Texas Healthcare Transformation and Quality Improvement Program

Section 1115 Quarterly Report

Texas Health and Human Services Commission

Demonstration Reporting Period:

2015 State Fiscal Quarter 4, June-August

Demonstration Year (DY) 4 October2014-September 2015

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I. INTRODUCTION

The Texas Healthcare Transformation and Quality Improvement Program Section 1115 waiver enabled the State to expand its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth;
- Protect and leverage financing to improve and prepare the healthcare infrastructure to serve a newly insured population; and
- Transition to quality-based payment systems across managed care and hospitals.

This report documents the State's progress in meeting these goals. It addresses the quarterly biannual, and annual reporting requirements for the STAR and STAR+PLUS programs, as well as Children's Medicaid Dental Services (Dental Program), which are found in the waiver's Special Terms and Conditions (STCs), items 14, 20, 22, 24(e), 27 39(a), (b) and (c), 40(b) and (c), 41, 49, 53, 65, 67, 68, and 71. These STCs require the State to report on various topics, including: enrollments and disenrollments; access to care; anticipated changes in populations or benefits; network adequacy; encounter data; operational, policy, systems, and fiscal issues; action plans for addressing identified issues; budget neutrality; member months; consumer issues; quality assurance and monitoring; demonstration evaluation; and Regional Healthcare Partnerships (RHPs). STC 68 requires the State to report on various topics, including: accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The Program Funding and Mechanics Protocol also require the State to submit an annual report to CMS.

The State collects performance and other data from its managed care organizations (or "plans") on a State Fiscal Quarter (SFQ) cycle; therefore, some of the quarterly information presented in this report is based on data compiled for 2015 SFQ4 (June-August) instead of Demonstration Year (DY) 4, Q4 ("2015 D4," covering July-September). Throughout the report, the State has identified whether the quarterly data relates to 2015 SFQ4 or 2015 D4.

A. MANAGED CARE PLANS PARTICIPATING IN THE WAIVER PROGRAM

During the 2015 SFQ4 the State contracted with 18 STAR, 5 STAR+PLUS and 2 Dental program plans. Each health plan covers one or more of the 13 STAR service delivery areas or 13 STAR+PLUS service delivery areas, and each dental plan provides statewide services. Please refer to Attachment A for a list of the STAR, STAR+PLUS, and Dental plans by area.

B. MONITORING MANAGED CARE PLANS

The Health and Human Services Commission (HHSC) staff evaluates and routinely monitors managed care organization (MCO) and dental maintenance organization (DMO) performance reported by the MCOs and DMOs or compiled by HHSC. If an MCO or DMO fails to meet a performance expectation, standard, schedule, or other contract requirement such as the timely submission of deliverables or at the level of quality required, the managed care contracts give HHSC the authority to use a variety of remedies, including:

- Monetary damages (actual, consequential, direct, indirect, special, and/or liquidated damages (LD)),
- Corrective action plans (CAPs).

The information reflected in this document represents the most current information available at the time that it was compiled. At the time the report was submitted to the Centers for Medicare and Medicaid Services (CMS), the sanction process between HHSC and the health and dental plans may not be complete. HHSC posts the final details of any potential enforcement actions taken against a health or dental plan each for each quarter on the following website: https://www.hhsc.state.tx.us/medicaid/managed-care/sanctions.shtml.

HHSC is committed to ensuring compliance with the federal HCBS regulations. In accordance with STC 41(a), the following description includes the steps HHSC has taken to determine and come into compliance.

1. In March 2015, HHSC submitted an amended Texas Statewide Settings Transition Plan detailing compliance, remediation strategies, and timelines for the STAR+PLUS waiver program operating under the State's 1115 Demonstration waiver to CMS.
2. In August and September 2015, HHSC reviewed contracted managed care organizations' (MCOs) internal policies and procedures to determine if they were in compliance with the settings requirements of the federal HCBS regulations.
3. In August through September 2015, HHSC reviewed the state's policies and procedures to determine if they were in compliance with the settings requirements of the federal HCBS regulations.
4. In September and October 2015, HHSC revised its policies and procedures to more clearly state that HCB services are provided in a setting of the member's choosing and detailed that HCB services may not be delivered in or on the grounds of an institutional setting outlined in 42 CFR, Subpart K, Section 441.530(a) (2) . The update will be published in March 2016; it is in the process of being incorporated into operational guidance to MCOs.
5. In October and November 2015, HHSC and operating agencies traveled around the state to provide multiple stakeholder meeting opportunities to highlight the upcoming

availability of the HCBS provider survey, answer stakeholder questions, and provide updated information about the Texas transition plan.

6. HHSC posted the survey document for a 30-day public comment period. Feedback was due December 7th. HHSC staff is currently reviewing the feedback received.
7. Beginning in March 2016, HHSC will survey a representative sample of individuals served through HCBS STAR+PLUS as part of its validation of the provider surveys also completed in 2016. The surveys will be administered through August 2016.

C. DEMONSTRATION FUNDING POOLS

The Section 1115 Demonstration establishes two funding pools created by savings generated from managed care expansion and diverted supplemental payments to reimburse providers for uncompensated care costs and provide incentive payments to participating providers that implement and operate delivery system reforms.

Texas worked with private and public hospitals, local government entities and other providers to create Regional Healthcare Partnerships (RHPs) that are anchored by public hospitals or other specific government entities. RHPs identified performance areas for improvement that may align with the following four broad categories to be eligible for incentive payments: (1) infrastructure development, (2) program innovation and redesign, (3) quality improvements and (4) population focused improvements. The non-Federal share of funding for pool expenditures is largely financed by State and local intergovernmental transfers (IGTs).

Waiver activities are proceeding and detailed information on the status is included in the sections below.

II. ENROLLMENT AND BENEFITS INFORMATION

This section addresses STCs 24 (e), 39(a), 53, 67, 68, including quarterly and biannual trends and issues related to STAR, STAR+PLUS, and Dental Program eligibility and enrollment; enrollment counts for the quarter; Medicaid eligibility changes; anticipated changes in populations and benefits; and disenrollment from managed care. Unless otherwise provided, quarterly managed care data covers the 2015 SFQ4 reporting period (June-August) instead of 2015 D4 (July-September). Supporting data are located in Attachments B and Q.

A. ELIGIBILITY AND ENROLLMENT

This subsection addresses the quarterly reporting requirements found in STC 24(e) and 67. Attachment B includes enrollment summaries for the three managed care programs. The enrollment data in this subsection are based on prospective managed care enrollment counts in

the last month of the quarter and represent a snapshot of the number of members enrolled in Texas Medicaid managed care programs and health plans.

The total enrollment in Texas Medicaid managed care programs, Dental, STAR and STAR+PLUS, decreased by .22% from 2015 SFQ3 to 2015 SFQ4. Overall enrollment in STAR and Dental grew by less than 1%, while STAR+PLUS enrollment decreased by 5% during the same time period.

1. STAR

The number of members enrolled in STAR plans remained about the same, with a slight increase of .76% from 2,808,033 in 2015 SFQ3 to 2,829,471 in 2015 SFQ4. Across the STAR program, all MCOs and service delivery areas experienced less than a 2% change in enrollment from the prior quarter. Only three MCOs and one service delivery area lost membership, but these declines were very small (MCOs: Christus (-1.2%), Molina (-.3%), and Parkland (-.14%), and service delivery area: Travis (-.06%)).

B. Enrollment by STAR MCO (2015 SFQ3-SFQ4)

STAR	2015 Q3	2015 Q4	Total Change	% Change
Statewide	2,808,033	2,829,471	21,438	**0.76%**
Aetna	71,062	71,329	267	**0.38%**
Amerigroup	548,427	552,916	4,489	**0.82%**
BCBS	24,069	24,220	151	**0.63%**
CHC	225,954	228,003	2,049	**0.91%**
Christus	6,520	6,442	-78	**-1.20%**
Community 1st	105,452	106,004	552	**0.52%**
Cook Children's	94,871	95,647	776	**0.82%**
Driscoll	129,801	132,280	2,479	**1.91%**
El Paso 1st	63,458	63,869	411	**0.65%**
FirstCare	90,263	90,961	698	**0.77%**
Molina	98,311	98,018	-293	**-0.30%**
Parkland	174,676	174,436	-240	**-0.14%**
Scott & White	40,135	40,787	652	**1.62%**
Sendero	11,498	11,523	25	**0.22%**
Seton	16,704	16,821	117	**0.70%**
Superior	673,512	677,914	4,402	**0.65%**
Texas Children's	318,177	321,966	3,789	**1.19%**
United	115,143	116,335	1,192	**1.04%**

C. Enrollment by Service Delivery Area (2015 SFQ3-SFQ4)

STAR	2015 Q3	2015 Q4	Total Change	% Change
Statewide	2,808,033	2,829,471	21,438	**0.76%**
Bexar	240,825	242,564	1,739	**0.72%**
Dallas	391,976	393,967	1,991	**0.51%**
El Paso	122,380	122,509	129	**0.11%**
Harris	656,933	664,007	7,074	**1.08%**
Hidalgo	348,488	349,491	1,003	**0.29%**
Jefferson	71,725	72,298	573	**0.80%**
Lubbock	71,933	73,137	1,204	**1.67%**
MRSA Central	123,126	124,046	920	**0.75%**
MRSA Northeast	159,396	159,795	399	**0.25%**
MRSA West	141,011	143,784	2,773	**1.97%**
Nueces	80,094	81,585	1,491	**1.86%**
Tarrant	256,226	258,454	2,228	**0.87%**
Travis	143,920	143,834	-86	**-0.06%**

The STAR market share by MCOs also remained steady from the prior quarter, with a maximum percentage point change from 2015 SFQ3 to 2015 SFQ4 of -.06 percentage points, as shown in the table below. Over the past year, STAR market share distribution has only had very minor

fluctuations. Driscoll and Parkland had the largest changes in market share: Driscoll gained .24 percentage points over the four quarters, while Parkland lost .23 percentage points.

Market Share by STAR MCO (2014 -2015)

STAR	2015 Q1	2015 Q2	2015 Q3	2015 Q4	Percentage Point Change Q1 to Q4
Aetna	2.53%	2.50%	2.53%	2.52%	-0.01%
Amerigroup	19.64%	19.63%	19.53%	19.54%	-0.10%
BCBS	0.78%	0.82%	0.86%	0.86%	0.07%
CHC	8.00%	8.01%	8.05%	8.06%	0.06%
Christus	0.25%	0.24%	0.23%	0.23%	-0.02%
Community 1st	3.76%	3.75%	3.76%	3.75%	-0.01%
Cook Children's	3.42%	3.41%	3.38%	3.38%	-0.04%
Driscoll	4.44%	4.52%	4.62%	4.68%	0.24%
El Paso 1st	2.21%	2.22%	2.26%	2.26%	0.05%
FirstCare	3.21%	3.19%	3.21%	3.21%	0.01%
Molina	3.56%	3.53%	3.50%	3.46%	-0.09%
Parkland	6.40%	6.34%	6.22%	6.16%	-0.23%
Scott & White	1.38%	1.40%	1.43%	1.44%	-0.06%
Sendero	0.42%	0.42%	0.41%	0.41%	0.02%
Seton	0.57%	0.58%	0.59%	0.59%	-0.02%
Superior	23.96%	23.96%	23.99%	23.96%	0.00%
Texas Children's	11.44%	11.41%	11.33%	11.38%	-0.06%
United	4.05%	4.05%	4.10%	4.11%	0.07%

2. STAR+PLUS

The number of members enrolled in STAR+PLUS plans decreased by 5% from 553,836 in 2015SFQ3 to 526,157 in 2015SFQ4. All MCOs experienced decreased enrollment. Over half of the total decrease was driven by Amerigroup and Molina. Both plans also had the largest percent change in their enrollment and attributed part of the declines to members transitioning to the dual eligible demonstration. The tables below show the decrease in enrollment in STAR+PLUS by MCO and service delivery area from 2015SFQ3 to 2015SFQ4.

