial Statistical Reports (FSRs) from State Fiscal Year (SFY) 2016 and SFY2017, with considerations to membership size and programs serviced, as well as the detailed FSR cost categories and relevant changes from SFY2016 to SFY2017.
2. **Develop and release Texas MCO survey** — Pursuant to Rider 61d requirements, a survey was developed and provided to the State's 20 MCOs to collect information on staff supporting the Medicaid and CHIP programs, gather additional details on certain FSR functional categories to better understand cost drivers, changes in costs year over year,

allocation of cost assumptions, and solicit feedback from MCOs on current administrative challenges and potential opportunities for new efficiencies or cost savings.

3. **Analyze and document findings** — Following receipt of completed surveys from each of Texas's MCOs, the survey results were analyzed for trends and information to help broaden the understanding of administrative expenditures, and recommendations were developed on potential opportunities for new administrative cost savings or program efficiencies.

1.1.1. Current Data and Reports Summary

The report examines recently available administrative expenditure data from MCOs, including annual FSRs and other MCO financial data provided to HHSC. Each year, Texas MCOs must submit FSRs and financial summaries detailing administrative expenditures across 24 cost categories. While the STAR and STAR+PLUS programs have the highest administrative expenditures in total dollars, the STAR Kids program in its first year is the most expensive on a per member per month (PMPM) basis.

Also evaluated were recent federal regulatory changes that altered the way administrative expenditures are measured, especially reclassification of quality improvements and the new Medical Loss Ratio (MLR) standards that show the percentage of Medicaid dollars spent on medical care. While the new MLR standard of 85 percent will put increased pressure on MCOs to limit administrative expenditures, most already exceed the threshold (and on average, all of Texas's Medicaid Managed Care programs (STAR, STAR+PLUS, STAR Kids, STAR Health, CHIP, and Dental) are above 85 percent MLR in SFY2016 and SFY2017).

In addition, Texas includes an experience rebate provision in the Medicaid MCO contracts, a profit-sharing mechanism which allows Texas to recoup a portion of MCO net income before taxes that exceed three percent of revenue. This calculation considers both the fixed and variable administrative expense components included in the capitation rates. Recent State reports indicate that the Texas experience rebate contractual provision with the Medicaid MCOs produces more cost savings than a penalty for not achieving an 85 percent MLR.

1.1.2. Survey Overview

The review of the data and new federal policies were used to create a nine-question survey of Texas MCOs to gather more information about the

specific administrative expense details from the FSR and to develop potential recommendations on streamlining reporting and identifying new cost and process efficiencies. Questions included requests for details on staffing, corporate allocations, outsourced services, and reporting requirement costs, as well as additional context on certain FSR cost category spending, cost allocation methodologies, changes from SFY2016 to SFY2017, and recommendations to the State on MCOs' greatest challenges and recommendations.

All 20 Texas MCOs completed the survey between April 23, 2018 and May 11, 2018.

1.1.3. Survey Results and Summary of Opportunities

The completed surveys provided a valuable picture of the range of administrative expenditures across several cost drivers and additional details not available in the public FSRs. For example, the surveys showed that:

- Approximately 70 percent of MCO staff are employed in Texas.
- Most of corporate allocations expenditures are for salary and other compensation.
- Claims processing (non-capitated) and behavioral health services (capitated) are the most common outsourced services.
- Approximately three percent of total administrative expenditures were indicated as the result of Texas reporting requirements.

As a result of the review of the information available and survey responses, several options can be offered, including:

1.2. Transparency

Greater transparency on reporting of administrative expenses, especially corporate allocations

Texas requires MCOs to report quarterly on their administrative expenditures through the FSRs. These FSRs provide some detailed data on the magnitude of each MCO's expenses in managing Medicaid coverage for most of the more than four million Texans that rely on the program.

Yet, while MCOs are required to report on top-level expenditure data, there remain many unknowns on the reports. For example, the corporate allocations category accounts for almost four out of every 10 dollars in administrative expenditures, but the FSR does not require an itemized

breakdown of the expenses charged to the corporate allocations cost category.

The Administrative Expenses survey showed 1) that MCOs have the capability to provide the data and 2) that the corporate allocation expenditures are primarily for additional salary and compensation on top of the more than $340 million in total salaries, wages, and benefits already disclosed by MCOs on Line 1 of the FSRs in SFY2017. In addition, four MCOs account for more than 80 percent of the total corporate allocations. Two of these four MCOs have an administrative cost PMPM at or near the overall average for MCOs, while the other two are greater than the average. This mixed result shows that it may be possible for MCOs to balance out high corporate allocations with lower spending on other cost categories.

Requiring MCOs to fully disclose compensation paid for through Medicaid funding, including the number of full-time equivalents (FTEs) as well as the total compensation for the size and population served by MCO, would increase the level of transparency in the FSR reports and help State policymakers in examining the total amount MCOs spend on compensation (including through corporate allocations). With this increased transparency, Texas would be able to conduct additional comparative analyses of spending patterns and develop additional expenditure benchmarks across all MCOs to aid in the review of overall Texas MCO administrative expenditures. This transparency may also help Texas better understand the roles and responsibilities of the staff included as corporate overhead and how their services are benefiting the Texas Medicaid and CHIP programs.

Additional detail regarding outsourced services to compare administrative costs by FSR cost category in a more consistent manner across the MCOs.

Similarly, MCOs must report on outsourced payments to third-party vendors to manage certain aspects of the managed care business within the Texas Medicaid and CHIP programs. Outsourced services generally are for typical MCO functions, such as non-capitated payments for claims management and capitated payments for behavioral health or dental benefits.

The FSRs require MCOs to disclose the vendors receiving funds for outsourced services and the total aggregate payments for those services, but there is little disclosure required on the types of services provided or spending by FSR cost category. Asking MCOs for additional details regarding the types of services provided by third-party vendors could allow for a more comprehensive and consistent analysis of expenditures by cost category

within the FSR for each MCO, encompassing both services performed in-house and those outsourced.

For example, the survey proved inconclusive on whether outsourcing services to third-party vendors correlated with lower overall administrative expenses (some MCOs with outsourced services had lower PMPM administrative expenses, while others did not). Collecting additional information to compare MCOs by FSR cost category in a more consistent manner may allow Texas to further assess which FSR cost categories are driving variances by MCO.

1.3. Workforce

Annual reporting on FTEs supporting the Texas Medicaid and CHIP managed care programs

MCOs are not required to report the total number of FTEs employed in each aspect of their Texas managed care business. HHSC surveyed MCOs in 2012 as part of its review of the local and regional financial impact of Medicaid Managed Care. As noted earlier, the Administrative Expenses survey requested a similar breakdown of FTEs, this time adding out-of-state FTEs to the request.

The annual reporting by MCOs to the State should include a breakdown of FTEs supporting their managed care business. This is valuable information to determine the size and scope of managed care operations in Texas and, on a year-to-year basis, can help the State evaluate programmatic and operational efficiency of each managed care plan.

In addition, this level of reporting can help the State analyze staffing outliers to determine if efficiencies can be gained. Analysis may include elements, such as: 1) determining if the number of FTEs aligns with the compensation-related expenditures, 2) assessing if the number of FTEs and roles of the staff correspond to the needs of the Medicaid and CHIP populations being served, 3) helping develop the administrative component of the capitation rates, and 4) conducting a comparative analysis of in-state and out-of-state staff roles and compensation.

1.4. Cost Containment

Increased evaluation of MCO cost allocation approaches to better understand the various methodologies and potential ways to standardize the process

Question #7 in the Administrative Expenses survey asked MCOs to outline their approach in allocating costs to the Texas Medicaid and CHIP programs. The question generated a range of approaches, from those based on membership and/or revenue, to others that are focused on costs/expenditures or time and effort.

Undoubtedly, there can be more than one approach to effectively and accurately allocate costs across different programs and lines of business of an MCO. However, an in-depth evaluation of the approaches could yield insight into the best and most efficient methods that could become accepted best practices for MCOs.[82]

Potential strengthening of the experience rebates for those MCOs deemed to have excessive administrative expenses or profits above the profit-sharing thresholds

As discussed earlier in the section, the experience rebate contractual provision in Texas's Medicaid Managed Care program can provide greater incentive for MCOs to moderate total program expenditures, including administrative expenses, than a potential penalty for not meeting an 85 percent MLR requirement.[83] If the State seeks to provide an increased incentive to moderate administrative expense growth over time, consider revisiting the various profit-sharing thresholds within the experience rebate calculation. For instance, the State currently has a claw back of 20 percent on profits between 3 percent and 5 percent. Increasing that percentage or getting to 100 percent at a lower level of net income (currently in excess of 12 percent) could provide an increased incentive for MCOs to moderate expenditures.

Adjustments to the profit-sharing thresholds within the experience rebate calculation should consider the impact the experience rebate contractual provision has on MCO medical expenditures. The experience rebate allows MCOs to retain some profits, some of which may currently be reinvested within the Texas Medicaid and CHIP programs. Texas MCO investments around value-based purchasing, quality improvement programs, or other innovative quality and efficiency reforms may result in a reduction in overall program expenditures and improved member access and quality of services. Therefore, the potential short-term impact of an adjustment to the experience rebate thresholds needs to be considered against the potential

[82] *HHSC plans to require MCOs to choose a methodology to allocate administrative costs to individual programs (describing the methodology used, replacing the current method to allocate administrative costs to each program as a percentage of revenue).*

[83] *Evaluation of the 1115(a) Texas Demonstration Waiver - Healthcare Transformation and Quality Improvement: Final Evaluation Report, May 30, 2017.*

longer-term impacts the profit-sharing mechanism has on the Texas Medicaid and CHIP programs.

Further analysis of high-cost outliers by FSR reporting category

As noted in Sections 4, 5, and 6, in the review of the FSR data and survey responses, we identified several categories of administrative expenditures with a wide variation of reported costs by MCO. Further evaluation of the MCOs with above-average costs in total (for example, for-profit versus non-profit) and specific categories may identify opportunities for cost efficiencies that could be gained if incentives or reimbursement mechanisms were utilized to move such costs closer to the statewide averages. Categories with variations highlighted in our review included compensation expenses, including corporate allocations, legal and professional fees, marketing, computer hardware, and travel expenses.

Additionally, we noted that there are some inconsistencies in how MCOs report expenditures by FSR category. An opportunity exists for additional guidance to support the MCOs in categorizing the expenses in a consistent manner to support equitable comparisons across MCO.

Coordination with the MCOs to refine the reporting requirements within the Uniform Managed Care Manual (UMCM)

In the survey, MCOs responded that one of the top suggestions in potentially reducing the overall administrative expenses for the Texas Medicaid and CHIP programs was to revisit the State's reporting requirements. While the MCOs reported that less than 5 percent of total administrative expenses are attributable to HHSC reporting requirements as defined by the UMCM, there was variation by MCO with several low- and high-cost outliers.

There may be an opportunity to further discuss this response with the MCOs to determine the level of effort and staffing required to support HHSC reporting requirements, in addition to the ongoing efforts between HHSC and MCOs to streamline deliverables. Some existing activities may be unnecessary or streamlined to reduce overall programmatic expenditures. Additional discussion of the UMCM can be found in the **Rider 61(b) Report Section**.

In addition, the MCOs provided several ideas to potentially reduce administrative expenses across Texas Medicaid and CHIP. As part of the coordination with the MCOs on the existing MCO reporting requirements, the State may want to expand the discussion to revisit the MCO ideas, particularly around the ideas related to reporting, including simplifying or streamlining requirements, increasing transparency, and improving efficiencies through standardization and automation.

2. Introduction

According to the General Appropriations Act for the 2018-19 Biennium, Senate Bill No. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, **Rider 61, Subsection (d)):**

"Out of funds appropriated above, HHSC shall conduct an audit of administrative expenditures made by managed care organizations in Medicaid and the Children's Health Insurance Program. HHSC shall use the audit process to identify opportunities for savings."

The scope of work requested that Rider 61(d) include an analysis of Texas Medicaid and CHIP MCO administrative costs, and develop and submit a survey of each of the Texas Medicaid and CHIP MCOs. The use of a survey allowed for a comparison across MCOs and an evaluation of the current status of the program and opportunities for cost savings and new efficiencies.