Enrollment by STAR+PLUS MCO (2015 SFQ3-SFQ4)

STAR+PLUS	2015 Q3	2015 Q4	Total Change	% Change
Statewide	553,836	526,157	-27,679	**-5.00%**

Amerigroup	142,900	133,538	-9,362	**-6.55%**
Cigna-HealthSpring	51,386	50,309	-1,077	**-2.10%**
Molina	96,845	87,899	-8,946	**-9.24%**
Superior	148,753	142,388	-6,365	**-4.28%**
United	113,952	112,023	-1,929	**-1.69%**

Eight of the thirteen services areas had decreases in STAR+PLUS enrollment from 2015 SFQ3 to 2015 SFQ4, of which five (Bexar, Harris, Hidalgo, El Paso and Dallas) lost more than 3,500 members. In 2015 SFQ4, Bexar and Harris service delivery areas had the largest reductions in the number of individuals enrolled, which represented a 14% decrease in Bexar (-6,919 members) and 6% decrease in Harris (-6,270 members). Hidalgo (-4,657 members), El Paso (-4,415 members) and Dallas (-3,674) had the next largest reductions in members from the prior quarter. All STAR+PLUS MCOs in these five service delivery areas had declines in enrollment. The largest percent change from the prior quarter was in El Paso, where enrollment went down by 19%. Amerigroup and Molina, the two STAR+PLUS MCOs in El Paso, each had a decrease in enrollment of about 2,000 from the prior quarter due to previously mentioned reason for members being enrolled in the dual eligible demonstration.

Enrollment by Service Delivery Area (2015 SFQ3-SFQ4)

STAR+PLUS	2015 Q3	2015 Q4	Total Change	% Change
Statewide	553,836	526,157	-27,679	**-5.00%**
Bexar	51,049	44,130	-6,919	**-13.55%**
Dallas	64,099	60,425	-3,674	**-5.73%**
El Paso	23,217	18,802	-4,415	**-19.02%**
Harris	106,128	99,858	-6,270	**-5.91%**
Hidalgo	71,017	66,360	-4,657	**-6.56%**
Jefferson	20,468	20,471	3	**0.01%**
Lubbock	13,846	13,873	27	**0.20%**
MRSA Central	29,544	29,668	124	**0.42%**
MRSA Northeast	46,549	46,534	-15	**-0.03%**
MRSA West	38,567	38,639	72	**0.19%**
Nueces	22,402	22,304	-98	**-0.44%**
Tarrant	41,054	39,094	-1,960	**-4.77%**
Travis	25,896	25,999	103	**0.40%**

STAR+PLUS market share by MCO fluctuated slightly from the prior quarter. Amerigroup and Molina had smaller market shares in 2015 SFQ4 as a result of their enrollment declines during that period. Despite Superior's drop in enrollment in 2015 SFQ4, their market share increased because of Amerigroup's and Molina's larger enrollment declines. Over the past four quarters, STAR+PLUS market share has changed slightly. Amerigroup and Molina market share declined somewhat each quarter, while Cigna-HealthSpring and United saw small increases in market

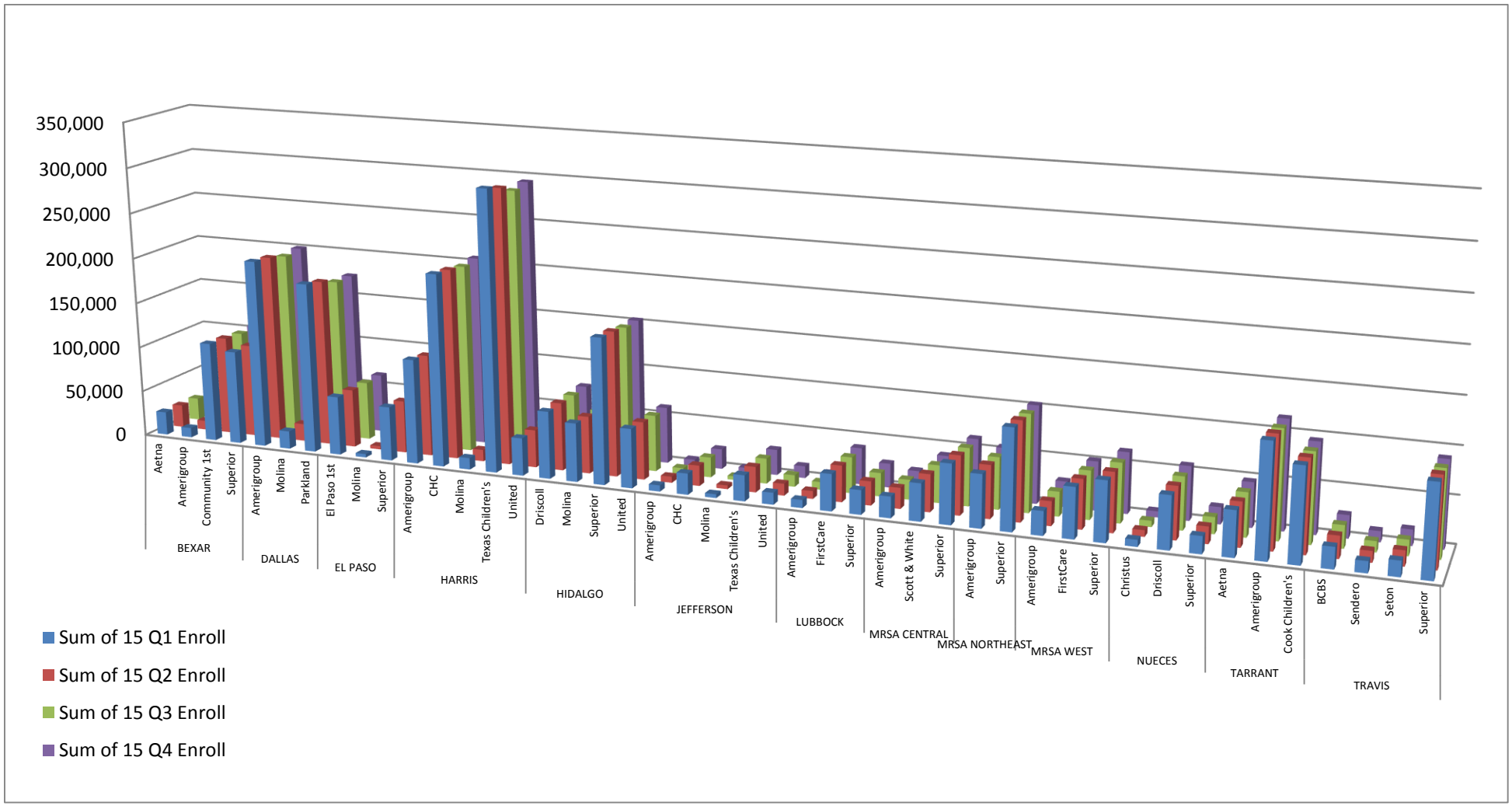
share each quarter. Despite these trends, the order of MCOs by market share remained consistent.

Market Share by STAR+PLUS MCO (2014-2015)

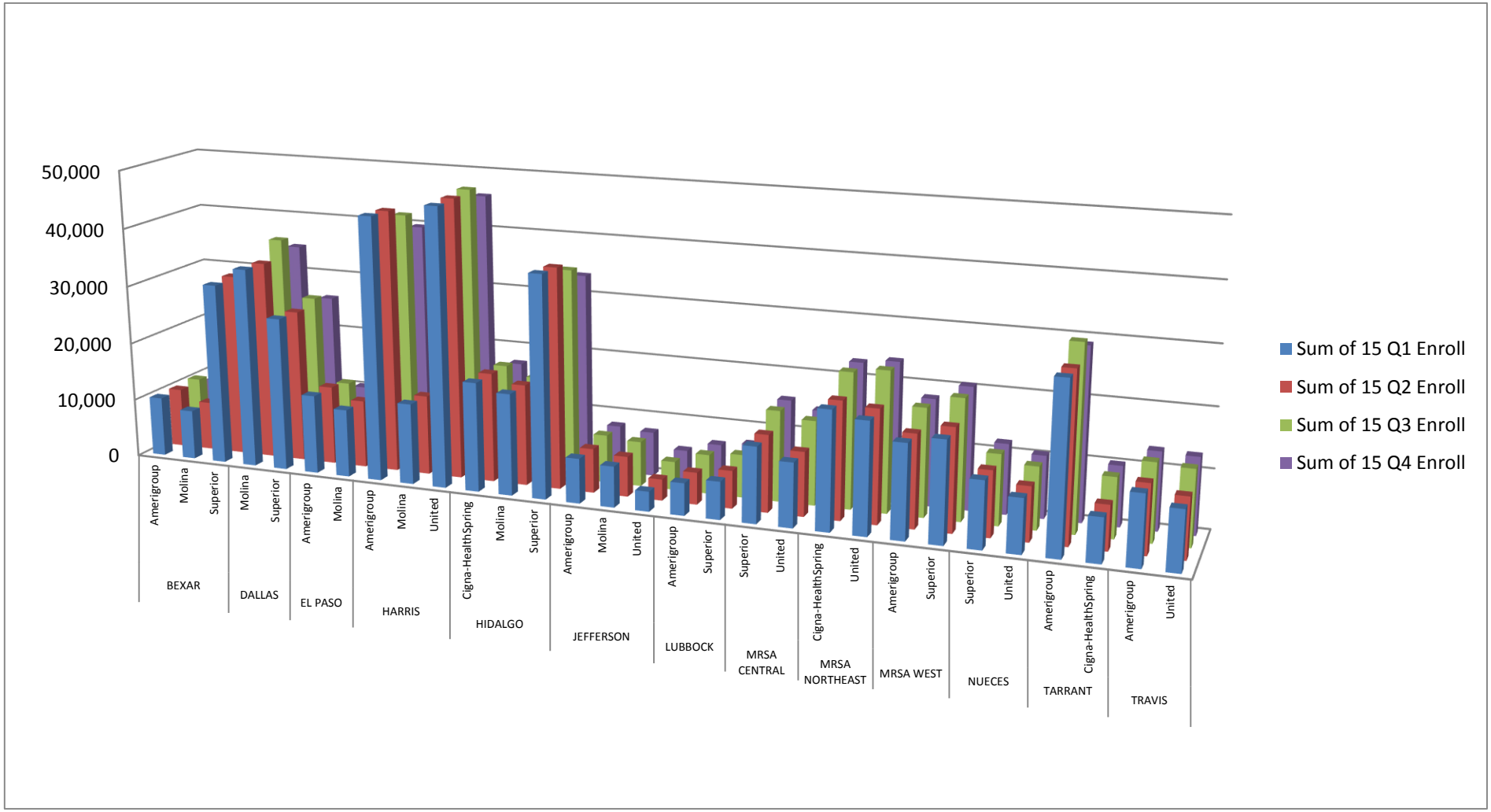
STAR+PLUS	2015 Q1	2015 Q2	2015 Q3	2015 Q4
Amerigroup	26.59%	26.44%	25.80%	25.38%
Cigna-HealthSpring	8.89%	8.89%	9.28%	9.56%
Molina	17.79%	17.68%	17.49%	16.71%
Superior	27.49%	27.56%	26.86%	27.06%
United	19.25%	19.43%	20.58%	21.29%

The two following graphs show STAR and STAR+PLUS quarterly enrollment by MCO and service delivery area over the last year. The third graph shows STAR+PLUS quarterly enrollment in the MRSA service delivery areas by MCO since the program has been expanded to the MRSA service delivery areas.