3. Approach and Methodology

The overall approach and methodology to accomplish the goals of Rider 61(d) involved three main tasks:

1. Gather and review existing data on MCO administrative expenditures
2. Develop and release a survey of Medicaid and CHIP MCOs
3. Analyze and document findings, developing recommendations on potential cost savings

3.1. Gather and Review Existing Data

Texas currently requires transparency from MCOs in documenting spending of State and federal appropriations in providing health coverage to more than four million program beneficiaries. MCOs must file a FSR quarterly that itemizes spending on medical care, quality improvements, and administrative expenditures. This data is publicly released on the HHSC website, which is a leading transparency practice in publishing Medicaid costs on a publicly available environment.

Before embarking on the survey required under Rider 61(d), changes in national Medicaid policy and existing Texas data sources on Medicaid spending were examined.

3.1.1. Examine National Regulatory Changes

Two changes codified into law in the 2016 Centers for Medicare & Medicaid Services (CMS) Medicaid and CHIP Managed Care Final Rule[84] had notable implications for MCO administrative expense policy.

3.1.1.1. MLR

Under the first change, state Medicaid MCOs were required to meet a new minimum MLR, meaning the MCO must spend at least 85 percent of Medicaid capitated payments on medical care and not on administrative expenses, such as salaries and marketing. This new requirement is similar to the MLR

[84] *CMS - Medicaid, "Medicaid and CHIP Managed Care Final Rule", https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html.*

required in the Affordable Care Act (ACA) for individual, small, and large group insurance plans.[85]

Although states are allowed broad discretion on enforcement penalties if a MCO fails to meet the minimum MLR, the change signaled an emphasis on ensuring that most Medicaid funding is used for providing health care services to beneficiaries of the program.

Texas includes an experience rebate provision in the Medicaid MCO contracts, a profit-sharing mechanism which allows Texas to recoup a portion of MCO net profits that exceed three percent of revenue. This calculation considers both the fixed and variable administrative expense components included in the capitation rates. These MCO administrative expense loads are set using a targeted administrative cost approach that estimates the percentage of medical and administrative costs an MCO is expected to incur during the rating period through a review of all MCOs' FSR data from the three most recent fiscal years. The administrative expense load is then used to determine the administrative expenditure cap for each individual MCO within the experience rebate calculation. If administrative costs exceed the target amount, the experience rebate calculation incorporates only the original administrative expense estimate included in the capitation rate, and the excess administrative costs are disallowed in determining MCO net profit.

Under the experience rebate provision, MCOs must return to the State a share of profits more than three percent of revenue on a sliding scale[86,87], as shown in the following **Figure 1**.

[85] *Under the ACA, health plans in the individual and small group markets must reach an 80 percent MLR while large group fully insured plans must comply with an 85 percent MLR. Unlike the discretion given to Medicaid programs, failure to meet these MLRs result in rebates back to the consumer.*

[86] *Evaluation of the 1115(a) Texas Demonstration Waiver - Healthcare Transformation and Quality Improvement: Final Evaluation Report, May 30, 2017.*

[87] *If an MCO experiences a net loss in either of the past two years prior to the experience rebate calculation, the calculation incorporates those losses when determining the potential experience rebate required in the current year.*

Figure 1. Experience Rebate on MCO Profit Margin.

Profit	Percent of profit MCO can keep
<3%	100%
3-5%	80%
5-7%	60%
7-9%	40%
9-12%	20%
>12%	0%

The experience rebate contractual provision creates a disincentive for MCOs to incur excessive medical and administrative expenses while also creating an incentive to manage program costs as MCOs are allowed to retain a portion of their profits. Some of these profits may currently be reinvested within the Texas Medicaid and CHIP programs. Texas MCO investments around value-based purchasing, quality improvement programs, or other innovative quality and efficiency reforms may result in a reduction in overall program expenditures and improved member access and quality of services.

The May 2017 final evaluation of Texas's Healthcare Transformation and Quality Improvement 1115(a) waiver found that the experience rebate is more effective at moderating administrative expenditures than a penalty for an MCO not achieving an 85 percent MLR. In SFY2014, the experience rebate resulted in MCOs returning $302 million to the State from profits in excess of the three percent threshold. A rebate based on the 85 percent MLR provision in the final CMS managed care rule would have returned $243 million to the State in SFY2014.[88]

3.1.1.2. Quality Improvements

The CMS managed care final rule also made a change to the categorization of quality improvement expenditures. Beginning in SFY2017, quality improvements undertaken by MCOs, previously counted as administrative expenditures, now are considered medical care components.

Federal Medicaid policy has placed increased emphasis on improving quality, including reforms to provider networks, prescription drug pricing, care coordination, and other MCO functions. Allowing quality improvements to be charged as medical expenses will further incentivize MCOs to pursue quality

[88] *Evaluation of the 1115(a) Texas Demonstration Waiver - Healthcare Transformation and Quality Improvement: Final Evaluation Report, May 30, 2017.*

improvements and reforms with less worry about compliance with the new MLR thresholds or other limitations such as Texas's risk-sharing experience rebate mechanism.

3.1.2. Analyze FSRs from SFY2016 and SFY2017

The Texas MCO FSRs break down administrative expenses into 24 categories, including salaries, bonuses, outsourced services, and corporate allocations, allowing the State to further understand how MCOs allocate administrative expenditures. A comparative MCO analysis was conducted, with consideration to membership size and programs served, relevant changes from SFY2016 to SFY2017, and variation in the cost categories, including direct versus indirect expenditures. The analysis found that reported amounts varied across the MCOs when reviewing by detailed expense component (and in aggregate total) for similar size membership and analogous programs served.

Various changes in the FSR instructions between SFY2016 and SFY2017 caused differences among the reported amounts for the two years. One of the primary drivers of the changes was due to the previously mentioned CMS managed care final rule regarding the consideration of Quality Improvement expenditures as medical expenditures rather than administrative expenditures. As a result of this regulation, HHSC modified the FSR instructions for SFY2017 to require MCOs to identify Quality Improvement expenditures, including acute care coordination expenses for the STAR+PLUS program, to be reflected as medical expenditures rather than administrative expenditures. Additionally, expenditures related to HHSC's newly implemented STAR Kids program was included in the FSR for the first time in SFY2017.

Due to these required reporting changes, it was more appropriate to review the two years individually.

3.2. Develop and Release a Survey of Medicaid and CHIP MCOs

Following the analysis of the current State of Texas MCO data and national policy, the approach included the development of a survey of each of the 20 Medicaid and CHIP MCOs operating in the State.

The survey was developed in accordance with the Legislative Rider 61(d), enacted during the 2017 Texas Legislature's biannual session. The goal of the survey was to gather more information about the administrative

expenditures of MCOs, especially around the largest drivers for aggregate administrative expenditures.

The approach produced a survey, which allowed for a comparative analysis paying consideration to membership size and programs served which included the STAR, STAR+PLUS, STAR Kids, STAR Health, CHIP, and Dental programs. The survey was also mindful that SFY2017 was the first year that quality improvements were fully counted as a medical expenditure instead of an administrative expense. Each of the 20 MCOs in the Medicaid and CHIP programs participated in the survey, released in April 2018 and returned by May 11, 2018.

3.3. Analyze and Document Findings

The completed surveys were consolidated into a single document, allowing for comprehensive analysis and comparisons.

The survey responses were analyzed, with consideration of membership size and other MCO variations, to more fully understand the administrative expenses and potential cost and efficiency opportunities.

The survey data provided additional transparency into the administrative costs and detailed buildup of those costs for each of the MCOs. Through analysis of the survey responses, options were identified for the State and its MCOs to pursue efficiency gains in the future.

4. Summary of Current Data and Reports

A review was conducted of MCO FSRs, independent MCO audit reports, and results of the 2012 managed care staffing and spending survey previously conducted by HHSC, to identify gaps in the available data and determine where further information may be needed for full comprehension of administrative expenditures.

4.1. Texas MCO Administrative Expenditures

Texas Medicaid and CHIP managed care spending topped $20.9 billion in SFY2017, up from approximately $17.8 billion in SFY2016[89], largely fueled by the introduction of the STAR Kids program.

Despite the increase in total spending, overall MCO administrative costs declined in SFY2017 (**Figure 2**). This decline is primarily driven by more than $535 million in quality improvement costs being reclassified as medical expenses in SFY2017. The reduction of quality improvement costs from administrative expenses is partially offset by the introduction of the STAR Kids program, which added almost $167 million in MCO administrative expenditures in SFY2017.[90, 91, 92]

[89] *2009 – 2017 Enrollment and Expenditure Data files, data provided by HHSC.*

[90] *Expenditures and PMPMs include quality improvement (QI) costs for SFY2016, but are excluded for SFY2017. The values are not adjusted to account for QI reallocation.*

[91] *2009 – 2017 Enrollment and Expenditure Data files, data provided by HHSC.*

[92] *Financial Summary 2017 – 90-day working and Financial Summary 2016 and 334-day working files, provided by HHSC.*

Figure 2. Texas MCO Administrative Expenditures SFY2016 and SFY2017.

Program	SFY2016 Total Administrative Expenses	SFY2017 Total Administrative Expenses	SFY2016 Administrative Expense PMPM	SFY2017 Administrative Expense PMPM
STAR	$654,366,000	$536,871,000	$18.45	$14.98
STAR+ PLUS	$606,333,000	$504,037,000	$94.15	$79.65
STAR Kids	N/A	$166,956,000	N/A	$102.28
STAR Health	$23,922,000	$20,348,000	$64.52	$52.83
Subtotal	**$1,284,621,000**	**$1,228,212,000**	**$30.38**	**$27.80**
CHIP	$60,085,000	$53,586,000	$12.65	$10.51
Dental	$90,364,000	$90,014,000	$2.57	$2.54
Grand Total	**$1,435,070,000**	**$1,371,812,000**	**$30.50**	**$27.83**

The STAR and STAR+PLUS programs provide coverage for a majority of Texas Medicaid beneficiaries and thus account for the majority of MCO administrative expenditures, with more than 85 percent of the total in SFY2016 and more than 75 percent in SFY2017.

On a PMPM basis, Texas has lower than average administrative expenses, more than $4 PMPM less than the national mean in SFY2017 of $32.69 according to external studies.[93] The STAR+PLUS, STAR Health, and STAR Kids programs (in SFY2017) are costlier on a PMPM basis than STAR or CHIP (**Figure 2**, above). While enrollment and total spending in these Medicaid programs is lower, the higher administrative expense PMPMs reflect the increased medical needs of the underlying populations.

[93] *Medicaid Managed Care financial results for 2017," Milliman Research Report, May 2018.*

4.1.1. Administrative Expenses by MCO Size

While the larger MCOs have higher administrative expenditures in aggregate dollars, on a PMPM basis, size is not a correlation to magnitude of the administrative cost PMPM (**Figure 3**). [94, 95, 96]

Figure 3. Medicaid Administrative Expense PMPM by Enrollment Bands (excluding dental services).

Medicaid Member Month Bands	SFY2016 # MCOs	SFY2016 Average PMPM	SFY2017 # MCOs	SFY2017 Average PMPM	Percent Change
0 - 300,000	2	$39.26	3	$62.81	60%
300,001 - 900,000	4	$49.90	4	$48.72	2%
900,001 - 2,000,000	6	$19.19	5	$18.04	-6%
2,000,001 - 5,000,000	5	$29.33	5	$31.86	9%
5,000,001	2	$29.31	3	$22.60	-23%
Total	**19**	**$28.47**	**20**	**$25.96**	**-9%**

As **Figure 3** indicates, MCOs between 900,001 and 2,000,000 member months[97], midsize MCOs, had the lowest PMPM administrative expenditures in both SFY2016 and SFY2017. In SFY2017, the largest MCOs had administrative expenditures on a PMPM basis at or below the statewide average for all MCOs. Economies of scale, such as sharing business functions between multiple states, could help explain the relative efficiency of the largest MCOs. However, the MCOs with member months between two and five million were above the average statewide PMPM.

One caveat is that only 10 MCOs participated in the STAR Kids program in SFY2017, which may have impacted the total PMPM. STAR Kids is not as large as STAR or STAR+PLUS in membership or overall spending, but medical and administrative costs were higher than all other Texas Medicaid programs on a PMPM basis during its first year in SFY2017.