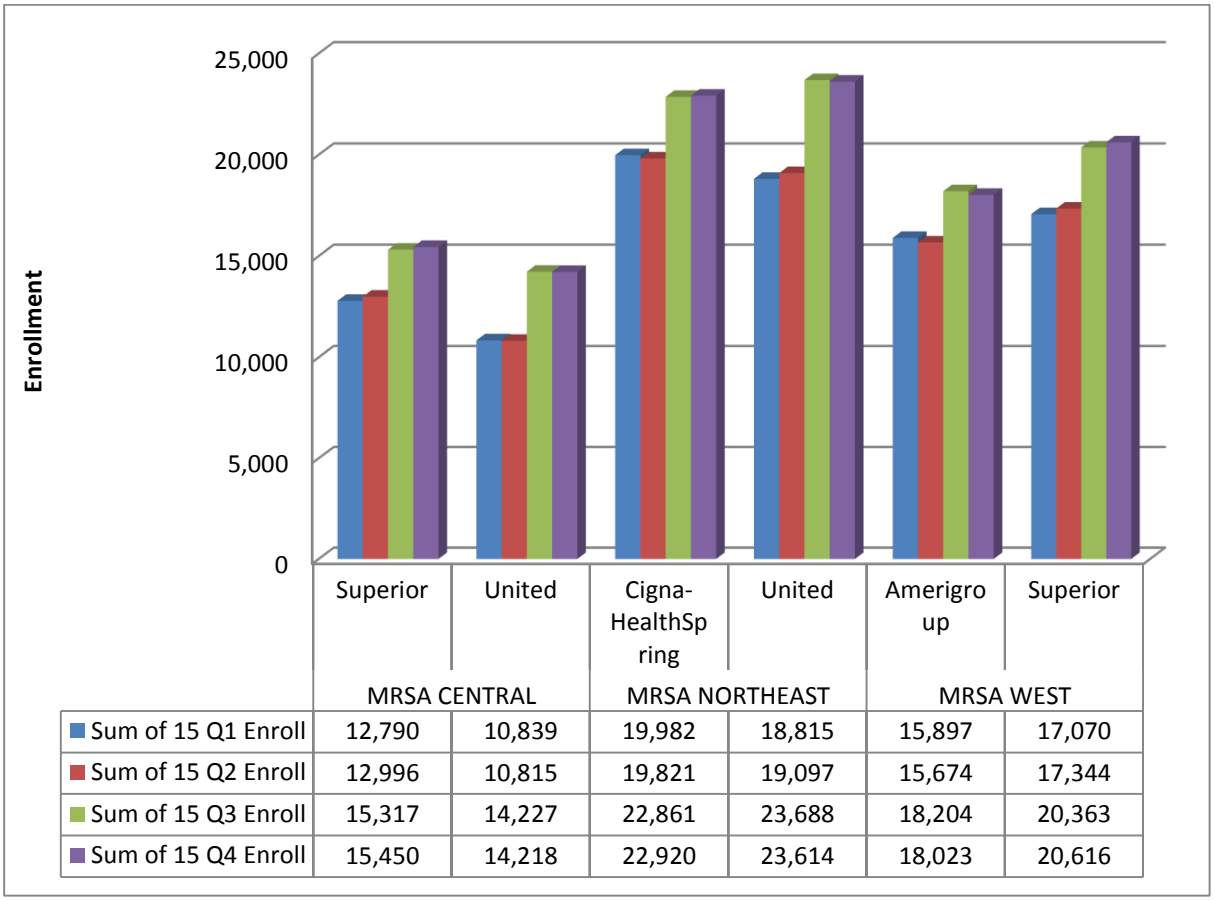
STAR Program Enrollment by MCO and Service Delivery Area (2015 SFQ1-2015 SFQ4)



STAR+PLUS Non-MRSA Program Enrollment by MCO and Service Delivery Area (2014 SFQ3-2015 SFQ3)



STAR+PLUS MRSA Program Enrollment by MCO and Service Delivery Area (SFY2015 through SFQ4)



	Superior	United	Cigna-HealthSpring	United	Amerigroup	Superior
	MRSA CENTRAL		MRSA NORTHEAST		MRSA WEST	
Sum of 15 Q1 Enroll	12,790	10,839	19,982	18,815	15,897	17,070
Sum of 15 Q2 Enroll	12,996	10,815	19,821	19,097	15,674	17,344
Sum of 15 Q3 Enroll	15,317	14,227	22,861	23,688	18,204	20,363
Sum of 15 Q4 Enroll	15,450	14,218	22,920	23,614	18,023	20,616

3. Dental Program

Total enrollment in the Dental Program had a slight increase of 0.70% to 2,846,474 members in 2015SFQ4. Both MCOs experienced less than a 1 percent increase. Market share remained steady: DentaQuest has approximately 55% while MCNA has 45%. Annual enrollment data indicates enrollment went down by 2.35% from 2015SFQ1 to 2015SFQ4. Data comparison of SFQ1-SFQ4 revealed that market share remained steady.

B. ENROLLMENT COUNTS FOR THE QUARTER BY POPULATION

This subsection includes quarterly enrollment counts as required by STC 67. Due to the time required for the data collection process, unique member counts per quarter are reported on a two quarter lag. The following table includes enrollment counts for the 2015D2. Enrollment counts are based on persons and not member months.

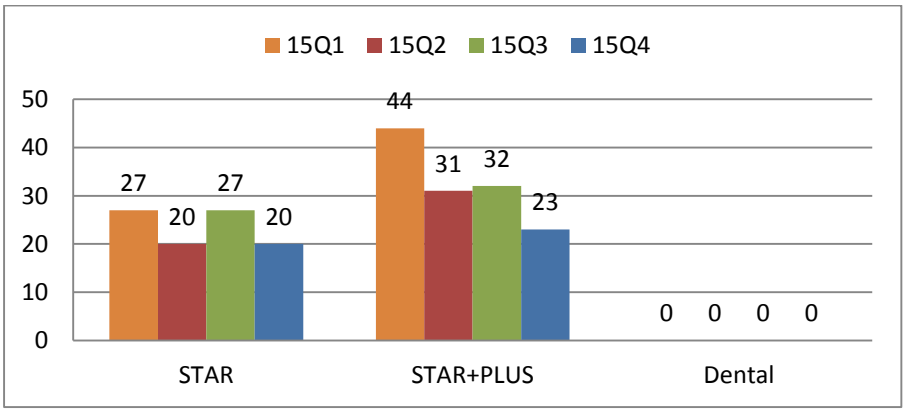
Enrollment Counts (DY4 Q2, January-March 2015)

Demonstration Populations	Total Number
Adults	341,260
Children	2,850,640
Aged and Medicare Related (AMR)	384,516
Disabled	439,528

C. DISENROLLMENT AND PLAN CHANGE

This subsection of the report addresses STC 39(b). In 2015 SFQ3 and SFQ4, the enrollment broker, MAXIMUS, reported 2,531 plan changes processed. Regarding disenrollment requests from Medicaid managed care to the fee-for-service delivery model, the state received the following in 2015 SFQ1 and SFQ2: 47 disenrollment requests for STAR, 75 for STAR+PLUS, and none for the Dental Program. During 2015 SFQ3 and SFQ4 disenrollment requests for STAR remained at 47, whereas requests decreased from 75 to 55 for SFQ3 and SFQ4 in the STAR+PLUS program. No disenrollment requests were reported for the dental program.

Managed Care Disenrollment Requests (SFY2015 Q1 to SFY2015 Q4)



D. ENROLLMENT OF MEMBERS WITH SPECIAL HEALTH CARE NEEDS

This subsection of the report addresses STC 39(b) regarding the enrollment into managed care for people with special healthcare needs. The state's Medicaid application asks potential enrollees to identify any family members with special health care needs (MSHCN). MSHCN means a member including a child, or children with special health care needs (CSHCN) who (1) has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or is anticipated to last for a significant period of time, and (2) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel. The state's enrollment broker conveys this and other information concerning potential MSHCN to health and dental plans, who then verify whether the members meet the plans' assessment criteria for MSHCN. All STAR+PLUS members and Former Foster Care Children (FFCC) enrolled in STAR are deemed to be MSHCN.

Health and dental plans must also develop their own processes for identifying MSHCN, including CSHCN and others with disabilities or chronic or complex medical and behavioral health conditions.

HHSC developed additional contract requirements related to MSHCN effective March 2015. The new language requires MCOs to include additional populations in the groups that must be identified as MSHCN including pregnant women identified as high risk and Early Childhood Intervention program participants. In addition, the new language defines contractual requirements regarding service management and developing appropriate service plans for MSHCN requiring care coordination to meet short and long-term goals.

1. Reporting

In the past, HHSC has provided the enrollment broker's MSHCN data in the annual reports. This data showed the number of self-identified MSHCN for the quarter, and did not reflect the total number of verified MSHCN. HHSC requested MCOs to submit the total number of MSHCN that they have verified and the number of MSHCN requiring a service plan. The data presented in Attachment Q of this report shows a snapshot of the total number of MSHCN for the month of August 2015. HHSC is developing contractual requirements and a template for the MCOs to submit MSHCN data on a regular basis.

2. Analysis

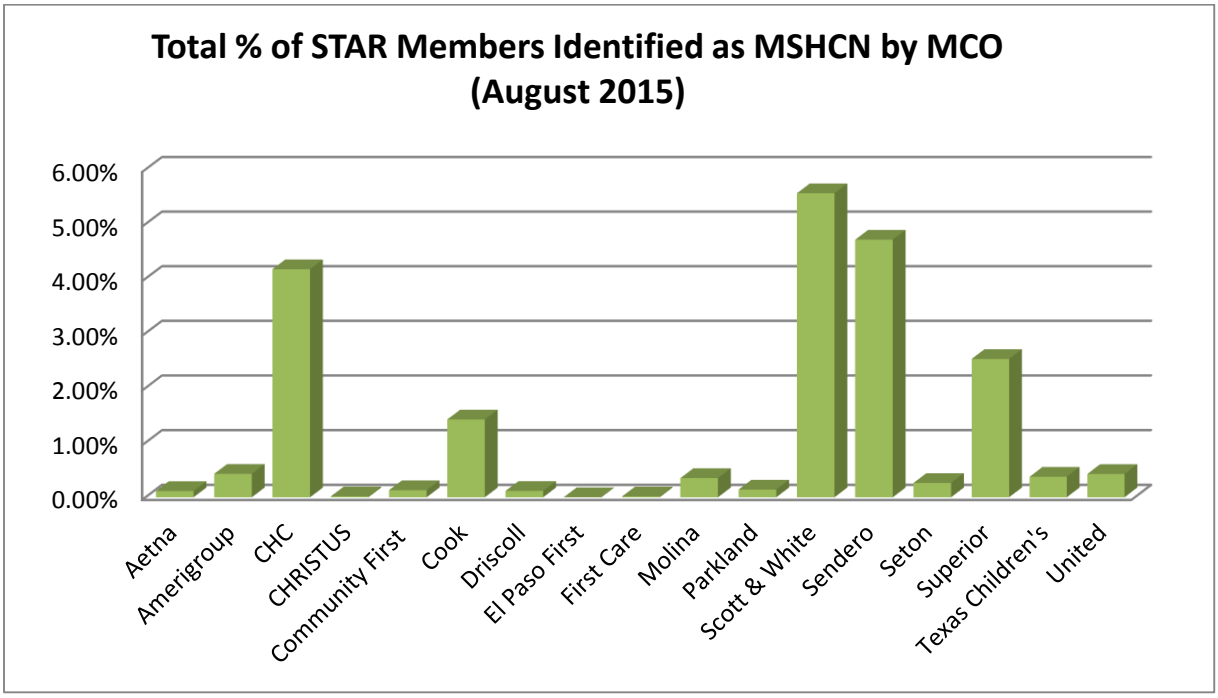
All STAR+PLUS plans reported 100% MSHCN, as required in the contract. STAR+PLUS plans are required to provide service coordination to all members. In August 2015, there were a total of 35,915 children and adults identified as MSHCN in STAR MCOs, which is less than 2% (1.27%) of all STAR members. MCOs reported 26.35% of MSHCN had service plans in August 2015.

See Attachment Q for detail by service delivery area and MCO.