[94] *The total PMPMs do not match **Figure 2** due to differences in the underlying data sources.*

[95] *SFY2016 and SFY2017 MCO Reported FSR, excluding dental services.*

[96] *Financial Summary 2017 – 90-day working and Financial Summary 2016 and 334-day working files, provided by HHSC, excluding dental services.*

[97] *2009 – 2017 Enrollment and Expenditure Data files, data provided by HHSC.*

4.1.2. Administrative Expenses by Tax Status

In SFY2017, the average administrative expense PMPM for MCOs with a non-profit tax status was approximately 31 percent less than MCOs with a for-profit tax status (**Figure 4**), declining from the 41 percent difference in SFY2016. The decline may be attributable to the reclassification of quality improvement expenses between SFY2016 and SFY2017. [98,99]

As noted in Section 4.1.1, some differences may be attributable to the size of the MCO, the specific Texas Medicaid programs they support, and the number and health status of beneficiaries served. For example, only for-profit MCOs currently participate in the STAR+PLUS program, which generally has higher cost members than some of the other Texas programs. Yet there may be an opportunity to explore the higher cost outliers of for-profit MCOs to determine if there are methods to reduce the total administrative expenditures closer to the statewide average.

Figure 4. Medicaid Administrative Expense PMPM by Tax Status.

Profit Status for Administrative Expenses	SFY2016 # MCOs	SFY2016 PMPM	SFY2017 # MCOs	SFY2017 PMPM
Non-Profit	12	$19.96	13	$20.31
For-Profit	7	$33.56	7	$29.36
Total	**19**	**$28.47**	**20**	**$25.96**

4.1.3. Administrative Expenses by FSR Expense Category

While the overall level of administrative expenditures can help present comprehensive data on how much MCOs are spending, review of the FSR data helps to show the reporting categories in which the MCOs are incurring administrative expenditures.

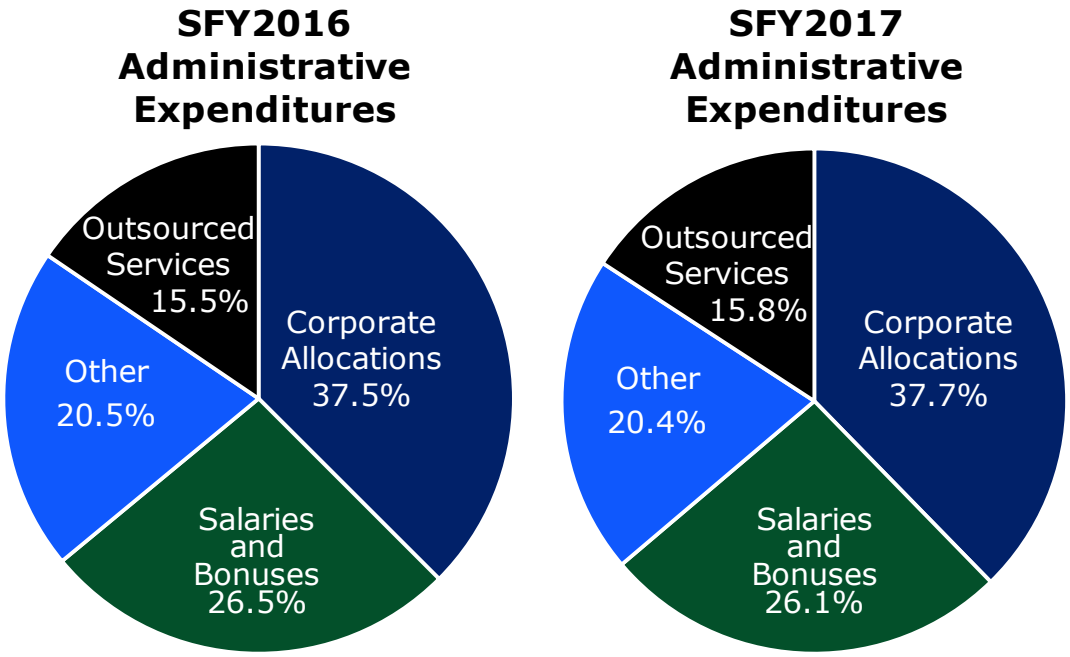
The review of MCO FSRs identified the most prevalent categories of administrative data, including corporate allocations, salaries, bonuses, and outsourced services (**Figure 5**).[100]

[98] *SOA data on MCO type, https://www.soa.org/Files/Research/medicaid-managed-data.xlsx.*

[99] *Financial Summary 2017 – 90-day working and Financial Summary 2016 and 334-day working files, provided by HHSC, excluding dental services.*

[100] *SFY 2016 and SFY 2017 MCO Reported Financial Statistical Reports.*

Figure 5. Percentage of Administrative Expenditure by Cost Category.



4.1.3.1. Corporate Allocations

Corporate allocations accounted for approximately 38 percent of total MCO administrative expenses in both SFY2016 and SFY2017, ranging by MCO from no corporate allocations to approximately 80 percent of total expenditures. In SFY2016, the average PMPM for corporate allocations was approximately $11 PMPM across all MCOs.

Despite a larger portion of administrative expenditures allocated to this cost category, there is little detail provided on the specific costs incurred under the corporate allocations FSR line item. In addition, the latest audit reports from 2014 revealed that, of the 16 MCOs that reported corporate allocations, 13 reported unallowable corporate expenses.[101] The Administrative Expenses survey presented an opportunity to learn more about these expense details among the MCOs.

4.1.3.2. Compensation

In the FSRs, the line items for salaries and bonuses account for more than 26 percent of the total aggregate administrative expenses. However, a review of the past audit reports indicates that corporate allocations include

[101] *SFY2014 Final 334-Day FSR Agreed-Upon Procedures Reports for all Texas MCOs.*

salaries and compensation expenses for corporate staff that allocate a portion of their time to the Texas managed care program. Therefore, the actual percentage of administrative expenses tied to compensation is greater than what is reported on the salary and bonus lines of the Texas MCO FSRs.

4.1.3.3. Outsourced Services

In both SFY2016 and SFY2017, some MCOs' outsourced services made up more than 80 percent of their total administrative expenses, on a PMPM basis, these costs ranged from near zero to more than $18 PMPM. However, in aggregate, the outsourced services category composed approximately 16 percent of the total administrative expenses in SFY2016 and SFY2017.

For each MCO, a comparative analysis was performed to determine if the amount of outsourced services expenditures was inversely correlated to the reported compensation expenditures. The results varied by MCO and there was not a clear indicator that outsourcing more services led to lower total compensation expenditures.

Within the FSRs, MCOs include the names of vendors used for outsourced services, but they are not required to share the types of services being provided. In some cases, the name of vendor provides enough detail to ascertain the specific service being outsourced, but for many MCOs it remains unclear based on the information in the FSR. The Administrative Expenses survey presented an opportunity to gather more detail on the types of outsourced services purchased by MCOs.

4.1.3.4. Other Expenses

The remaining 20 percent of reported administrative expenses fell into the "Other" category, comprising administrative costs, such as Pharmacy Benefit Manager (PBM) fees, marketing, legal and professional services, and travel. While these amounts were smaller drivers of overall administrative expenses, there was enough variation among MCOs (with some showing $0 for certain cost categories) and a lack of detail on the nature of the expenditures to warrant requests for additional information through the survey. The review focused on variations among the legal and professional services, marketing, computer hardware, and travel expense categories (**Figure 6**). Only MCOs with expenditures in a cost category were included in the PMPM calculation, providing for a more accurate comparison on the

magnitude of administrative expenditures within the four specific cost categories in **Figure 6**.[102, 103]

Figure 6. PMPM Range for Various MCO Expenditures.

FSR Reporting Category	SFY 2016 # MCOs	SFY 2016 PMPM Range	SFY 2016 Statewide PMPM	SFY 2017 # MCOs	SFY 2017 PMPM Range	SFY 2017 Statewide PMPM
Legal and Prof. Services, incl. External Audit, Tax, and Consulting	17	$0.21 - $8.70	$0.97	20	$0.02 - $7.04	$0.81
Marketing, PR, and Outreach (excl. Salaries)	16	$0.01 - $2.97	$0.31	17	$0.01 - $1.94	$0.30
Computer hardware/ Software purch., uncapitalized	12	$0.01 - $1.42	$0.30	13	$0.01 - $7.42	$0.32
Travel Expenses	18	$0.01 - $0.87	$0.19	18	$0.01 - $1.10	$0.17
Total	**19**	**$0.01 - $8.70**	**$1.67**	**20**	**$0.01 – $7.42**	**$1.50**

4.1.3.5. Staffing Financial Impact

The FSR does not include information on the number and types of FTE staff that work for each MCO; hence, this topic became an area of inquiry for the survey. How many staff are employed by MCOs in the Texas managed care program?

In 2012, HHSC completed a local and regional economic impact of managed care assessment. MCOs were asked at the time for information on the amount of resources allocated by the type of service for both in-state and out-of-state staff.

[102] *SFY2016 and SFY2017 MCO Reported Financial Statistical Reports.*

[103] *Only MCOs that listed expenditures in each category were included in the Figure. MCOs with $0 for an expense category may have accounted for the function in a different cost category (such as outsourced services).*

4.2. MLR

As mentioned in Section 3, the new federal managed care regulations promulgated by CMS established a minimum Medicaid MLR at 85 percent for MCOs in the Medicaid marketplace. In the aggregate, this is a standard that Texas MCOs currently are meeting or exceeding (**Figure 7**).

The MCOs in the STAR Kids program, serving the most expensive population in Medicaid (at $1,474 PMPM), had an average MLR of 94.2 percent, which was the highest MLR percentage of any specific Texas Medicaid program.

Texas's MLR in SFY2016 and SFY2017, at 89.9 percent and 90.9 percent, respectively, exceeded the national averages. In SFY2016, the national state-by-state average for Medicaid MCOs was 86.9 percent, rising to 88.2 percent in SFY2017 according to an external state-by-state analysis.[104] Certain MCOs in Texas have fallen below the national average or the 85 percent MLR threshold, but in total, Texas is keeping pace with national trends in both MLR and total MCO administrative expense PMPMs.[105, 106]

Figure 7. Texas MLR.

Program	SFY2016 MLR	SFY2017 MLR
STAR	88.5%	89.5%
STAR+PLUS	91.6%	92.2%
STAR Kids	N/A	94.2%
STAR Health	90.2%	90.7%
Sub Total	**90.1%**	**91.3%**
CHIP	85.9%	85.4%
Dental	88.6%	87.8%
Grand Total	**89.9%**	**90.9%**

[104] *"Medicaid Managed Care financial results for 2017," Milliman Research Report, May 2018.*

[105] *Financial Summary 2017 – 90-day working and Financial Summary 2016 and 334-day working files, provided by HHSC.*

[106] *The MLR percentages do not include the impact from experience rebates.*

5. Survey Overview

The Texas HHSC MCO Administrative Expenses survey was developed to collect additional data points and details that could provide more insights into non-medical expenditures (administrative expenditures) associated with the State's Medicaid and CHIP managed care programs.

5.1. Survey Question Development

Based on the FSR and other data reviewed, MCO administrative staffing, corporate allocation, and outsourced services were areas that needed to be explored in greater detail through the MCO survey. These areas composed the highest total value of administrative expenses, totaling almost 80 percent of the aggregate non-medical costs in both SFY2016 and SFY2017, and would form the basis of several questions to Texas's MCOs.

In addition, as noted in Section 4, there were other findings from the data review that required additional follow-up through the survey process. The additional areas of inquiry included:

5.1.1. Cost Reporting Granularity

Several of the MCOs reported $0 on the FSR for some typical business costs, such as computer hardware/software, travel, professional/legal services, or marketing. This lack of reporting suggested that some MCOs may not be able to provide the same level of cost granularity as other MCOs or that a portion of these expenses were outsourced. The survey sought to ask questions that would enable MCOs to explain the variations in reporting and allow for a better understanding of the capabilities of accounting for different administrative expense categories.

5.1.2. Cost Allocation Approaches

While the FSR provides comprehensive data on administrative expenditures, there are several expenditure line items with wide variation across MCOs. In each cost area, some MCOs had sizable expenditures while others had $0 or minimal costs assigned to the functions.

These cost discrepancies raised questions regarding the methods MCOs were using to allocate their administrative expenses and if varying cost allocation methods could cause some of the discrepancies in the reported Medicaid program administrative expenditures. To help provide additional information on how MCOs allocate costs, the survey sought to inquire about the methods used to divide costs among the FSR categories, as well as the methods used

to distribute administrative time across the various insurance markets (often in multiple states) that the MCO participates in.

5.1.3. Changes between SFY2016 and SFY2017

Taking into consideration the addition of the STAR Kids program (and removal of quality improvements as an administrative cost), there were wide variations in some cost categories between SFY2016 and SFY2017 on the FSR. The survey sought to learn more about the changes that impacted expenditures.