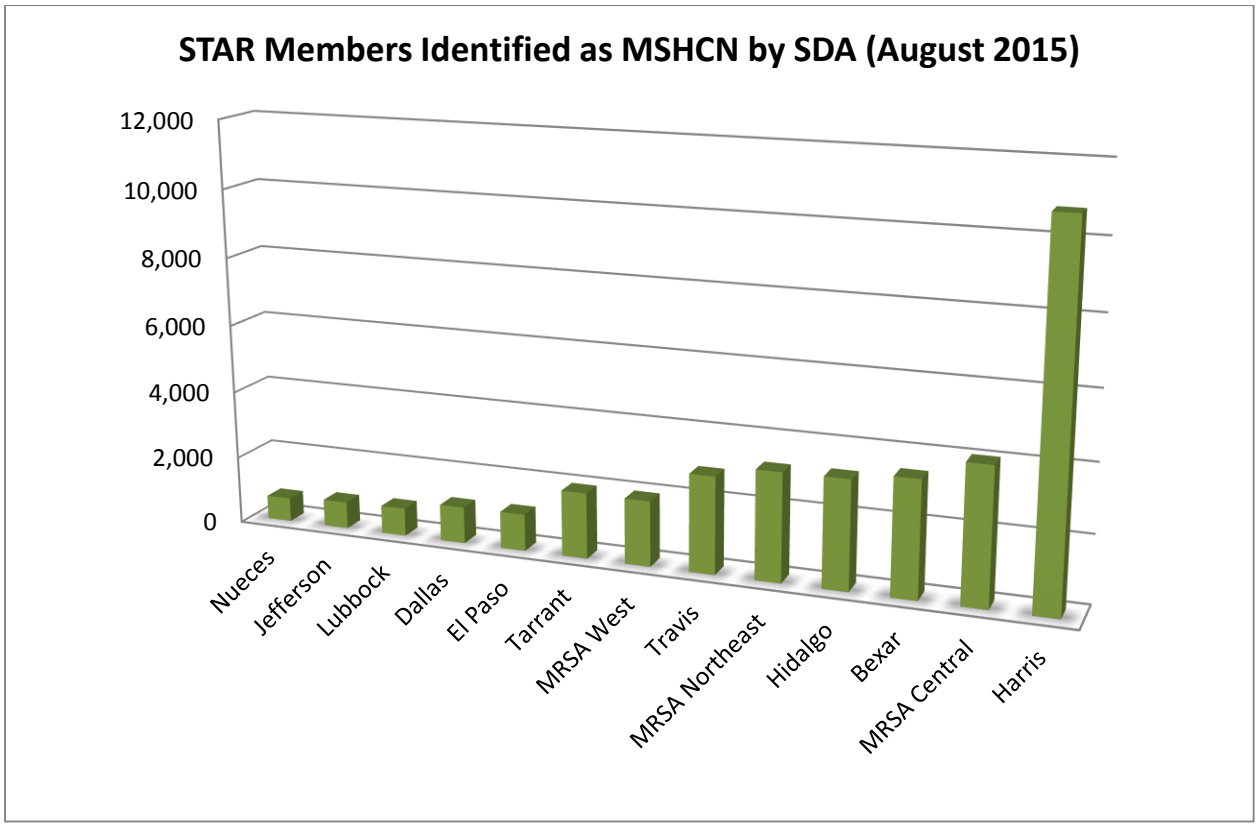
Approximately half of all STAR members with special health care needs are concentrated in the Harris, Bexar, and MRSA Central service delivery areas. Four STAR plans reported more than 2% of members were classified as MSHCN: CHC (4.17%), Superior (2.53%), Scott & White (5.56%) and Sendero (4.71%). The remaining plans reported less than 1% of members were MSHCN.

STAR MCOs rely on various mechanisms to identify and verify MSHCN in addition to member self- identification. HHSC does not provide MCOs an all-inclusive list of conditions that should be included in MSHCN criteria. Most STAR MCOs employ a combination of methods including provider referrals, risk assessments, and utilization reviews. For example, one MCO relies on a combination of member screening and predictive modeling to identify members while another identifies members as MSHCN if they meet specific diagnosis criteria. A small number of STAR MCOs use predictive modeling and specific diagnosis criteria.

The number of MSHCN has increased over time for some plans that have changed identification processes. For example CHC, reported 322 in August 2014 and 9,511 in August 2015. CHC attributes this increase to several factors: the inclusion of additional groups as MSHCN, increased efforts to reach members, and incorporating data analytics to identify members based on claims data. Superior is also using the enrollment broker data file to identify MSHCN resulting in higher numbers.



* MSHCN data will be submitted for BCBS as an addendum to the next biannual report, the 2016 Quarter 2 report.



E. MEDICAID ELIGIBILITY CHANGES

No eligibility changes were made to the 1115 waiver populations in 2015.

F. ANTICIPATED CHANGES IN POPULATIONS OR BENEFITS

On March 1, 2015, most people living in a nursing facility (NF) began receiving Medicaid services through STAR+PLUS MCOs. The STAR+PLUS MCOs are responsible for reimbursing providers for services rendered to NF managed care members, and ensuring appropriate utilization of NF add-on and acute care services. The STAR+PLUS service coordinator works with the member (or caretaker) and NF staff to ensure care is coordinated, and to find ways to avoid preventable hospital admissions, readmissions, and emergency room visits, resulting in shared savings to benefit all participants.

In April 2015, HHSC began to passively enroll full-dual eligible non-facility adults (age 21 and above) who are required to receive their Medicaid benefits through the STAR+PLUS managed care program and who live in one of the six demonstration counties: Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant. In the dual demonstration model, the Medicare Medicaid Plan (MMP) is responsible for coordinating the full array of Medicaid and Medicare services. This includes benefits added to the STAR+PLUS service array in March 2015, such as nursing facility services. From August 1, 2015 – October 1, 2015, nursing facility dual eligibles were included in the passive enrollment process.

HHSC is committed to improving care for dual eligibles and values the opportunity to participate in this innovative model that enhances care, ensures service coordination, reduces administrative burden for enrollees and providers, and most importantly, improves the health and well-being of the dual eligible population. We look forward to our continued partnership with CMS on this important endeavor.

Beginning June 2015, STAR+PLUS MCOs were required to make Community First Choice (CFC) a benefit for certain individuals who meet an institutional level of care including a nursing facility, hospital, an intermediate care facility for individuals with intellectual disabilities or a related condition (ICF-IID), or an institution for mental disease (IMD) for individuals under 21 and over 64 and upon assessment are determined to require attendant, habilitation, emergency response services (ERS) or support management.

III. DELIVERY NETWORKS AND ACCESS

This subsection addresses the quarterly and annual reporting requirements found in STCs 24(e), 39(a), 39(c), 40(b), and 67. Supporting data are located in Attachments C through K. HHSC routinely reviews various measures related to network adequacy, including those reported in the

following section of this report: provider network counts, open panel, service utilization, geo-access, provider availability and accessibility, and out-of-network utilization. HHSC monitors these measures in combination with member complaints in order to assess the adequacy of MCO provider networks.

A. PROVIDER NETWORKS

This subsection addresses quarterly reporting requirements in STCs 24(e) 39(a), 40(b) and 67 about quarterly healthcare and pharmacy provider counts for STAR and STAR+PLUS and dental provider counts for the Dental Program. The provider network methodology is contained in Attachment C1, provider network counts are reported in Attachment C2, and provider termination counts are reported in Attachment C3.

1. Primary Care Providers (PCPs)

MCOs are required to assign 100% of non-dual members to a PCP within five business days of MCO enrollment. HHSC confirmed that all MCOs assign members to a PCP, and all adult members have access to at least one PCP and children to at least two age-appropriate PCPs within established mileage standards, as outlined in the following section of this report.

Across the STAR program statewide, the MCOs reported a total of 18,155 unique PCP providers, an increase of 548 from the prior quarter. The MCOs reported 13,481 unique PCP providers in the STAR+PLUS program statewide, an increase of 315 from the prior quarter.

2. Specialists (non-pharmacy)

Across the STAR program statewide, the MCOs reported 56,254 unique specialty providers, an increase of 2,051 from the prior quarter. The MCOs reported 47,357 unique specialty providers in the STAR+PLUS program statewide, an increase of 889 providers.

3. Provider Terminations

Attachment C3 details data reported by the MCOs regarding the number of PCPs and specialists terminated in 2015 SFQ4. The MCOs reported a variety of reasons for provider termination. Among the most common reasons reported were termination requested by provider, MCO terminated for cause, provider left group practice or provider closed practice.

4. Pharmacy Providers

Across the STAR program statewide, the MCOs reported a total of 4,872 unique pharmacies, a decrease of 21 pharmacies from the prior quarter. The MCOs reported 4,789 unique pharmacies in the STAR+PLUS program statewide, a decrease of 55 pharmacies from the prior quarter. All

MCOs contract with the pharmacies outside their primary SDA to ensure members have access to a pharmacy if they travel outside the SDA.

5. Dental Program Provider Counts

In 2015 SFQ4, DentaQuest reported a total of 4,956 unique dental providers, an increase of 68 dental providers from the prior quarter. MCNA reported 4,374 unique dental providers, an increase of 154 dental providers from the prior quarter.

B. PROVIDER OPEN PANEL

This section addresses annual reporting requirements found in STC 24(e) and 40(b), regarding the number of network providers accepting new Demonstration populations. Supporting data is located in charts below. All MCOs submit monthly files to the enrollment broker identifying the number of PCPs and main dentists who are accepting new Medicaid patients, described here as "open panel" PCPs and "open practice" dentists. This section reports the open panel percentage for the overall provider network; section D of the report includes open panel data as a geoaccess measure. The state does not track the number of specialty providers accepting new patients, which is consistent with the Texas Department of Insurance's network review practices. To determine whether the plans have adequate specialist networks, HHSC monitors member and provider complaints and tracks total network participation, geomapping results, and out-of-network utilization. Other sections of this report discuss these monitoring results.

1. STAR and STAR+PLUS Statewide

Across the STAR program, open panel PCP rates reached 90% in 2015 SFQ2 and remained steady at 90% in 2015SFQ4. Across the STAR+PLUS program in 2015SFQ2, the open panel PCP rate reached 90% and slightly decreased to 89% in 2015SFQ4.

2. STAR and STAR+PLUS by SDA

Throughout 2015 in the STAR program, most of the service delivery areas maintained high open panel PCP rates. Open panel PCP rates fell one percentage point below the 80% benchmark in MRSA Central in SFQ2. In the STAR+PLUS program, open panel PCP rates fell below the 80% benchmark in at least one quarter in Bexar, Dallas, MRSA Central, and Travis counties. Notable service delivery areas with open panel PCP rates at 94% or higher throughout 2015 included STAR: El Paso, Hidalgo and Nueces and STAR+PLUS: El Paso, Hidalgo, MRSA Northeast and Nueces.

3. STAR and STAR+PLUS by MCO

Broken down by MCO, most open panel PCP rates remained relatively stable throughout 2015. MCO performance remained consistent across all quarters in 2015. Cook Children's Health Plan failed to meet the 80% standard and informed HHSC that it contracts with PCPs that elect to keep a closed panel and accept patients on a case-by-case basis. Furthermore, MCO assured HHSC that MCO access to care is not an issue for members. Due to the previously mentioned, HHSC approved a special consideration request. Texas Children's Health Plan failed to meet the benchmark by a small margin at 79%. In the STAR+PLUS program all plans met or exceeded the 80% benchmark. The open panel PCP standard is a benchmark and the state routinely monitors additional measures discussed in this section of the report as indicators of network adequacy.

Even though the open panel rates for certain MCOs or service delivery areas do not meet the 80% benchmark, MCOs are required to assign 100% of non-dual eligible members to a PCP within five business days of MCO enrollment. Notable plans with open panel PCP rates at 95% or higher throughout 2015 included STAR: Christus, Driscoll, El Paso First, Seton and STAR+PLUS: United.

4. Dental Program

Both dental plans met the state’s 90% standard for main dentists with open practices in every fiscal quarter of 2015.

Open Panel PCP by MCO (2015 Q2-Q4)

Program	MCO	Feb - 15	May-15	Aug-15
STAR	Aetna	93%	93%	93%
	Amerigroup Texas, Inc.	83%	85%	86%
	BCBS	92%	92%	92%
	Christus	100%	100%	100%
	Community First Health Plan	94%	93%	93%
	Community Health Choice	91%	91%	91%
	Cook Children's Health Plan	66%	63%	63%
	Driscoll Children's Health Plan	97%	97%	97%
	El Paso First	95%	96%	96%
	FirstCare	81%	86%	86%
	Molina Healthcare of Texas	91%	91%	91%
	Parkland Community Health Plan	93%	94%	94%
	Scott & White RightCare	97%	97%	93%
	Sendero	92%	93%	93%
	Seton Health Plan	100%	100%	100%
	Superior Health Plan	87%	83%	84%
	Texas Children's Health Plan	79%	79%	79%
	United Health Care	93%	93%	93%
STAR Average		90%	90%	90%
STAR+PLUS	Amerigroup Texas, Inc.	86%	85%	86%
	Cigna-HealthSpring	92%	91%	92%
	Molina Healthcare of Texas	90%	89%	90%
	Superior Health Plan	87%	83%	84%
	United Health Care	95%	95%	95%
STAR+PLUS Average		90%	89%	89%

Open Panel PCP by SDA (2015 Q2-Q4)

Program	SDA	Feb-15	May-15	Aug-15
STAR	Bexar	87%	88%	88%
	Dallas	87%	89%	90%
	El Paso	95%	95%	95%
	Harris	89%	90%	90%
	Hidalgo	97%	97%	97%
	Jefferson	90%	91%	91%
	Lubbock	84%	86%	86%
	MRSA Central	80%	79%	80%
	MRSA Northeast	86%	85%	86%
	MRSA West	84%	85%	85%
	Nueces	96%	96%	96%
	Tarrant	83%	85%	85%
	Travis	90%	89%	89%
STAR+PLUS	Bexar	82%	79%	79%
	Dallas	83%	79%	80%
	El Paso	95%	95%	95%
	Harris	92%	91%	91%
	Hidalgo	97%	97%	97%
	Jefferson	91%	91%	91%
	Lubbock	89%	87%	87%
	MRSA Central	84%	79%	80%
	MRSA Northeast	95%	94%	95%
	MRSA West	91%	89%	90%
	Nueces	95%	94%	95%
	Tarrant	84%	82%	83%
	Travis	75%	76%	76%

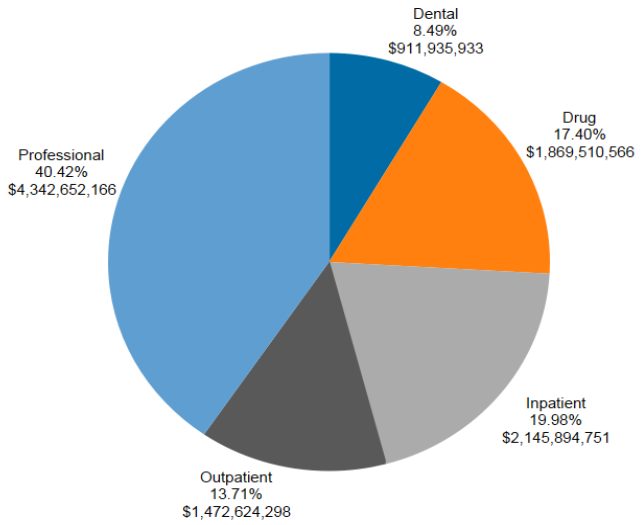
C. SERVICE UTILIZATION

This subsection addresses annual reporting requirements found in STC 24(e). Analysis of service utilization is based on the completed year SFY 2014 for acute care services and pharmacy services and based off encounter data. Long term services and supports are not included and expenditures represent the amount the MCO reimbursed the provider.

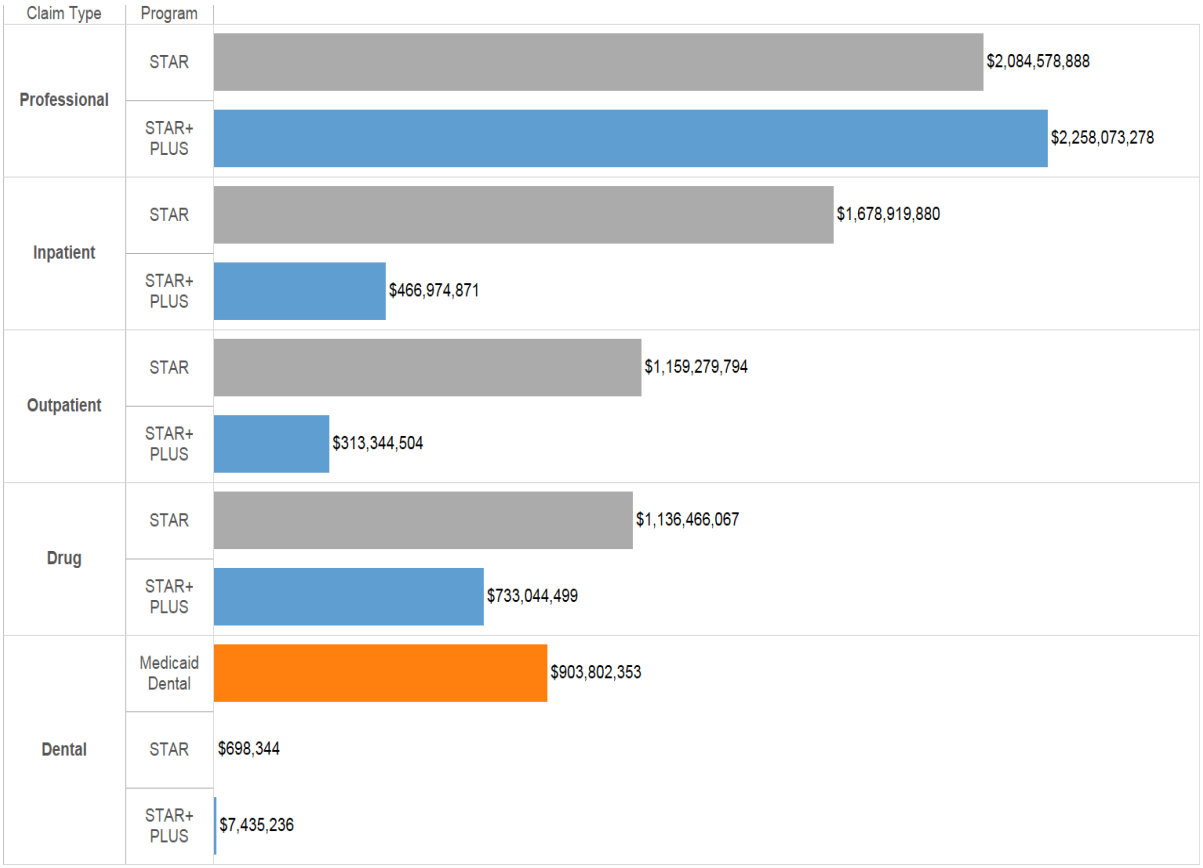
Depicted in the figures below, professional claims made up over 40% of the total expenditures in STAR and STAR+PLUS in SFY 2014. "Inpatient" refers to inpatient hospital services and "outpatient" refers to services received at a hospital on an outpatient basis and at non-hospital facilities. Inpatient and outpatient combined, account for about one-third of expenditures. For

inpatient, outpatient, and pharmacy, the STAR program overall spent more than STAR+PLUS while STAR+PLUS spent slightly more than STAR on professional claims.

Expenditures by Claim Type (2014)

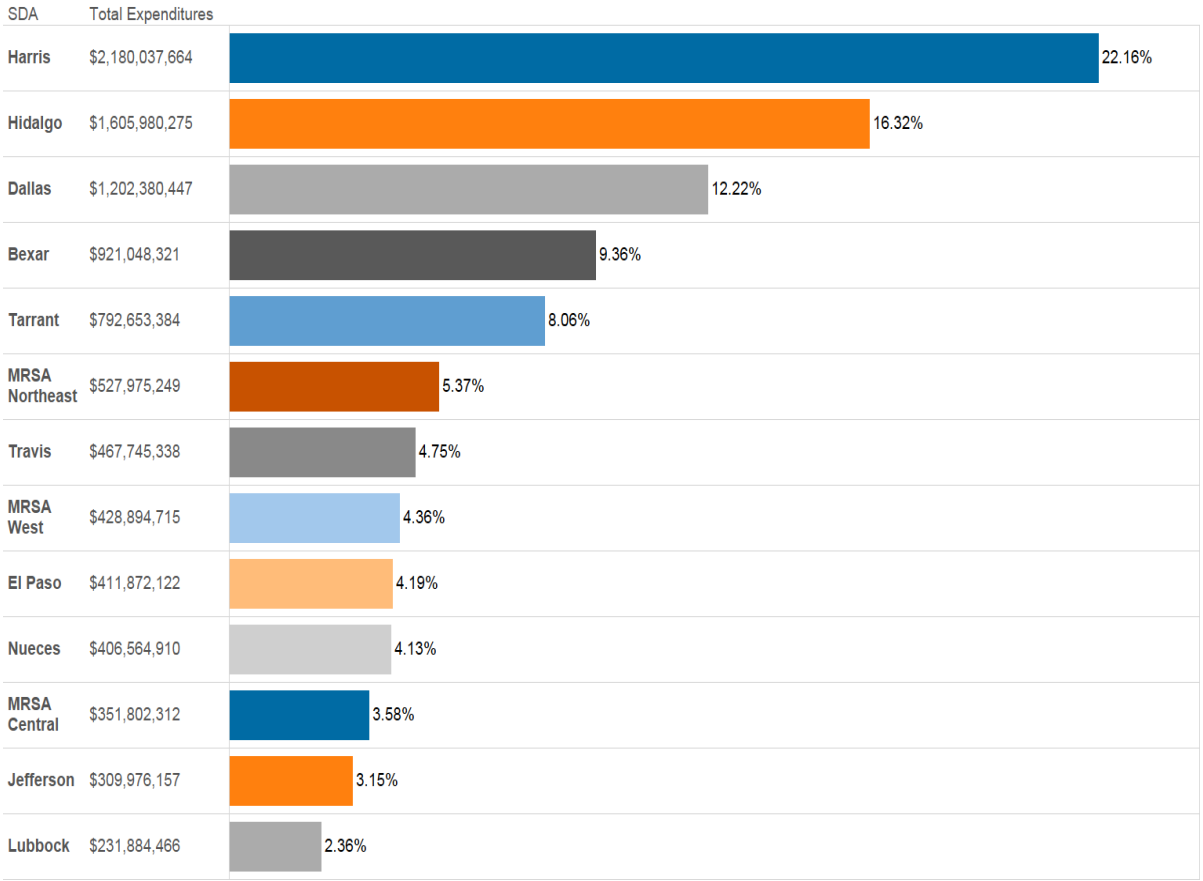


Expenditures by Program and Claim Type (2014)



The figure below shows percentage of expenditures by SDA.

Expenditures by SDA (2014)



Compared to average monthly enrollment market share, average monthly expenditures as a percentage by MCO and program were fairly consistent, reflected in the figures below. In the STAR program, Superior, Community Health Choice, Driscoll, FirstCare, Aetna, Scott & White, BCBS, and Sendero's average monthly expenditures as a percent by MCO slightly exceeded their average monthly enrollment market share all by less than 2%. In the STAR+PLUS program, Superior and Cigna Health Spring's average monthly expenditures as a percent by MCO exceeded their average monthly enrollment market share by less than 5%. MCNA's average monthly dental expenditures as a percent by MCO was about 2% higher than their average monthly enrollment market share.

Average Monthly STAR Enrollment and Expenditures by SDA (2014)

SDA	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditure
Harris	578,628	22.51%	$109,214,399	21.63%
Hidalgo	329,038	12.80%	$58,478,935	11.58%
Dallas	350,183	13.62%	$59,199,856	11.72%
Tarrant	223,402	8.69%	$41,546,513	8.23%
Bexar	214,348	8.34%	$40,308,700	7.98%
MRSA Northeast	166,879	6.49%	$43,997,937	8.71%
MRSA West	141,037	5.49%	$35,741,226	7.08%
MRSA Central	123,425	4.80%	$29,316,859	5.81%
Travis	126,662	4.93%	$24,807,746	4.91%
El Paso	113,584	4.42%	$18,133,186	3.59%
Nueces	72,328	2.81%	$17,602,794	3.49%
Lubbock	65,598	2.55%	$12,980,253	2.57%
Jefferson	65,604	2.55%	$13,666,842	2.71%

Average Monthly STAR+PLUS Enrollment and Expenditures by SDA (2014)

SDA	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditure
Hidalgo	73,350	17.85%	$75,352,754	23.93%
Harris	102,121	24.85%	$72,455,406	23.01%
Dallas	58,389	14.21%	$40,998,515	13.02%
Bexar	48,729	11.86%	$36,445,326	11.57%
Tarrant	33,788	8.22%	$24,507,935	7.78%
Nueces	20,193	4.91%	$16,277,615	5.17%
El Paso	24,577	5.98%	$16,189,491	5.14%
Travis	21,019	5.11%	$14,171,032	4.50%
Jefferson	17,522	4.26%	$12,164,505	3.86%
Lubbock	11,306	2.75%	$6,343,453	2.01%

Average STAR Monthly Expenditures by Program and MCO (2014)

MCO Name	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditure
Superior Health Plan	659,221	25.64%	$137,042,314	27.14%
Amerigroup Texas, Inc.	514,659	20.02%	$90,031,301	17.83%
Texas Children's Health Plan	271,453	10.56%	$48,943,480	9.69%
Community Health Choice	203,509	7.92%	$45,538,809	9.02%
Parkland Community Health Plan	163,196	6.35%	$29,192,829	5.78%
Driscoll Children's Health Plan	106,788	4.15%	$23,037,957	4.56%
United Health Care	101,948	3.97%	$18,874,509	3.74%
FirstCare	88,330	3.44%	$22,389,486	4.43%
Molina Healthcare of Texas	94,099	3.66%	$16,510,926	3.27%
Community First Health Plan	89,807	3.49%	$16,476,835	3.26%
Cook Children's Health Plan	80,585	3.13%	$15,764,008	3.12%
Aetna	61,497	2.39%	$13,005,847	2.58%
El Paso First	53,878	2.10%	$8,795,504	1.74%
Scott & White RightCare	35,737	1.39%	$9,173,698	1.82%
BCBS	16,619	0.65%	$3,621,702	0.72%
Seton Health Plan	12,344	0.48%	$2,147,017	0.43%
Sendero	9,662	0.38%	$3,021,079	0.60%
Christus	7,387	0.29%	$1,427,948	0.28%

Average STAR Monthly Expenditures by Program and MCO (2014)

MCO Name	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditure
Superior Health Plan	111,723	27.18%	$99,420,883	31.57%
Amerigroup Texas, Inc.	118,947	28.94%	$81,233,924	25.80%
Molina Healthcare of Texas	90,646	22.06%	$64,355,358	20.44%
United Health Care	64,798	15.77%	$46,199,840	14.67%
Cigna-HealthSpring	24,879	6.05%	$23,696,027	7.52%

Average Dental Monthly Expenditures by MCO (2014)

MCO Name	Monthly Average Number of Clients Utilizing Services	Monthly Average Expenditure	% of Total - Monthly Average Expenditure
DentaQuest	162,683	$42,661,527	56.64%
MCNA Dental	114,837	$32,631,202	43.33%
Delta Dental	238	$24,133	0.03%

D. GEOACCESS

This subsection includes quarterly geo-access information based on geo-mapping data provided by HHSC Strategic Decision Support (SDS) and self-reported by MCOs, in accordance with STCs 24(e) and 39(a).