5.1.4. Discretionary Expenditures

Several elective or non-business-related cost categories, including travel expenses and marketing, showed a wide range of expenditures among MCOs. A survey goal was to learn more about the particular expenditures behind these total costs to provide an understanding of the costs to Texas.

5.2. Survey Questions

The survey was based on the guiding principles and the lessons learned from the initial review of existing administrative expense data. The survey sought to:

1. Develop ***standardized questions*** so that one survey can be shared across all MCOs
2. Utilize a format that is **easy to use** and allows for efficient data consolidation
3. Ask questions with a combination of ***numeric responses,*** as well as ***narrative responses,*** keeping narrative responses brief
4. Enable ***two-way communication*** by allowing the MCOs an opportunity to provide input on how to better control administrative costs

The following is a description of the survey questions and brief explanation of the intent of each.

5.2.1. Number of Resources by Functional/ Operational Components

The first question of the survey asked Medicaid and CHIP MCOs to detail the number of FTE staff employed in each of the primary cost areas, both in-state and outside of Texas. The information requested is similar to a 2012 survey conducted by HHSC.

In SFY2017, Texas MCOs spent more than $350 million directly on salaries, in addition to the indirect salaries charged within the corporate allocations. The survey questions sought to learn more about the areas of the business utilizing these FTEs and the distribution of in-state and out-of-state resources, information that is not discernible from the FSR reports.

5.2.2. Corporate Allocations

The largest single administrative expense line item for Texas MCOs is corporate allocations, accounting for more than 35 percent of the total administrative expenses in both SFY2016 and SFY2017.

While the total value is reported every year on the FSR, relatively little has been reported on the overall breakdown of this administrative expense. A recent audit provided evidence that the largest portion of the corporate allocation expenses are compensation related, with a smaller portion on non-compensation expenditures, such as information technology costs and travel.[107] However, outside of audits by the State auditor and others, a comprehensive understanding of these expenses is not easily attainable from publicly available information.

The survey asked about the specifics of these administrative expenses, both compensation and non-compensation. MCOs were asked for specifics on salaries, bonuses, incentive payments, in addition to non-compensation costs for marketing, travel, capital expenditures, and other line-items.

5.2.3. Outsourced Services

Texas MCOs spent more than $200 million on outsourced services annually in SFY2016 and SFY2017. The FSR requires MCOs to list the vendors that provide the capitated or non-capitated service, with the majority providing a specific benefit, such as behavioral health services, vision, or dental coverage.

The survey sought to capture additional details about outsourced services to show the types of activities that are being performed by a third-party vendor.

[107] *Texas State Auditor's Office, "Recent Reports," https://www.sao.texas.gov/.*

5.2.4. MCO Reporting Requirement Expenditures

Common feedback among MCOs in the Medicaid marketplace nationwide is that state reporting requirements are a distinct effort and add to the program's administrative expenses.

The survey asked the MCOs to report on the amount of administrative expenses deriving from Texas-specific reporting requirements. While most reporting, including the information presented in the annual FSRs, is a requirement, the request was for an annual estimate of the total administrative expenditures associated with providing HHSC with required deliverables outlined in the Section 5.0 Consolidated Deliverable Matrix of UMCM. The intent was for this targeted data to shed light on the true effort faced by MCOs in complying with state-based requirements from HHSC and the Texas Legislature.

5.2.5. Clarification on Reported Expenditures

As mentioned earlier, the FSR appeared to show variations in the ability of some MCOs to provide more granular details on administrative expenses for certain cost categories. Some MCOs listed $0 for normal operating expenses. The clarification on reported expenditures question intended to gather examples of specific expenses for several cost categories included in the FSR and other State reports. MCOs without any expenses in a particular category were asked to explain the lack of expenditures.

5.2.6. Cost Allocation Methodology

With MCOs employing varying cost allocation methodologies, this question asked for a narrative explanation for the process the MCOs used to allocate administrative expenses, especially with indirect costs for categories, such as corporate allocations.

5.2.7. Administrative Expenditure Changes SFY2016 to SFY2017

This survey question sought to gather more information about the specific changes (other than the reclassification of quality improvement costs as medical expenses) to Texas MCOs over the past fiscal year, such as the introduction of the STAR Kids program.

5.2.8. Areas of Opportunity

The final survey question provided the Texas MCOs with an opportunity to share their thoughts on areas of opportunity in gaining cost efficiencies and reducing regulatory reporting efforts in their Medicaid and CHIP managed care programs.

5.3. Survey Distribution

The Administrative Expenditure survey was distributed on April 23, 2018, to each of the 20 MCOs serving the Texas Medicaid and CHIP populations. The list of those receiving the survey were (**Figure 8**):

Figure 8. Texas MCOs Receiving the Administrative Expense Survey.

- **Aetna Better Health of Texas Inc.**
- **Amerigroup Texas Inc.**
- **Blue Cross Blue Shield of Texas**
- **Children's Medical Center**
- **Cigna-HealthSpring**
- **Community First Health Plans Inc.**
- **Community Health Choice Inc.**
- **Cook Children's Health Plan**
- **Dell Children's Health Plan**
- **DentaQuest LLC**
- **Driscoll Children's Health Plan**
- **El Paso Health Plans Inc.**
- **FirstCare Health Plans**
- **MCNA Dental**
- **Molina HealthCare of Texas Inc.**
- **Parkland Community Health Plan Inc.**
- **Scott & White Health Plan**
- **Superior Health Plan**
- **Texas Children's Health Plan Inc.**
- **United HealthCare Community**

5.4. Survey Response

An email inbox was established for MCOs to pose clarifying or technical questions on the survey. While the number of questions submitted were low, there were a few areas that required additional clarification.

On May 7, 2018, each MCO was invited to a webinar where certain common questions were addressed, and MCO representatives were given an

opportunity to ask additional questions as they worked toward completion of the survey. Question topics included:

- Should we account for quality improvement costs?
- Should FTE headcount calculations include third-party vendors?
- What counts as a reporting requirement?

Over 40 representatives of the MCOs participated in the webinar, and a recording of the event was distributed to the entire MCO survey distribution list on May 8, 2018.

On May 11, 2018, each of the 20 MCOs returned an on-time and completed survey as requested.

6. Survey Results

The completed survey responses were consolidated and analyzed, looking for expenditure trends across MCOs, increased understanding of the more granular details of certain cost areas, and potential cost savings opportunities for the Texas Medicaid and CHIP programs.

The following is a discussion of findings from the responses to each of the questions in the Administrative Expenses survey.[108]

6.1. Number of Resources by Functional/Operational Components

6.1.1. Question

In 2012, HHSC conducted an assessment of certain Medicaid MCO administrative expenditures. We asked at the time for information on the amount of resources allocated to a number of Functional/Operational domains supporting the Texas Medicaid program, both working inside and outside the state of Texas. We would like to refresh this data for SFY2016 and SFY2017.[109]

6.1.2. Observations and Findings

1. Over one-third of all FTEs in Texas's Medicaid and CHIP MCOs support utilization management services.
2. Approximately 7 out of 10 Medicaid Managed Care staff are employed in the State of Texas; however, claims management processing, financial/accounting services, and information technology services all had more total out-of-state staff.
3. There is not a strong correlation between the number of in-state and out-of-state staff and the amount of each MCO's administrative expenditures. However, there is an opportunity to further understand how out-of-state compensation compares across services the staff are providing. Higher

[108] *Unless otherwise cited, all figures are based on data from the 2018 Texas HHSC MCO Administrative Expenses Survey.*

[109] *The survey question contained a drafting error which implied that the 2012 survey asked about out-of-state FTEs. The 2012 survey explicitly asked MCOs to exclude FTEs that worked outside of the state of Texas. The 2018 Texas MCO Administrative Expenses survey asked for all FTEs, including those based outside of Texas.*

cost outliers for specific MCOs could be analyzed to determine if those costs could be more closely aligned with the statewide average.

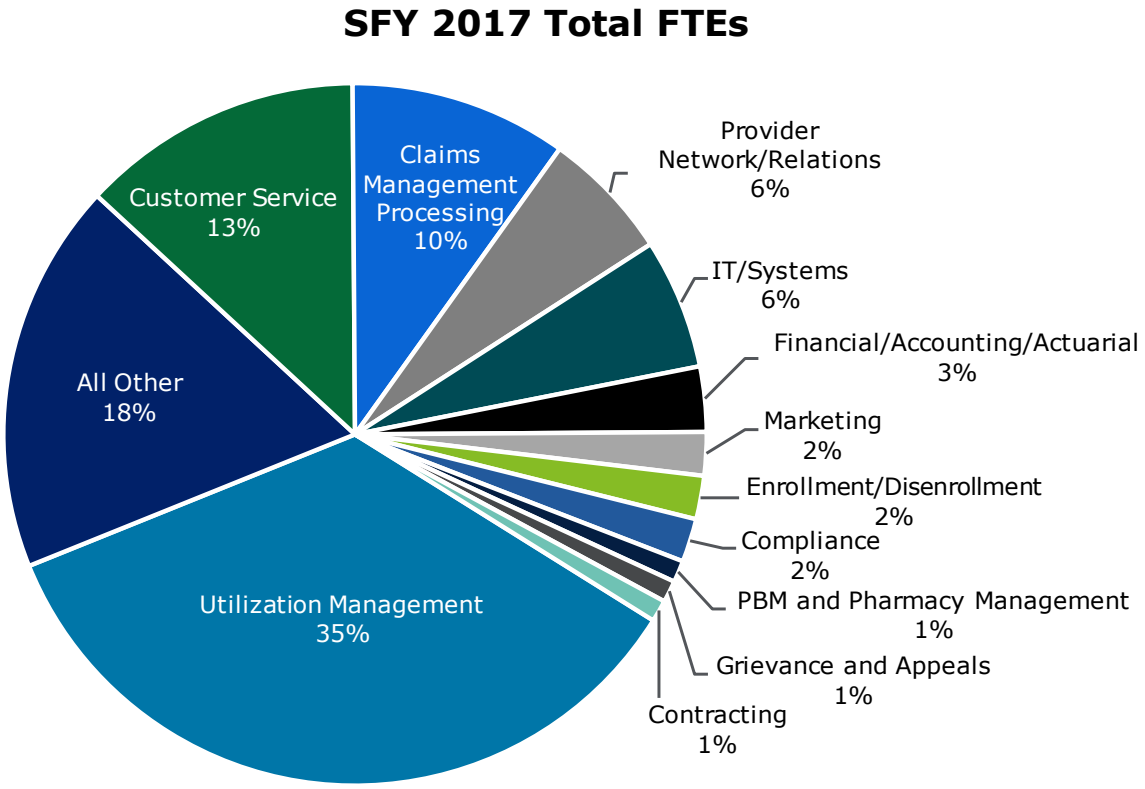
4. The number of FTEs and the amount of administrative expenses on an FTE basis vary by MCO, partially attributable to the size of the underlying population served. However, there is an opportunity for HHSC to further examine staffing outliers to determine if the level of staffing and spending per staff is appropriate in comparison to other MCOs with similar size populations.

6.1.3. Supporting Information

6.1.3.1. Breakdown of FTEs by Functional/Operational Domain

Texas MCOs employed over 11,000 FTEs in SFY2016 and over 12,000 FTEs in SFY2017. These FTEs are spread across 13 categories. **Figure 9** shows the breakdown of FTEs by functional/operational domain in SFY2016 and SFY2017.

Figure 9. Breakdown of FTEs by Functional/Operational Domains.



Utilization management is used by MCOs to evaluate the medical necessity of care and certain health care procedures. Effective utilization management can produce overall Medicaid cost savings by relying on efficient and cost-effective treatment options. Over 90 percent of FTEs in utilization management work within the State of Texas.

The other functional areas with a large percentage of FTEs are customer service and claims management processing. These functional areas are essential components of a successful managed care plan. Approximately 60 percent of customer service FTEs are Texas-based. Most MCOs have the entirety of their customer service functionality in-state. Only two MCOs reported a majority of their customer service staff as out-of-state.