Attachments E, G and H show HHSC geo-mapping results by plan and SDA for the following provider types and populations:

- All STAR and STAR+PLUS members: open panel PCP and pharmacy;
- Children STAR and STAR+PLUS: otolaryngologist (ENT);
- Dental members: main dentists, endodontic, oral surgery, orthodontic, periodontist and prosthodontist.

Attachments I, J, and K provide a summary of the plans' self-reported geo-mapping data by plan and SDA for several provider types. The requirements for provider types vary by program and population as described below.

- All STAR and STAR+PLUS members: open panel PCPs, obstetrician/gynecologist for female members, orthopedic surgeon, outpatient behavioral health services, acute care hospitals and pharmacy;
- Adults and children in STAR and children in STAR+PLUS: orthopedic surgery;
- Children in STAR and STAR+PLUS: ENT;
- Adults in STAR+PLUS: urology, ophthalmology, cardiovascular disease specialist;
- Dental members: main dentists, endodontic, oral surgery, orthodontic; periodontist and prosthodontist.

For all STAR and STAR+PLUS service delivery areas, the following benchmarks were applied for access to PCPs and specialists as a geoaccess measure (see Attachments I1 and I2 for mileage standards by provider type):

- 90% – two open panel PCPs for children and one open panel PCP for adults
- 90% – access to at least one of all other provider types for adults and children.

If the MCO does not meet the mileage or out-of-network standards, it may submit a time-limited special exception request. The request must include supporting documentation explaining why the exception should be granted. HHSC staff review the special consideration request and supporting documentation. HHSC staff may consider additional factors such as known marketplace issues. HHSC may grant an exception for up to three state fiscal quarters and plans will not be subject to remedy.

1. Access to PCPs and ENTs

Geoaccess to PCPs and ENTs is reported in Attachment E. In 2015 SFQ4 across the state, the STAR and STAR+PLUS programs exceeded the State's 90% benchmarks for access to PCPs and ENTs.

Based on the HHSC Geo-Mapping results, all plans met the access standards for children's and adults' access to a PCP with an open panel in 2015 SFQ4. Most plans also met the access standard for children's access to an ENT with an open panel, with a few exceptions. The following plans failed to meet the 90% standard:

STAR: Amerigroup - MRSA West and First Care MRSA West: HHSC approved special consideration requests for both MCOs. **STAR+PLUS:** Amerigroup - MRSA West: HHSC approved a special consideration request.

2. Access to Specialty Care

Attachment I shows the geo-access measures by MCO for specialty care. The attachment is separated by children and adults and by program: STAR and STAR+PLUS programs.

Children

In the children's category, most of the MCOs met the geomapping standards for providing specialty care to child members with the exception of a few MCOs which are listed by SDAs. In the STAR program the following plans failed on at least one standard, MRSA West SDA: Amerigroup and First Care, Nueces SDA: Christus and Jefferson SDA: Molina.

Similarly, in the STAR+PLUS program, in the MRSA West SDA, Amerigroup experienced difficulty with achieving the standard. It is important to note that HHSC approved a special exception requests for Amerigroup MRSA WEST in both the STAR and STAR+PLUS program.

Adults

In the adult's category of the STAR program, the majority of the MCOs met the geomapping standards for providing specialty care. However, a small number of STAR plans failed on at least one standard including MRSA West: Amerigroup and First Care, Nueces: Christus, Jefferson: Molina, and El Paso: Superior. In the STAR+PLUS program, Amerigroup in the MRSA West SDA failed on at least one standard. Likewise, as previously mentioned in the children's category, HHSC granted special consideration requests for Amerigroup MRSA West SDAs for both STAR and STAR+PLUS programs.

3. Access to Pharmacy

Attachment G provides summaries of HHSC geo-mapping data by plan and SDA for pharmacies. For all STAR and STAR+PLUS service delivery areas, the following benchmarks applied:

- 80% – access to a network pharmacy in urban counties within 2 miles
- 75% – access to a network pharmacy in suburban counties within 5 miles
- 90% – access to network pharmacy in rural counties within 15 miles

- 90% – access to a 24-hour pharmacy in all counties within 75 miles (only available on MCO self-reported data).

The following plans were noted to have deficiencies in meeting access standards in SFQ4 as evidenced by the following data tables. MCOs that did not meet the aforementioned standards are indicated in red bold font and are separated by categories children and adults, program and MCO. MCOs that did not meet the standard were granted a special exception request with the exception of one MCO that HHSC recommended for liquidated damages.

STAR Pharmacy Geoaccess Metric Achievement Children 2015SFQ4

Program	Service Area	MCO	Plan Code	80 Percent of Child Members in Urban Counties Residing w/in 2 Miles of One Pharmacy	75 Percent of Child Members in Suburban Counties Residing w/in 5 Miles of One Pharmacy	90 Percent of Child Members in Rural Counties Residing w/in 15 Miles of One Pharmacy	80 Percent of Child Members in Urban Counties Residing w/in 2 Miles of Two Pharmacies	75 Percent of Child Members in Suburban Counties Residing w/in 5 Miles of Two Pharmacies	90 Percent of Child Members in Rural Counties Residing w/in 15 Miles of Two Pharmacies
STAR	BEXAR	AETNA Better Health	43	94.09	74.05	NA	90.22	63.42	NA
		Amerigroup	44	93.50	76	NA	89.86	69.15	NA
		Community First Health Plans	42	94.21	78.93	NA	89.2	73.79	NA
		Superior HealthPlan	40	93.88	73.12	NA	88.95	61.45	NA
	EL Paso	El Paso First Premier Plan	37	84.62	0	NA	80.93	0	NA
		Molina Healthcare of Texas	31	86.90	0	NA	81.6	0	NA
		Superior HealthPlan	36	85.36	0	NA	79.94	0	NA
	HARRIS	Molina Healthcare of Texas	7G	97.84	92.32	100	95.75	86.78	80.41
		Texas Children's Health Plan	72	97.11	91.88	99.49	94.12	85.77	86.7
		UnitedHealthcare Community Plan	7H	96.94	93.44	99.35	93.43	88.2	87.23
	HIDALGO	Driscoll Children's Health Plan	H4	80.54	NA	99.1	74.7	NA	88.98
		Molina Healthcare of Texas	H3	81.04	NA	99.29	75.21	NA	95.63
		Superior Healthplan	H2	75.06	NA	99.22	68.48	NA	93.68
		UnitedHealthcare Community Plan	H1	79.68	NA	99.51	71.77	NA	94.44
	JEFFERSON	Amerigroup	8G	89.65	78.67	99.21	79.49	74.29	97.74
		Community Health Choice	8H	90.58	71.43	98.77	80.22	63.76	94.82
		Molina Healthcare of Texas	8J	88.74	80.34	98.96	80.49	74.7	97.1
		Texas Children's Health Plan	8K	90.63	76.69	97.81	81.21	70.38	93.29
		UnitedHealthcare Community Plan	8L	88.93	81.75	98.83	76.26	76.82	97.51
	LUBBOCK	Amerigroup	53	90.78	87.91	99.64	83.04	83.99	86
		FirstCare STAR	50	90.79	85.73	96.42	84.35	80.55	91.6
		Superior HealthPlan	52	90.93	91.75	95.53	83.64	87.37	79.17
	MRSA Central	Amerigroup	C1	90.61	80.16	96.06	69.55	69.05	91.04
		RightCare from Scott and White Health Plan	C3	78.70	81.65	99.03	64.82	71.56	92.29
		Superior HealthPlan	C2	81.29	76.73	93.84	69.09	48.02	89.59
	MRSA Northeast	Amerigroup	N1	75.43	65.1	99.59	64.59	55.33	96.45
		Superior HealthPlan	N2	72.84	52.74	98.15	62.83	48.07	93.9
	MRSA West	Amerigroup	W2	77.45	56.91	97.52	71.45	19.11	85.94
		FirstCare STAR (MRSA)	W4	84.63	61.87	90.1	77.31	30.36	78.96
		Superior HealthPlan	W3	80.44	60.44	92.74	72.82	11.93	78.03
	NUECES	CHRISTUS Health Plan	88	0.00	0	8.9	0	0	0
		Driscoll Children's Health Plan	82	89.56	94.02	99.45	86.19	52.62	94.93
		Superior HealthPlan	83	90.97	86.64	97.2	83.57	55.58	95.12
	TARRANT	Cook Children's Health Plan	66	95.09	83.88	NA	92.1	72.98	NA
	TRAVIS	Blue Cross Blue Shield of Texas	1P	83.23	81.94	97.25	74.9	79.14	96.13
		Sendero Health Plans	1N	81.81	80.98	95.07	74.49	77.63	95.07
		Seton Health Plan	1A	83.19	84.91	96.82	75.37	82.14	96.15
		Superior HealthPlan	10	81.67	78.31	96.07	74.39	73.94	95.14

STAR+PLUS Pharmacy Geoaccess Metric Achievement Children 2015SFQ4

Program	Service Area	MCO	Plan Code	80 Percent of Child Members in Urban Counties Residing w/in 2 Miles of One Pharmacy	75 Percent of Child Members in Suburban Counties Residing w/in 5 Miles of One Pharmacy	90 Percent of Child Members in Rural Counties Residing w/in 15 Miles of One Pharmacy	80 Percent of Child Members in Urban Counties Residing w/in 2 Miles of Two Pharmacies	75 Percent of Child Members in Suburban Counties Residing w/in 5 Miles of Two Pharmacies	90 Percent of Child Members in Rural Counties Residing w/in 15 Miles of Two Pharmacies
STAR Plus	BEXAR	Amerigroup	45	93.66	84.21	NA	92.25	73.68	NA
		Molina Healthcare of Texas	46	94.29	71.43	NA	94.29	71.43	NA
		Superior HealthPlan	47	92.43	71.96	NA	88.14	58.88	NA
	EL Paso	Molina Healthcare of Texas	33	91.61	NA	NA	86.45	NA	NA
	HARRIS	Molina Healthcare of Texas	75	98.07	93.7	100	96.39	92.13	100
		UnitedHealthcare Community Plan	7R	96.76	94.17	100	93.05	90	100
	HIDALGO	HealthSpring	H7	77.62	NA	100	67.51	NA	100
		Molina Healthcare of Texas	H6	80.00	NA	100	74.87	NA	93.33
		Superior HealthPlan	H5	76.23	NA	98.11	69.99	NA	94.34
	JEFFERSON	Amerigroup	8R	91.73	81.25	100	78.2	79.17	100
		Molina Healthcare of Texas	8T	87.23	85	100	80.85	85	100
		UnitedHealthcare Community Plan	85	90.00	83.93	100	75.71	78.57	92.86
	LUBBOCK	Amerigroup	5A	86.27	100	94.74	84.31	100	78.95
		Superior HealthPlan	5B	87.43	100	90.62	81.15	64.29	59.38
	MRSA Central	Superior HealthPlan	C4	83.42	76.19	85.71	72.19	57.14	84.13
		UnitedHealthcare Community Plan	C5	86.84	85.71	94.44	71.05	85.71	94.44
	MRSA Northeast	Cigna-HealthSpring	N3	77.78	77.78	95.71	67.78	77.78	88.57
		UnitedHealthcare Community Plan	N4	82.43	71.43	100	75.68	71.43	96.05
	MRSA West	Amerigroup	W5	89.47	100	100	76.32	0	86.11
		Superior HealthPlan	W6	84.17	50	95.1	80	0	81.37
	NUECES	Superior HealthPlan	86	90.12	86.21	97.1	83	37.93	92.75
		UnitedHealthcare Community Plan	85	94.12	83.33	55.56	92.16	50	55.56
	TARRANT	Amerigroup	69	95.68	91.7	NA	93.09	83.84	NA
		HealthSpring	6C	93.39	92	NA	90.91	76	NA
	TRAVIS	Amerigroup	19	79.60	84.21	100	68.16	78.95	100
		UnitedHealthcare Community Plan	18	80.95	73.33	100	73.33	65.33	100

STAR Pharmacy Geoaccess Metric Achievement Adults 2015SFQ4

Program	Service Area	MCO	Plan Code	80 Percent of Adult Members in Urban Counties Residing w/in 2 Miles of One Pharmacy	75 Percent of Adult Members in Suburban Counties Residing w/in 5 Miles of One Pharmacy	90 Percent of Adult Members in Rural Counties Residing w/in 15 Miles of One Pharmacy	80 Percent of Adult Members in Urban Counties Residing w/in 2 Miles of Two Pharmacies	75 Percent of Adult Members in Suburban Counties Residing w/in 5 Miles of Two Pharmacies	90 Percent of Adult Members in Rural Counties Residing w/in 15 Miles of Two Pharmacies
STAR	BEXAR	Community First Health Plans	42	95.09	75.63	NA	90.53	70.14	NA
		Superior HealthPlan	40	93.83	74.1	NA	89.55	61.05	NA
	EL Paso	El Paso First Premier Plan	37	87.38	0	NA	83.29	0	NA
		Molina Healthcare of Texas	31	89.63	NA	NA	85.9	NA	NA
		Superior HealthPlan	36	87.35	0	NA	81.44	0	NA
	HARRIS	Molina Healthcare of Texas	7G	97.38	92.21	100	94.6	87.3	73.33
		Texas Children's Health Plan	72	96.87	92.15	98.09	93.84	86.45	82.8
		UnitedHealthcare Community Plan	7H	96.43	92.05	98.28	92.41	84.29	91.38
	HIDALGO	Driscoll Children's Health Plan	H4	82.62	NA	98.9	76.23	NA	81.87
		Molina Healthcare of Texas	H3	84.42	NA	99.43	79.04	NA	96
		Superior Healthplan	H2	79.44	NA	99.19	73.58	NA	94.8
		UnitedHealthcare Community Plan	H1	81.72	NA	98.12	74.57	NA	90.23
	JEFFERSON	Amerigroup	8G	85.53	80.62	98.57	75.88	76.21	97.86
		Community Health Choice	8H	90.19	76.07	98.56	79.97	68.56	93.27
		Molina Healthcare of Texas	8J	90.36	86.87	97.2	82.53	81.82	96.26
		Texas Children's Health Plan	8K	89.13	82.39	97.41	77.72	74.17	93.97
		UnitedHealthcare Community Plan	8L	88.54	84.81	97.99	76.43	81.01	94.54
	LUBBOCK	Amerigroup	53	91.76	81.67	100	84.59	81.67	83.33
		FirstCare STAR	50	90.34	85.28	96.32	84.21	80.96	90.37
		Superior HealthPlan	52	89.61	93.8	93.82	83.61	89.3	77.53
	MRSA Central	Amerigroup	C1	75.44	76.38	96.08	62.84	60.63	88.51
		RightCare from Scott and White Health Plan	C3	79.37	81.77	98.75	65.32	71.7	92.16
		Superior HealthPlan	C2	78.2	78.87	94.57	64.19	55.53	89.4
	MRSA Northeast	Amerigroup	N1	76.34	61.11	99.19	64.44	52.14	94.07
		Superior HealthPlan	N2	73.26	50.96	97.88	62.81	42.74	93.21
	MRSA West	Amerigroup	W2	80.56	54.05	97.4	75.2	10.81	86.34
		FirstCare STAR (MRSA)	W4	83.86	66.97	89.55	75.83	26.61	80.21
		Superior HealthPlan	W3	81.05	62.89	93.39	71.57	11.34	80.51
	NUECES	CHRISTUS Health Plan	88	0	0	8.82	0	0	0
	TRAVIS	Blue Cross Blue Shield of Texas	1P	86.5	84.82	97.96	79.97	82.11	96.94
		Sendero Health Plans	1N	83.43	81.62	96.88	76.53	77.57	96.88
		Superior HealthPlan	10	84.88	84.47	95.13	77.6	79.73	94.25

STAR+PLUS Pharmacy Geoaccess Metric Achievement Adults 2015SFQ4

Program	Service Area	MCO	Plan Code	80 Percent of Adult Members in Urban Counties Residing w/in 2 Miles of One Pharmacy	75 Percent of Adult Members in Suburban Counties Residing w/in 5 Miles of One Pharmacy	90 Percent of Adult Members in Rural Counties Residing w/in 15 Miles of One Pharmacy	80 Percent of Adult Members in Urban Counties Residing w/in 2 Miles of Two Pharmacies	75 Percent of Adult Members in Suburban Counties Residing w/in 5 Miles of Two Pharmacies	90 Percent of Adult Members in Rural Counties Residing w/in 15 Miles of Two Pharmacies
STAR Plus	BEXAR	Amerigroup	45	93.66	69.83	NA	90.3	61.56	NA
		Molina Healthcare of Texas	46	94.8	76.49	NA	91.57	69.12	NA
		Superior HealthPlan	47	93.57	72.71	NA	89.74	60.4	NA
	EL Paso	Molina Healthcare of Texas	33	91.19	0	NA	87.05	0	NA
	HARRIS	Molina Healthcare of Texas	7S	97.44	91.43	99.09	95.4	86.64	85.84
		UnitedHealthcare Community Plan	7R	97.18	92.79	97.03	93.75	86.79	90.1
	HIDALGO	HealthSpring	H7	82.81	NA	94.96	77.02	NA	91.04
		Superior HealthPlan	H5	83.08	NA	97.81	77.44	NA	91.08
	JEFFERSON	Amerigroup	8R	91.41	81.11	98.88	78.57	74.25	97.29
		Molina Healthcare of Texas	8T	90.82	83.93	99.24	79.16	79.17	97.71
		UnitedHealthcare Community Plan	8S	89.04	80.06	98.14	74.1	73.71	94.62
	LUBBOCK	Amerigroup	5A	91	85.06	99.68	84.69	80.52	78.86
		Superior HealthPlan	5B	90.38	90.84	94.13	83.36	86.51	70.81
	MRSA Central	Superior HealthPlan	C4	81.7	76.34	94.4	69.7	50.89	89.99
		UnitedHealthcare Community Plan	C5	82.45	81.54	93.81	70.76	66.12	85.9
	MRSA Northeast	Cigna-HealthSpring	N3	76.96	58.03	98.08	68.28	52.98	92.34
		UnitedHealthcare Community Plan	N4	77.61	56.43	99.12	68.32	50.66	93.96
	MRSA West	Amerigroup	W5	84.31	66.67	97.76	78.92	25.64	86.65
		Superior HealthPlan	W6	83.78	54.84	91.41	75.21	10.14	75.78
	NUECES	Superior HealthPlan	86	88.9	84.18	96.23	79.4	47.87	94.68
		UnitedHealthcare Community Plan	85	90.92	81.27	63.93	87.17	61.87	58.4
	TRAVIS	Amerigroup	19	87.44	77.37	94.82	78.85	73.5	91.19
		UnitedHealthcare Community Plan	18	87.05	65.78	97.54	80.04	58.3	97.04

It is important to note that 100% of members have access to mail order pharmacies; this serves as an important accessibility benefit for both members who require maintenance medications to manage chronic health conditions and for members who lack access to transportation. Additionally, according to the Pharmacy Benefits Managers (PBMs) for all MCOs, Medicaid members may access any network pharmacy enrolled with the Texas Medicaid Vendor Drug Program within or outside of the distance criteria.

2. Dental Geo-mapping

Dental geo-mapping results are divided into eleven Texas regions. Within each region, HHSC generates a report on the percentage of members in urban and rural areas with access to main dentists, endodontists, oral surgeons, orthodontists, periodontists and prosthodontists.

Attachment H provides summaries of HHSC geo-mapping information for both dental plans and Attachment K provides DMO reported geo-mapping for both dental plans.

The dental contracts require plans to provide access to at least two providers within the following benchmarks and travel distances:

- 100% – open practice main dentist in urban areas within 30 miles;
- 100% – open practice main dentist in rural areas within 75 miles; and
- 95% – specialists in urban and rural areas within 75 miles.

In 2015 SFQ4, both DentaQuest and MCNA maintained sufficient provider networks for main dentists in rural and urban counties as well as pediatric dentists statewide with the exception of the Upper Rio Grande region due in part to overall provider shortages in these areas. Access to dental specialty providers (periodontists, endondontists and prosthodontists) is limited in some parts of Texas as depicted in Attachment H. It should be noted that statewide data from Attachment H indicates both DMOs have experienced extreme difficulty procuring prosthodontists within 75 miles. A reason for the low figures for statewide data is that particular specialty is mostly located in the Central Texas region. Both DMOs report monitoring the State Licensing Board's and HHSC claims administrator's websites and utilizing other internet resources in an effort to identify potential recruitment opportunities. HHSC received and approved special exceptions from DentaQuest SF15Q1, SF15Q2, SF15Q3 and SF15Q4, and from MCNA for SF15Q2, SF15Q3 and SF15Q4for prosthodontist.

PROVIDER 24/7 AVAILABILITY

After-hours access is especially important on a recurring basis for access to PCPs, 24 hour pharmacies, emergency hospital care, and behavioral health services. This section fulfills the annual reporting requirement of STC 39(c), MCO compliance with access to providers 24 hours a day, 7 days a week (24/7). The managed care contracts outline accessibility and availability requirements, including access to emergency and behavioral health services; access to PCPs 24 hours a day, 7 days a week; and appointment availability and wait times.

According to the managed care contracts, MCOs must ensure compliance with provider 24/7 accessibility through their provider networks. HHSC recently requested the results of each MCO's efforts to systematically evaluate continuous access to PCPs in 2015.[1]

[1] Uniform Managed Care Terms and Conditions (UMCC) 8.1.3 and 8.1.4
See also Title 28 of the Insurance code, Rule 11.1607 that PCPs be available and accessible 24 hours per day, seven days per week within an HMO's service delivery area.

1. General Emergency Services

According to the managed care contracts, emergency services must be provided to members without regard to prior authorization or the provider's contractual relationship to the MCO, and general patterns of access are addressed in the out-of-network section of this report.

If medically necessary covered services are not available through network providers, the MCO must, upon the request of a network provider, allow a referral to a non-network physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation.

2. Pharmacy

According to the managed care contracts, MCOs must guarantee access to at least one 24-hour pharmacy within 75 miles for adult and children members. In 2015 SFQ4, most MCOs in most service delivery areas met the geoaccess standard in STAR and STAR+PLUS (see Attachment J).The service delivery areas that did not meet the access standard can be viewed in Attachment J.

3. Behavioral Health

According to the managed care contracts, the MCOs must have a toll-free hotline to handle routine, emergency, and crisis behavioral health calls. The hotline must be available 24 hours a day, 7 days a week. MCOs are required to meet and report hotline performance standards to HHSC each quarter (see Attachment M). More information is provided in the Consumer Issues section listed under the Hotline Call Volume and Performance subsection.

4. Twenty-four Hour PCP Access

HHSC requires MCOs to make best efforts to ensure that PCPs are accessible 24 hours per day, 7 days a week and outlines very specific criteria for what constitutes compliance in the managed care contracts. For example, providers must offer after-hours telephone availability through an answering service, recorded messages with contact information for on-call PCP, or call forwarding that routes the caller to the on-call PCP or an alternate provider.

Each MCO is also required to systematically and regularly verify that covered services furnished by PCPs meet the 24/7 access criteria and enforce access standards where the providers are non-

compliant. HHSC will review 24-hour PCP access in the 2016 SFY Q1 1115 report as an addendum.