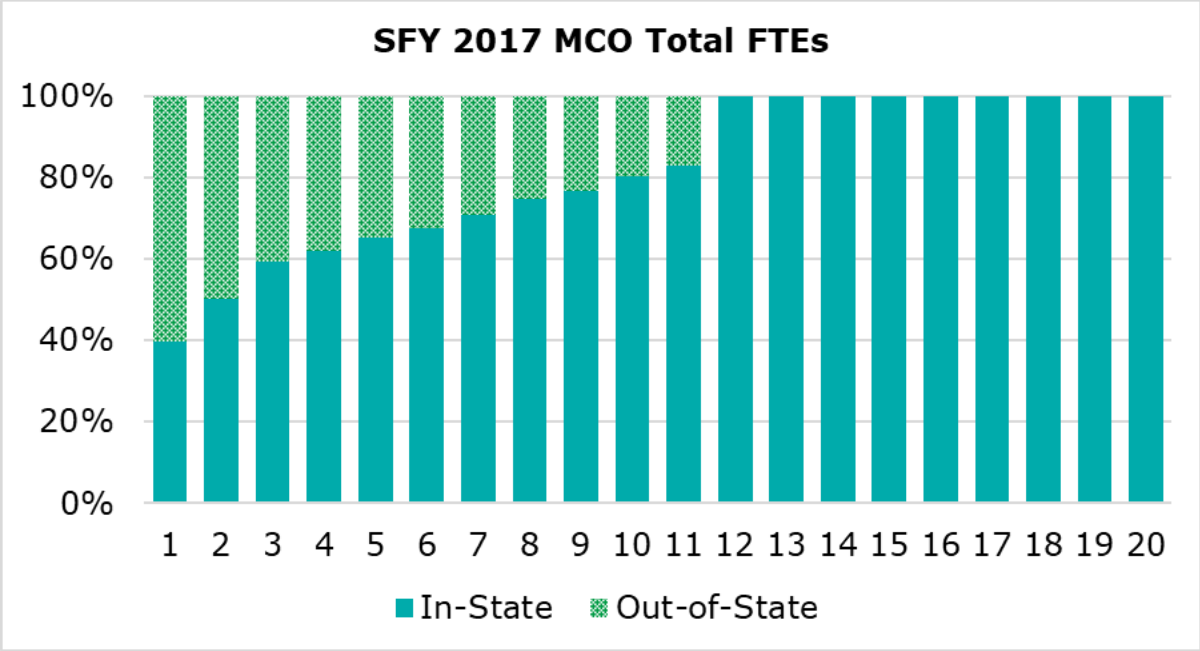
Conversely, claims management processing employees tend to be located outside of Texas. In both SFY2016 and SFY2017, the MCOs reported that more than 70 percent of FTEs supporting claims management functions were employed outside the State of Texas. Larger MCOs, with business in multiple states, typically have centralized claims processing units that support multiple states and jurisdictions.

6.1.3.2. Majority of FTEs supporting Texas Medicaid Managed Care are employed within Texas

On average, at least 70 percent of Texas's MCO FTEs are in-state workers. As **Figure 10** shows, this number is fairly consistent across the MCOs, as the range of in-state workers range from 40 percent to 100 percent, with only one plan having more workers out-of-state than within Texas (**Figure 10**). Almost half of the 20 MCOs in the Medicaid program have their entire workforce in-state.

Typically, a national or regional plan with Medicaid Managed Care business in several states is more likely to have some of its resources out-of-state as it shares resources for certain functionalities to efficiently manage multiple programs. However, each MCO survey reported a comprehensive in-state presence in providing coverage and health care services to the Medicaid population in Texas.

Figure 10. Breakdown of Texas MCOs, In-State and Out-of-State.



6.1.3.3. Average Administrative Expenses per FTE

Administrative expenses per FTE averaged approximately $127,000 in SFY2016 and $112,000 in SFY2017. When reviewing the expenses by FTE against the percentage of staffing located within the State of Texas versus out of state, the results were mixed (**Figure 11**).[110] There was not a clear indication that the relation of an MCO's administrative expenditures relative to all other MCOs was driven by the location of its staff.

Figure 11. Administrative Expenses per FTE.

Percent of In-State FTEs	SFY2016 # MCOs	SFY2016 Administrative Expenses per FTE	SFY2017 # MCOs	SFY2017 Administrative Expenses per FTE
0% to 39%	1	$127,620	1	$127,504
40% to 69%	5	$116,171	5	$86,013
70% to 99%	4	$117,345	5	$115,559
100%	9	$174,795	9	$159,866
Total	**19**	**$127,754**	**20**	**$112,421**

[110]*Administrative expenses from the SFY2016 and SFY2017 MCO Reported FSRs.*

6.2. Corporate Allocations

6.2.1. Question

Please provide additional information on your plan's reported corporate allocation expenditures as reported in line #24: Corporate allocations of the FSR, split between compensation and non-compensation related expenses. If no expenses were reported, please enter zero ($0).

6.2.2. Observations and Findings

1. Over 60 percent of corporate allocations are for salaries and other staff compensation.
2. Information technology is the largest single non-compensation corporate allocation across MCOs, accounting for seven percent of all corporate allocations in SFY2016 and nine percent in SFY2017.
3. Variation exists for MCOs in the amount of corporate allocations for compensation expenses. There is an opportunity for further analysis to understand the roles and responsibilities of the staff included as corporate overhead and how their services are benefiting the Texas Medicaid and CHIP programs.
4. Variation also exists for MCOs in the non-compensation components of corporate allocations. There is an opportunity to further analyze the higher cost outliers to determine if those expenditures could be more closely aligned with the statewide averages.

6.2.3. Supporting Information

6.2.3.1. Survey Shed Additional Light on Corporate Allocations

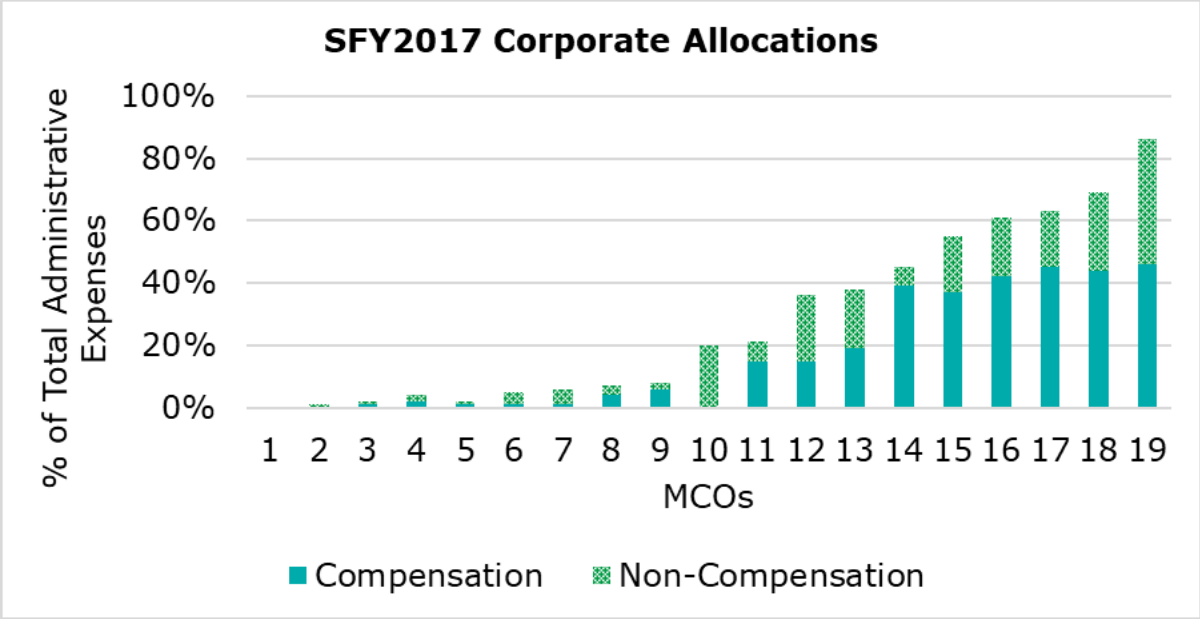
The FSRs require MCOs to report on the total amount of corporate allocations as follows in line 24 of the FSR: "Enter expenses allocated by the MCO's parent or affiliates." Each MCO has submitted data to the State to comply with the requirement in line 24, with over $510 million in corporate allocations administrative expenses reported in SFY2017. However, there are

no underlying details on the nature of these expenditures in the FSR reports.[111]

In the Administrative Expenses survey, MCOs reported spending approximately $350 million on corporate allocations compensation costs in SFY2016 and $325 million in SFY2017. Adding these costs reported in the survey to the aggregate salaries reported in line 1 of the FSR report ($367 million in SFY2016 and $347 million in SFY2017) almost doubles the total compensation costs for MCOs, representing approximately 50 percent of the total MCO administrative expenses in both years.

Overall, there is a wide range of corporate allocation expenditures by MCO. In SFY2017, corporate allocation spending as a percentage of overall administrative expenditures ranged from 0 percent to over 80 percent (**Figure 12**).[112]

Figure 12. Corporate Allocations by MCO.



The Administrative Expenses survey asked MCOs to provide compensation and non-compensation elements that comprise the corporate allocation cost

[111] *Note that the HHSC's contract auditors collect information during the annual agreed-upon-procedures (AUP) assignment in order to evaluate the allowability of MCO administrative costs and gain a better understanding of the MCO's corporate allocation process.*

[112] *Total administrative expenditures for corporate allocation taken from SFY2017 MCO Reported Financial Statistical Reports.*

category on the FSR report (with the breakdown of compensation/non-compensation expenditures included in **Figure 12**).

More than 60 percent of the corporate allocations are compensation expenses for FTEs partially or indirectly supporting the Texas Medicaid program as part of the broader corporate entity or an affiliate (**Figure 13**). The percentage of corporate allocation expenditures allocated to compensation varies by plan, ranging from 0 percent (three MCOs) to 87 percent.

Figure 13. Corporate Allocations by Category.

SFY2016 Corporate Allocations	Category	Percent of Total
Compensation	Salaries	56%
Compensation	Incentive Payments	6%
Compensation	Bonuses	2%
Non-Compensation	All Other	21%
Non-Compensation	Information Technology	7%
Non-Compensation	Capital Expenditures	4%
Non-Compensation	Marketing	3%
Non-Compensation	Travel	1%

SFY2017 Corporate Allocations	Category	Percent of Total
Compensation	Salaries	57%
Compensation	Incentive Payments	4%
Compensation	Bonuses	2%
Non-Compensation	All Other	20%
Non-Compensation	Information Technology	9%
Non-Compensation	Capital Expenditures	4%
Non-Compensation	Marketing	2%
Non-Compensation	Travel	1%

6.2.3.2. Non-compensation Costs Vary Among MCOs

The survey also provided additional details on the non-compensation elements of the corporate allocations cost category. Over 35 percent of corporate allocations ($200 million in SFY2016 and $186 million in SFY2017) were allocated to non-compensation elements. Over 20 percent of the non-compensation costs in each year went toward information technology costs across the corporate business, as the MCOs allocated a portion of the overall costs to the Texas Medicaid and CHIP programs. Marketing, travel and capital expenditures accounted for a relatively small portion of the overall non-compensation costs (**Figure 13**, above).

The largest combined category captured "Other" expenditures not specifically listed in the survey. These expenditures vary across MCOs, but the largest expenditures are for telecom and facilities-related expenses. Three MCOs account for approximately 70 percent of the expenditures in the "Other" portion of corporate allocations. The statewide PMPM for each expense is less than $3 for MCOs reporting expenses in each of the cost categories included in the Administrative Expenses survey (**Figure 14**).[113]

[113] *Only MCOs that reported expenses in each cost category are included in Figure 14. MCOs not reporting expenses may have accounted for these business functions through outsourced services or other categories.*

Figure 14. Non-Compensation Corporate Allocations.

Category	SFY 2016 # MCOs	SFY 2016 PMPM Range	SFY 2016 Statewide PMPM	SFY 2017 # MCOs	SFY 2017 PMPM Range	SFY 2017 Statewide PMPM
Information Technology	12	$0.14 - $10.80	$0.98	13	$0.01 - $11.47	$1.02
Capital Expenditures	4	$0.01 - $3.70	$1.36	5	$0.01 - $3.16	$1.15
Marketing	6	$0.01 - $1.11	$0.75	8	$0.01 - $1.07	$0.50
Travel	8	$0.01 - $0.63	$0.26	8	$0.01 - $0.70	$0.22
All Other	13	$0.06 - $11.10	$2.77	15	$0.08 - $14.54	$2.33
Total	**16**	**$0.01 - $11.10**	**$4.31**	**17**	**$0.01- $14.54**	**$3.81**

6.2.3.3. Corporate Allocations Vary Across MCOs

While corporate allocations remain the largest single line-item on the administrative expenditures FSR, there is a lot of variation across MCOs. MCOs only operating regionally within the State tend to have few corporate allocations. Specifically, four MCOs report no expenditures for compensation-related corporate allocations, and one MCO has no reported corporate allocations (compensation or non-compensation).

MCOs that operate more broadly within Texas or that have regional or national corporate entities or affiliates have higher corporate allocation expenditures. Four MCOs account for over 80 percent of the total corporate allocations. Yet, while these four MCOs have the highest corporate allocations, it remains unclear whether large amounts of corporate allocations correlate to high overall administrative expenditures. Two of these four MCOs have an administrative cost PMPM at or near the overall average for MCOs, while the other two are greater than the average. This mixed result shows that it is possible to offset high corporate allocations with lower costs in other expense categories, but not all MCOs are reaching this equilibrium.

6.3. Outsourced Services

6.3.1. Question

Please provide an estimate of the breakdown of the top three administrative services/functional activities that are contained within your plan's reported outsourced expenditures as reported in line #19: Outsourced Services (Non-Capitated Arrangements) and line #20: Outsourced Services (Capitated Arrangements) of the FSR. Please briefly describe the services and the estimated associated cost on a total dollars basis (i.e., do not use a percentage or a PMPM). If no expenses were reported, please enter zero ($0) and leave the descriptions blank.

6.3.2. Observations and Findings

1. There are a few commonalities among MCOs that choose to outsource services, including:
    a. Most common non-capitated outsourced services among Texas MCOs is claims processing and management. Nine out of the 15 MCOs that reported outsourced services in SFY2017 highlighted claims processing in their top three expenditures.
    b. Most capitated outsourced managed care services are behavioral health or vision services, with 12 out of 15 MCOs indicating vision as a top three capitated expense and 6 out of the 15 MCOs indicating behavioral health as a top three capitated expense.
2. Unclear whether outsourced services can be associated with higher or lower overall administrative expenses—no obvious correlation seen between higher than average amounts of outsourced services and overall administrative expenditures. Of the top four MCOs in total outsourced spending, only one has total administrative expenditures above the statewide average.
3. For MCOs which do not outsource administrative services, such as vision and dental administrative services, it is difficult to isolate these types of expenditures within the existing FSR reporting. There is an opportunity to further analyze these types of expenditures to determine if outsourcing these services is more cost effective than keeping them within the MCO.

6.3.3. Supporting Information

6.3.3.1. Most Outsourced Non-Capitated Services involve Claims Processing

Based on survey responses, many MCOs prefer to outsource claims processing to a third-party administrator or vendor. The majority of the top non-capitated outsourced services among the 15 MCOs that outsourced services in SFY2016 and/or SFY2017 involved claims processing. Other secondary costs include call center support/customer service, an after-hours nurse advice line, and network support/third-party recoveries (**Figure 15**).

6.3.3.2. Capitated arrangements focus on specific benefit coverage needs

Capitated outsourced services are less common than non-capitated arrangements, as is noted on the FSR reports. However, MCOs still reported over $57 million (four percent of total administrative costs) in capitated outsourced services administrative expenses in SFY2016 and $75 million (5.5 percent of total administrative costs) in SFY2017.

Administrative support for behavioral health related services is the most common outsourced service, accounting for a majority of MCOs' top outsourced service in both SFY2016 and SFY2017 (**Figure 15**). Several MCOs choose to outsource vision or dental coverage (as either a first or secondary outsourced service), but these services are less costly to provide than behavioral health and, as such, the administrative expenses are lower.

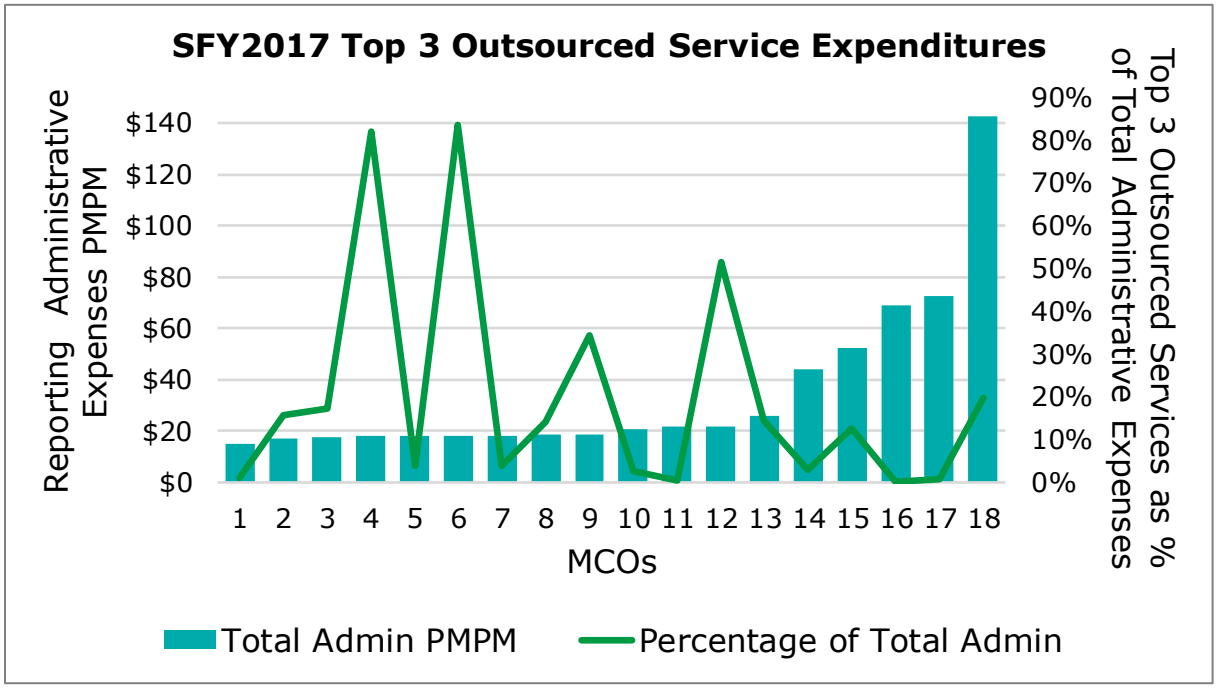
Figure 15. SFY2016 and SFY2017 Top Outsourced Services.

Outsourced Services with Capitated Arrangements	Outsourced Services with Non-Capitated Arrangements
Vision	Claims Processing
Behavioral Health	Third-Party Recovery
Dental	Behavioral Health
Radiology Services	Customer Service
Healthcare solutions	Call Center Support/Nurse line

6.3.3.3. Little relationship seen between Outsourced Services and Administrative Expenditures

MCO decision-making on outsourced services, as the survey confirms, is varied (**Figure 16**). MCOs appear to make decisions regarding completing functions internally vs. outsourcing that work best for their business model.

Figure 16. MCO range of Non-Capitated and Capitated Outsourced Services.



Based on survey responses and FSR data, it appears that there is little relationship between higher than average outsourced services and overall administrative expenditures. Of the top four MCOs with outsourced services, three had overall administrative expenses at or below the state average, while one MCO was higher than average on a PMPM basis. Outsourced services can be associated with lower administrative expenditures, but it appears to be an MCO-specific decision.

6.4. Reporting Requirements

6.4.1. Question

Please provide an estimate of the total administrative expenditures associated with meeting all reporting requirements outlined by HHSC. Please enter the amounts on a total dollar basis (i.e., do not use a percentage or a

PMPM). If you feel a supporting narrative response is also needed, please use the narrative input field.

6.4.2. Observations and Findings

1. Less than five percent of total administrative expenses are attributable to HHSC reporting requirements, as defined by the UMCM.
2. The PMPM cost of reporting requirements averaged approximately $2.30 in both SFY2016 and SFY2017.
3. Several MCOs commented that they believe the actual cost of reporting requirements to be higher than the amounts they listed in response to the survey question.
4. The responses to this question varied, and there appears to be a few lower cost and higher cost outliers. In addition to efforts already underway between HHSC and the MCOs to streamline the deliverables, there may be a further opportunity to discuss this response with the MCOs to determine the specific level of effort and staffing required to support HHSC reporting requirements to determine if some existing activities may be unnecessary and thus could reduce overall costs.

6.4.3. Supporting Information

6.4.3.1. Defining reporting requirements can be difficult

Responses to the Administrative Expenses survey indicates that MCO expenses associated with meeting various HHSC reporting requirements account for approximately three percent of overall administrative expenditures (**Figure 17**).[114,115] As noted in Section 4.2, MLRs were approximately 89.9 percent and 90.9 percent in SFY2016 and SFY2017, therefore, these expenditures represent less than 0.3 percent of total program expenditures.

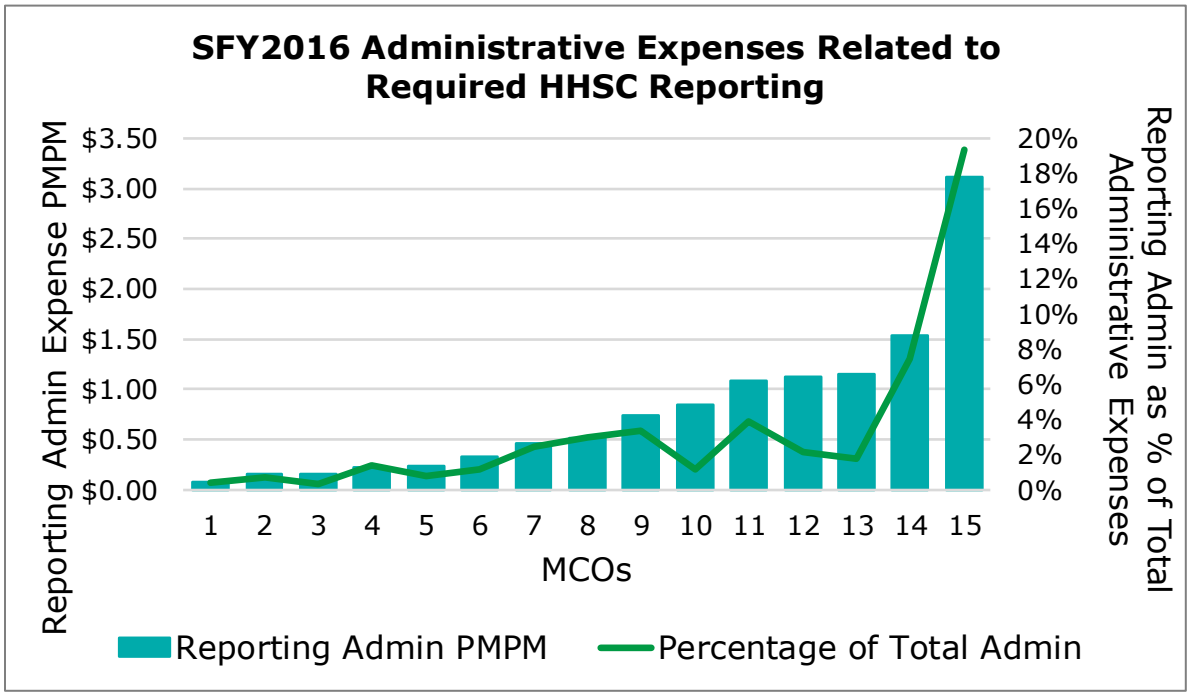
However, as mentioned in providing input to the State in a later survey question [Question 9], many MCOs believe that the true cost of reporting

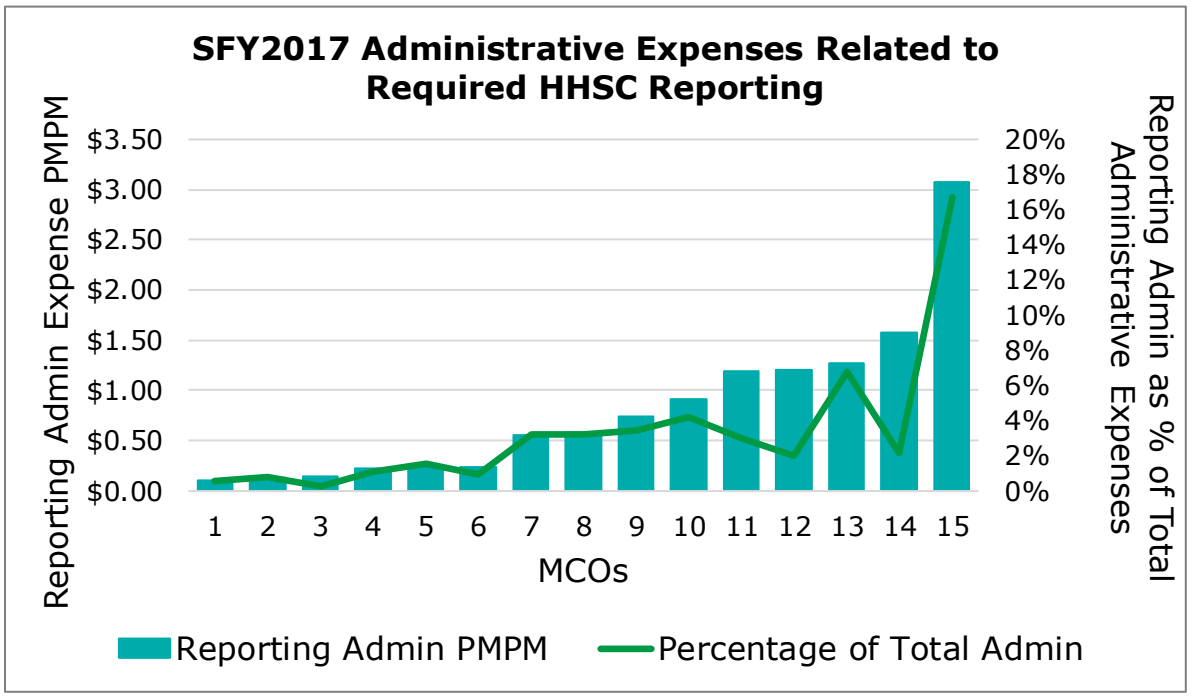
[114] *This amount includes two MCOs that included all of their administrative expenses as a reporting cost. These two MCOs accounted for over 60 percent of the total across all of the Medicaid Managed Care organizations. These two outliers were removed. An additional MCO was excluded because of a comment that the entity was not able to accurately reflect the reporting requirement costs.*

[115] *Total administrative expenditures data taken from SFY2016 and SFY2017 MCO Reported Financial Statistical Reports.*

requirements is higher than reported in their survey response, but difficult for them to fully quantify.

Figure 17. Administrative Expenses in SFY 2016 and SFY2017 Related to HHSC Reporting Requirements.





6.5. Clarification on Reported Expenditures

6.5.1. Question

For each of the following FSR expenditure categories, please list the amounts of the top three expenditure items included in the FSR category and a brief description of each expense. If the entry is zero/blank, please confirm if there is in fact no associated expenditure or if the amount is reported in a separate FSR line item. If in a separate FSR line item, please clarify the line item and the associated expenditures.

6.5.2. Observations and Findings

1. MCOs provided additional details on the primary expenditures behind certain FSR line-items, line-items that comprise approximately six percent of the total administrative expenses reported by Texas MCOs, according to FSR reports. Two high-level observations from the results included:
    a. The expenditures listed by MCOs typically included common expenditures for these categories, like consulting services (for professional services FSR line-item) and outreach and advertising (for the marketing FSR line-item)
    b. MCOs that reported $0 expenditures typically reported the expenditures in a separate cost category
2. As shown in **Figure 6**, there is an opportunity to further analyze the variations in the reported amounts for legal and professional services, marketing, computer hardware, and travel expense categories. Higher cost outliers may be able to be lowered closer to the statewide averages or further reviewed for the necessity of the expenditures.
3. Across all FSR categories, there remain some inconsistencies in how MCOs report expenditures by category. An opportunity exists for additional guidance to support the MCOs in categorizing the expenses in a consistent manner to support equitable comparisons across MCO.

6.5.3. Supporting Information

6.5.3.1. MCOs provided information and contextual details on FSR data

The question on FSR reported expenses was designed to provide additional context from MCOs, especially in areas where no expenses were noted in the FSR. The survey provided information showing that:

- Consulting and claims collection fees were the largest professional service expenses noted by MCOs.
- Outreach and advertising were the largest marketing activities among MCOs.
- Some MCOs with $0 for a particular expense category typically reported the expense in a separate line item, such as listing hardware/software costs under maintenance and repairs.
  - One plan listed no expenses to report for marketing in SFY2017
- A few MCOs noted that travel costs were either difficult to calculate as Medicaid related, were not identifiable by particular activity, or were "not included in the FSR."[116]

6.6. Cost Allocation Methodologies

6.6.1. Question

Please describe the process or methodology used to allocate administrative expenditures to the Texas Medicaid program (e.g., time study, etc.). If allocation items vary by expenditure type, please clarify.

6.6.2. Observations and Findings

1. MCOs employ a variety of cost allocation approaches, with a membership and/or revenue-based process as the most common approach.
2. Certain MCOs do not use cost allocation methodologies because they only participate in Texas Medicaid and CHIP managed care.

[116] *Note that HHSC's contract auditors have indicated that some MCOs will elect not to report a small expenditure on an FSR or survey if the effort to allocate or estimate the cost is deemed onerous or if the effort will be more expensive than the actual amount they are trying to allocate or estimate. This practice potentially saves Medicaid funds.*

3. As part of the annual FSR audit procedures, HHSC may want to conduct further sampling on cost allocation calculations to determine if processes are being completed accurately and the approach utilized is appropriate for the underlying expenditure (in instances where MCOs are leveraging more than one cost allocation process).

6.6.3. Supporting Information

6.6.3.1. Different Approaches on Cost Allocation Cost Methodologies

MCOs listed a diverse set of answers on how they allocated costs to the Texas Medicaid and CHIP programs (**Figure 18**). These included:

Figure 18. Cost Allocation Methods.

Primary Cost Allocation Methods Cited by Texas Medicaid and CHIP MCOs
1) Do not Leverage Cost Allocation Methodology (3 MCOs)
• Only participate in Texas Medicaid
2) Revenue- and Membership-Based Approaches (8 MCOs)
• Relative amount earned by each subsidiary • Percent of Revenue basis • 50 percent based on revenue, 50 percent based on membership • Corporate allocations based on revenue/capitated arrangements by membership • Percent of membership tied to Texas Medicaid • Various methodologies: Membership, revenue, claims, calls
3) Time and Effort (5 MCOs)
• Third Party Administrator (TPA) FTE methodology • Time and resources each product consumed
4) Cost Reviews (4 MCOs)
• Percent of operating cost ratio • Tiered/hierarchical approach allocating operating expenses to product lines • Direct and indirect cost review

The approach to cost allocation generally reflects the size and scope of the MCOs. The larger MCOs generally have a more sophisticated cost allocation process (such as using multiple methodologies, or combining a

revenue/membership approach) that is utilized across its business in Texas and other states. Smaller and more regional MCOs either do not need to allocate costs or only must allocate a small portion of costs, for instance third-party administrator costs for outsourced services.

6.7. Administrative Expenditure Changes between SFY2016 and SFY2017

6.7.1. Question

Please describe the key drivers of administrative expense changes (either positive or negative) between SFY2016 and SFY2017 (excluding changes from the Quality Improvement adjustment).

6.7.2. Observations and Findings

1. The largest change impacting administrative expenses between SFY2016 and SFY2017 cited by MCOs was the addition of the STAR Kids program.
2. While answers among MCOs varied, a number mentioned salary increases as a driver of administrative expense changes.

6.7.3. Supporting Information

6.7.3.1. MCOs are Adapting to Medicaid and CHIP Program Changes

A great deal has changed in Medicaid Managed Care programs across the country. The new CMS managed care rules have placed new standards on MCOs in their operating models and how they calculate their administrative expenditures with changes, such as charging quality improvements as a medical expense beginning in SFY2017 and complying with the new MLR.

MCOs also cited the inclusion of STAR Kids as leading to a shift in their administrative expenses, as they developed programs to provide managed care to children with disabilities in Texas. There are 10 MCOs that participate in the program, which provides managed care coverage to children with disabilities. While the children in STAR Kids are expensive to cover (approximately $1,474 in administrative expenditures on a PMPM basis), administrative expenses have been lower than in other Texas Medicaid programs during STAR Kids' first year, as the overall MLR for the program was 94.3 percent in SFY2017. MCOs that did not mention STAR Kids

discussed other drivers of change between 2017, including salary pressures, new hiring, capital expenditures, and corporate overhead (**Figure 19**).[117]

Figure 19. Texas Medicaid and CHIP MCO changes between SFY2016 and SFY2017.

Drivers of Administrative Expense changes between FY 2016 and FY 2017
STAR Kids
Corporate Overhead
Covered Services
Regulatory Requirements
Increased Enrollment
Value Purchasing
Healthcare Costs
Labor Demand
Salary Market

The addition of STAR Kids is balanced out by quality improvement costs being removed as an administrative expense in SFY2017. Below is a breakdown of the primary changes to administrative expenditures between SFY2016 and SFY2017 (**Figure 20**).[118] When these changes are accounted for (removing STAR Kids and incorporating quality improvement (QI) costs for SFY2017 to provide a more equitable comparison to SFY2016), PMPM administrative expenses decreased by approximately 1.4 percent between SFY2016 and SFY2017.

[117] *2009 – 2017 Enrollment and Expenditure Data files, data provided by HHSC and Financial Summary 2017 – 90-day working and Financial Summary 2016 and 334-day working files, provided by HHSC.*

[118] *2009 – 2017 Enrollment and Expenditure Data files, data provided by HHSC and Financial Summary 2017 – 90-day working and Financial Summary 2016 and 334-day working files, provided by HHSC.*

Figure 20. Adjusted administrative Expense difference between SFY2016 and SFY2017.

Expense	SFY2016	SFY2017	% Change
Admin	$1,435,072,000	$1,371,811,000	-4.4%
QI	-	$536,704,000	
Care Coordination	$180,631,000	-	
Subtotal	**$1,615,703,000**	**$1,908,515,000**	**18.1%**
Less STAR Kids Admin Expenses	-	($166,956,000)	
Less STAR Kids QI	-	($130,572,000)	
Total Admin Expenses	**$1,615,703,000**	**$1,610,987,000**	**-0.3%**
Subtotal Member Months	47,224,000	49,375,000	
Less STAR Kids Member Months	-	(1,632,000)	
Total Member Months	**47,224,000**	**47,743,000**	
PMPM	**$34.21**	**$33.74**	**-1.4%**

6.8. Areas of Opportunities

6.8.1. Question

What does your plan believe is the greatest challenge in controlling administrative expenses in operating within the Texas Medicaid program? What recommendations do you have to reduce the amount of administrative expenditures related to the Texas Medicaid program?

6.8.2. Observations and Findings

1. Seventeen of the 19 MCOs who responded to this question referenced HHSC reporting requirements as an area to reevaluate
2. Over half of the MCOs recommended HHSC reporting requirement changes despite the survey finding that only three percent of administrative expenses are due to reporting requirements
3. The other major recommendations from MCO responses center on increasing value, efficiency, and transparency in the system. Examples include:
    a. Simplifying requirements, including reducing the number of required elements, frequency of reports, and coordinating with other

agencies (Department of Insurance) for alignment and to reduce overlap

b. Seeking waivers to allow reductions in medical expenditures to be refocused on the administrative component of such expenditures

c. Increasing efficiency of reporting through more timely feedback on administrative reviews and increasing reporting automation and template standardization

d. Providing more transparency in the administrative expense development in the rate setting process

e. Considering how upcoming program changes, such as value-based reimbursement and social determinants of health, impact administrative expenditures

6.8.3. Supporting Information

6.8.3.1. MCOs want fewer regulations and reporting requirements

Figure 21 provides a sampling of the recommendations offered by the MCOs to help control Medicaid administrative expenses, grouped by the high-level reform category. These are entirely MCO-driven recommendations and many of them, it should be noted, have been discussed or are currently under discussion with HHSC.

As mentioned, the most common survey response was to reduce or refine the reporting and regulatory requirements that the State requires MCOs to meet. MCOs objected to both the number and the frequency of the reporting requirements, and the burden it places on their administrators to try to meet the requests. However, it should be noted that based on the annual estimate of the total administrative expenditures associated with providing HHSC with required deliverables outlined in the Section 5.0 Consolidated Deliverable Matrix of UMCM, MCOs report only three percent of expenses tied to specific reporting requirements.

A few MCOs suggested a top-down review to remove duplicative reports and ad hoc/unexpected requests, and a process to move toward administrative simplification. This could mean providing for more automation, such as electronic transactions.

Figure 21. Recommendations Offered by MCOs on Reducing Administrative Expenditures.

MCO Survey Recommendations to Reduce Texas Medicaid Administrative Expenditures
Simplify Requirements
• Simplify required reports and reduce the number of reports that are required • Restrict changes in rates or processes to annual or biannual contract amendments • Review deliverables (volume and frequency) to see if they can be reduced • Condense informational type documents down to one or two documents and require those (where possible and within regulatory standard) to be done upon enrollment into the program and not annually. • Stop requiring adherence to Texas Medicaid & Healthcare Partnership (TMHP) guidelines. • Evaluate the necessity of many reports, the frequency of reporting, and the need for supplementary ad hoc reporting. • Remove Federal Acquisitions Regulations requirements from contract and cost principles, and set appropriate limitations within state contract language. • Eliminate prescriptive requirements defining member levels, staff levels, and contact requirements. • Coordinate reports between Medicaid and those required by the Texas Department of Insurance - different reports for different agencies on different quarters. • Regulatory reporting templates should be shared both locked and unlocked and in a more current Excel version.

MCO Survey Recommendations to Reduce Texas Medicaid Administrative Expenditures

Increase Value

- Perform a top-down review of all reporting requirements to determine the value that each provides to the Medicaid program and ensure they are being utilized to manage the Medicaid program accordingly.
- Analyze contractual requirements for STAR/CHIP to determine what is beneficial given the populations vs. what may be overly prescriptive. HHSC seems to be requiring that STAR/CHIP be aligned with STAR+PLUS/STAR Kids Requirements. However, there is uncertainty that they are accounting for the significant difference in the capitation rates and the needs of the populations.
- Seek waivers that allow MCOs to spend administratively where it will save in total cost on the medical side - housing, home care, etc.
- Require babies to remain with their mothers' MCO for the first year. This will provide enrollment and administrative savings and offer better outcomes for the mother in regard to postpartum follow up with all of their baby's wellness visits.

Efficiency

- Provide quicker feedback from audits of the FSR
- Allow plans to retrieve email addresses for the members, much of what is mailed could be sent electronically
- Move toward industry file standards (834's, 837's, 835's) - versus Texas specific encounter formats or enrollment files. This costs extra on the configuration side when various vendors have to customize and often functionality suffers
- Streamline the member enrollment process
- Do not require that all nursing facility assessments be in person
- Promote automation, such as electronic transactions to increase efficiency and potentially lower administrative expenditures
- Change the billing matrix to ensure it aligns with national definitions of codes

MCO Survey Recommendations to Reduce Texas Medicaid Administrative Expenditures

Transparency

- Provide more transparency in the rating assumptions to avoid additional validation analysis and dispute resolution activities between HHSC and the plans
- Discuss new guidance for turnaround times and documentation needed to coordinate care for dual eligible members
- Apply a materiality threshold that must be met before Liquidated Damages kick in
- Increase administrative caps on experience rebate as additional requirements are set on the MCOs and as the program requirements change

Other

- Acknowledge that requirements placed on the plans for risk-based contracts and managing social determinants of health will increase overall costs to the plans
- Consider that programs instituted by the plans to improve health and lower medical expenses are actually going to increase administrative costs, so the costs to administer these programs should be excluded from basic administrative cost considerations
- Require that all providers be paid Electronic Funds Transfer rather than checks
- Remove carve-out programs that increase costs to both the plans and HHSC through increasing encounter submission and reconciliation efforts on both sides
- Allow MCOs to triage and assist members based on acuity with current quality metric oversight in place
- Remove some of the offshoring restrictions to allow services, such as IT support and claims processing to occur offshore
- Reduce the Historically Underutilized Business (HUB) expectation, so more HUB Subcontracting Plan/HUB vendors can compete on price
- Eliminate the need for Texas Provider Identification – it causes provider abrasion, confusion, and large-scale rework projects
- Discontinue fee-for-service processes

7. Summary of Opportunities

Texas MCOs' administrative expenditures in total appear to be in line with national managed care trends. The combined MLR by the 20 MCOs is at or slightly above the national average, and based on the May 2017 final evaluation of Texas's Healthcare Transformation and Quality Improvement 1115(a) waiver, the experience rebates have proven successful (perhaps more successful than an MLR penalty) at controlling program expenditures.

However, there are opportunities the State could implement to increase transparency, embrace cost containment opportunities, and continue to hold MCOs accountable in managing State and federal funds. These opportunities should be considered regarding potential new Medicaid and CHIP program changes that may impact MCO administrative efforts.

7.1. Transparency

Greater transparency on reporting of administrative expenses, especially corporate allocations

Texas requires MCOs to report quarterly on their administrative expenditures through the FSRs. These FSRs provide some detailed data on the magnitude of each MCO's expenses in managing Medicaid coverage for most of the more than four million Texans that rely on the program.

Yet, while MCOs are required to report on top-level expenditure data, there remain many unknowns on the reports. For example, the corporate allocations category accounts for almost four out of every 10 dollars in administrative expenditures, but the FSR does not require an itemized breakdown of the expenses charged to the corporate allocations cost category.

The Administrative Expenses survey showed 1) that MCOs have the capability to provide the data and 2) that the corporate allocation expenditures are for additional salary and compensation on top of the more than $340 million in total salaries, wages, and benefits already disclosed by MCOs on line 1 of the FSRs in SFY2017. In addition, four MCOs account for more than 80 percent of the total corporate allocations. Two of these four MCOs have an administrative cost PMPM at or near the overall average for MCOs, while the other two are greater than the average. This mixed result shows that it may be possible for MCOs to balance out high corporate allocations with lower spending on other cost categories.

Requiring MCOs to fully disclose compensation paid for through Medicaid funding, including the number of FTEs as well as the total compensation for the size and population served by MCO, would increase the level of transparency in the FSR reports and help State policymakers in examining the total amount MCOs spend on compensation (including through corporate allocations). With this increased transparency, Texas would be able to conduct additional comparative analyses of spending patterns and develop additional expenditure benchmarks across all MCOs to aid in the review of overall Texas MCO administrative expenditures. This transparency may also help Texas better understand the roles and responsibilities of the staff included as corporate overhead and how their services are benefiting the Texas Medicaid and CHIP programs.

Additional detail regarding outsourced services to compare administrative costs by FSR cost category in a more consistent manner across the MCOs.

Similarly, MCOs must report on outsourced payments to third-party vendors to manage certain aspects of the managed care business within the Texas Medicaid and CHIP programs. Outsourced services generally are for typical MCO functions, such as non-capitated payments for claims management and capitated payments for behavioral health or dental benefits.

The FSRs require MCOs to disclose the vendors receiving funds for outsourced services and the total aggregate payments for those services, but there is little disclosure required on the types of services provided or spending by FSR cost category. Asking MCOs for additional details regarding the types of services provided by third-party vendors could allow for a more comprehensive and consistent analysis of expenditures by cost category within the FSR for each MCO, encompassing both services performed in-house and those outsourced.

For example, the survey proved inconclusive on whether outsourcing services to third-party vendors correlated with lower overall administrative expenses (some MCOs with outsourced services had lower PMPM administrative expenses, while others did not). Collecting additional information to compare MCOs by FSR cost category in a more consistent manner may allow Texas to further assess which FSR cost categories are driving variances by MCO.

7.2. Workforce

Annual reporting on FTEs supporting the Texas Medicaid and CHIP managed care programs

MCOs are not required to report the total number of FTEs employed in each aspect of their Texas managed care business. HHSC surveyed MCOs in 2012 as part of its review of the local and regional financial impact of Medicaid Managed Care. As noted earlier, the Administrative Expenses survey requested a similar breakdown of FTEs, this time adding out-of-state FTEs to the request.

The annual reporting by MCOs to the State should include a breakdown of FTEs supporting their managed care business. This is valuable information to determine the size and scope of managed care operations in Texas and, on a year-to-year basis, can help the State evaluate programmatic and operational efficiency of each managed care plan.

In addition, this level of reporting can help the State analyze staffing outliers to determine if efficiencies can be gained. Analysis may include elements, such as: 1) determining if the number of FTEs aligns with the compensation-related expenditures, 2) assessing if the number of FTEs and roles of the staff correspond to the needs of the Medicaid and CHIP populations being served, 3) helping develop the administrative component of the capitation rates, and 4) conducting a comparative analysis of in-state and out-of-state staff roles and compensation.

7.3. Cost Containment

Increased evaluation of MCO cost allocation approaches to better understand the various methodologies and potential ways to standardize the process

Question #7 in the Administrative Expenses survey asked MCOs to outline their approach in allocating costs to the Texas Medicaid and CHIP programs. The question generated a range of approaches, from those based on membership and/or revenue, to others that are focused on costs/expenditures or time and effort.

Undoubtedly, there can be more than one approach to effectively and accurately allocate costs across different programs and lines of business of an MCO. However, an in-depth evaluation of the approaches could yield

insight into the best and most efficient methods that could become accepted best practices for MCOs.[119]

Potential strengthening of the experience rebates for those MCOs deemed to have excessive administrative expenses or profits above the profit sharing thresholds

As discussed earlier in the section, the experience rebate contractual provision in Texas's Medicaid Managed Care program can provide greater incentive for MCOs to moderate total program expenditures, including administrative expenses, than a potential penalty for not meeting an 85 percent MLR requirement.[120] If the State seeks to provide an increased incentive to moderate administrative expense growth over time, consider revisiting the various profit sharing thresholds within the experience rebate calculation. For instance, the State currently has a claw-back of 20 percent on profits between three percent and five percent. Increasing that percentage or getting to 100 percent at a lower level of net income (currently in excess of 12 percent) could provide an increased incentive for MCOs to moderate expenditures.

Adjustments to the profit sharing thresholds within the experience rebate calculation should consider the impact the experience rebate contractual provision has on MCO medical expenditures. The experience rebate allows MCOs to retain some profits, some of which may currently be reinvested within the Texas Medicaid and CHIP programs. Texas MCO investments around value-based purchasing, quality improvement programs, or other innovative quality and efficiency reforms may result in a reduction in overall program expenditures and improved member access and quality of services. Therefore, the potential short-term impact of an adjustment to the experience rebate thresholds needs to be considered against the potential longer term impacts the profit sharing mechanism has on the Texas Medicaid and CHIP programs.

Further analysis of high-cost outliers by FSR reporting category

As noted in Sections 4, 5, and 6, in the review of the FSR data and survey responses, we identified several categories of administrative expenditures with a wide variation of reported costs by MCO. Further evaluation of the MCOs with above-average costs in total (for example, for-profit versus non-

[119] *HHSC plans to require MCOs to choose a methodology to allocate administrative costs to individual programs (describing the methodology used, replacing the current method to allocate administrative costs to each program as a percentage of revenue).*

[120] *Evaluation of the 1115(a) Texas Demonstration Waiver - Healthcare Transformation and Quality Improvement: Final Evaluation Report, May 30, 2017.*

profit) and specific categories may identify opportunities for cost efficiencies that could be gained if incentives or reimbursement mechanisms were utilized to move such costs closer to the statewide averages. Categories with variations highlighted in our review included compensation expenses, including corporate allocations, legal and professional fees, marketing, computer hardware, and travel expenses.

Additionally, we noted that there are some inconsistencies in how MCOs report expenditures by FSR category. An opportunity exists for additional guidance to support the MCOs in categorizing the expenses in a consistent manner to support equitable comparisons across MCO.

Coordination with the MCOs to refine the reporting requirements as defined within the UMCM.

In the survey, MCOs responded that one of the top suggestions in potentially reducing the overall administrative expenses for the Texas Medicaid and CHIP programs was to revisit the State's reporting requirements. While the MCOs reported that less than five percent of total administrative expenses are attributable to HHSC reporting requirements as defined by the UMCM, there was variation by MCO with several low- and high-cost outliers.

There may be an opportunity to further discuss this response with the MCOs to determine the level of effort and staffing required to support HHSC reporting requirements, in addition to the ongoing efforts between HHSC and MCOs to streamline deliverables. Some existing activities may be unnecessary or streamlined to reduce overall programmatic expenditures. Additional discussion of the UMCM can be found in the **Rider 61(b) Report Section**.

In addition, the MCOs provided several ideas to potentially reduce administrative expenses across Texas Medicaid and CHIP. As part of the coordination with the MCOs on the existing MCO reporting requirements, the State may want to expand the discussion to revisit the MCO ideas, particularly around the ideas related to reporting, including simplifying or streamlining requirements, increasing transparency, and improving efficiencies through standardization and automation.