5. Appointment Availability

According to the managed care contracts, each MCO must ensure waiting times for appointments do not exceed 14 days for routine primary care and 24 hours for urgent care. HHSC will review appointment availability access in the 2016 SFY Q1 1115 report as an addendum.

6. EQRO Member Satisfaction Surveys

Currently, the most recent EQRO member satisfaction survey has not been approved by HHSC. HHSC will provide an update when the report is finalized.

E. OUT-OF NETWORK UTILIZATION

As required by Texas law,[2] the State monitors health and dental plans' use of out-of-network (OON) facilities and providers.[3] In each service delivery area, OON utilization should not exceed the following thresholds:

- 15% of inpatient hospital admissions;
- 20% of emergency room (ER) visits; and
- 20% of total dollars billed for other outpatient services.

[2] Texas Government Code §533.005(a)(11).
[3] 1 Texas Administrative Code §353.4(e)(2).

1. SFQ4 of 2015

Attachment D details the OON utilization rates by program, MCO and SDA. The following plans exceeded OON utilization standards in SFQ4 of 2015:

STAR

- Aetna : Bexar and Tarrant SDAs
- Amerigroup: Dallas and Harris SDAs
- Molina Dallas and Harris SDAs. In Dallas SDA, HHSC approved a special consideration request.
- Parkland STAR in Dallas SDA
- Scott & White MRSA Central SDA
- Seton Travis SDA
- Texas Children's Harris SDA

STAR+PLUS

- Cigna-HealthSpring Tarrant SDAs: HHSC approved a special consideration request in SFQ3 which and is valid for SFQ3 and SFQ4.
- Molina Dallas and Harris SDAs: HHSC approved special consideration request for OON utilization in the Dallas and Harris service delivery areas. In Harris SDA, MCO will be subjected to liquidated damages.
- Superior in Dallas SDA: HHSC approved a granted special consideration.
- United Harris, Jefferson and MRSA Central SDAs: In Harris SDA, HHSC approved a special consideration for SFQ3-SFQ4 SFY 2015.

The State will continue to monitor these plans, and will require corrective action or other remedies if appropriate. A description of the special consideration request process is detailed below.

Under certain circumstances, plans may request time-limited exemptions from the OON standards if the plans provide evidence warranting special consideration. In order to be granted an exemption the plan must demonstrate both that admissions or visits to a single OON facility account for 25% or more of the plan's admissions or visits in a reporting period; and the plan can demonstrate that it made good faith reasonable efforts to contract with an OON facility to no avail. If the state grants the special consideration, it removes the non-contracted provider from the plan's compliance calculations and recalculates the utilization rate. HHSC evaluates the recalculated OON rates to determine whether OON standards are met. MCOs with approved special considerations are not subject to remedies or assessed liquidated damages (LDs).

Attachment D provides utilization data, including recalculated rates, by program, MCO, and SDA.

Dental plans continued to report OON utilization well below the 20% threshold at less than 0.15%, as shown in the figure below. In the Dental Program, the 20% standard for "other services" applies to out-of-network dental services.

2. SFQ1 through SFQ4 of 2015

Analysis of the 2015 OON data revealed that, among STAR MCOs/SDAs, the average ER OON usage dipped slightly in 2015SFQ4, while inpatient and outpatient OON utilization rates decreased marginally during SFY2015. In the STAR+PLUS program, the average inpatient and outpatient OON usage among STAR+PLUS MCOs/SDAs fluctuated slightly, while average ER OON usage decreased to some extent through all four quarters in SFY2015.

The tables below include the average inpatient, ER and outpatient OON utilization rates among STAR and STAR+PLUS MCO/SDAs. The tables also identify the STAR and STAR+PLUS MCOs that exceeded OON utilization standards in at least one quarter of SFY2015. The values in red boldface font are not in compliance with the OON standards. Attachment D also shows a more detailed depiction of OON utilization rates for ER, inpatient, and other services by program, SDA, and MCO throughout all four quarters in 2015.

STAR and STAR+PLUS MCOs by SDA Exceeding Inpatient Out-of-Network Utilization Standards, 2015 SFQ1-SFQ4

Program	MCO	Service Area	OUT OF NETWORK (OON)			
			Inpatient (15%)			
			15Q1	15Q2	15Q3	15Q4
STAR	Aetna	Bexar	**23.00%**	19.00%	**17.36%**	**16.12%**
	Amerigroup	Dallas	**16.00%**	8.00%	7.90%	9.00%
	Community 1st	Bexar	**23.47%**	**26.00%**	12.66%	1.98%
	El Paso 1st	El Paso	1.00%	1.00%	**93.00%**	1.01%
	Molina	Dallas	**42.00%**	**40.00%**	**37.00%**	**31.19%**
		El Paso	**30.00%**	**29.00%**	0.00%	0.00%
		Harris	**23.00%**	**27.00%**	**17.92%**	14.81%
	Parkland	Dallas	13.00%	13.00%	**17.72%**	14.00%
	Seton	Travis	14.00%	1.00%	**18.62%**	**15.15%**
	STAR Average		**6.48%**	**6.27%**	**7.06%**	**4.37%**
STAR+PLUS	Amerigroup	Harris	**28.00%**	26.00%	**30.39%**	2.00%
		MRSA West	**33.94%**	20.00%	**18.79%**	2.00%
		MRSA NE	**27.00%**	8.00%	8.00%	8.46%
		Tarrant	**28.00%**	29.00%	**26.00%**	33.60%
	Molina	Dallas	**49.00%**	47.00%	**45.00%**	**45.14%**
		El Paso	14.00%	19.00%	1.00%	0.30%
		Harris	**29.00%**	29.00%	**24.00%**	**26.82%**
	Superior	Dallas	**49.00%**	**50.00%**	**21.00%**	13.09%
	United	Harris	**26.00%**	4.00%	**27.76%**	**33.72%**
		Jefferson	7.00%	1.00%	**16.60%**	**29.51%**
		MRSA Central	2.00%	**23.00%**	14.39%	9.04%
S+P Average			**12.14%**	**11.73%**	**12.11%**	**10.47%**

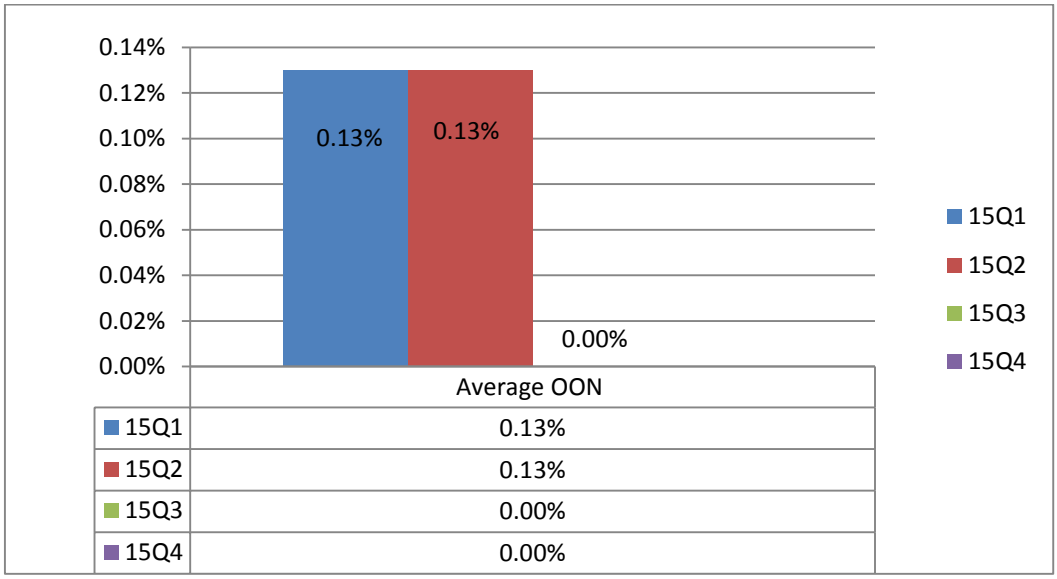
STAR and STAR+PLUS MCOs by SDA Exceeding ER Out-of-Network Utilization Standards, 2015 SFQ1 - SFQ4

Program	MCO	Service Area	OUT OF NETWORK (OON) ER (20%)			
			15Q1	15Q2	15Q3	15Q4
STAR	Aetna	Bexar	**39.00%**	**39.00%**	**40.91%**	**37.49%**
	Amerigroup	Dallas	**22.00%**	**26.00%**	**23.70%**	**25.00%**
		Harris	15.00%	**22.00%**	**23.58%**	**26.00%**
		MRSA Central	14.00%	17.00%	**21.20%**	16.00%
	Community 1st	Bexar	**21.76%**	**22.00%**	10.53%	3.40%
	Molina	Dallas	**44.00%**	**43.00%**	**38.00%**	**37.93%**
		El Paso	**39.00%**	**40.00%**	3.00%	1.99%
		Harris	**41.00%**	**43.00%**	**32.75%**	**33.12%**
	Parkland	Dallas	**21.00%**	19.00%	**24.45%**	**23.00%**
	Scott and White	MRSA Central	**31.00%**	**28.00%**	**21.00%**	**33.64%**
	Seton	Travis	**35.00%**	14.00%	**36.61%**	**38.18%**
	Texas Children's	Harris	**26.00%**	**30.00%**	**38.00%**	**31.00%**
	United	Harris	13.00%	13.00%	**21.00%**	17.21%
	STAR Average		**10.72%**	**10.40%**	**9.96%**	**9.94%**
STAR+PLUS	Amerigroup	Harris	**16.00%**	**23.00%**	**23.78%**	2.00%
		MRSA West	**40.75%**	**26.00%**	19.85%	2.00%
	Cigna-HealthSpring	Hidalgo	**18.00%**	**22.00%**	17.00%	19.42%
		MRSA NE	**28.00%**	6.00%	7.00%	5.87%
		Tarrant	**42.00%**	**41.00%**	**42.00%**	**42.39%**
	Molina	Dallas	**58.00%**	**56.00%**	**50.00%**	**50.03%**
		El Paso	**39.00%**	**39.00%**	1.00%	0.68%
		Harris	**33.00%**	**34.00%**	**29.00%**	**27.84%**
	Superior	Dallas	**28.00%**	**33.00%**	5.00%	**23.36%**
		Hidalgo	1.00%	1.00%	**24.00%**	1.82%
	United	Harris	**37.00%**	2.00%	**40.96%**	**40.92%**
		Jefferson	8.00%	3.00%	12.11%	11.07%
		MRSA Central	2.00%	**37.00%**	**28.95%**	**25.56%**
		Nueces	**25.00%**	2.00%	1.89%	2.59%
S+P Average			**14.79%**	**13.40%**	**12.55%**	**10.02%**

STAR and STAR+PLUS MCOs by SDA Exceeding Outpatient/Other Services Out-of-Network Utilization Standards, 2015 SFQ1 - SFQ4)

Program	MCO	Service Area	OUT OF NETWORK (OON)			
			Outpatient (20%)			
			15Q1	15Q2	15Q3	15Q4
STAR	Aetna	Bexar	14.00%	13.00%	16.25%	12.93%
		Tarrant	10.00%	16.00%	**21.66%**	**20.53%**
	Molina	Dallas	**27.00%**	20.00%	16.00%	13.68%
		El Paso	**25.00%**	**25.00%**	15.00%	7.84%
		Harris	**27.00%**	**27.00%**	14.58%	16.11%
		Jefferson	**25.00%**	13.00%	18.15%	16.97%
	STAR Average		**10.08%**	**9.67%**	**9.21%**	**9.68%**
STAR+PLUS	Amerigroup	Harris	17.00%	19.00%	11.96%	8.00%
		Jefferson	18.00%	**27.00%**	15.93%	8.00%
		MRSA West	**27.04%**	**27.00%**	18.07%	8.00%
		Tarrant	15.00%	**22.00%**	13.72%	8.00%
		Tarrant	**35.00%**	**38.00%**	**29.00%**	**31.21%**
	Superior	Dallas	**23.00%**	**24.00%**	**23.00%**	**24.59%**
S+P Average			**13.67%**	**15.17%**	**12.31%**	**11.93%**

Average Dental Program Out-of-Network Utilization (SFY2015)



	Average OON
15Q1	0.13%
15Q2	0.13%
15Q3	0.00%
15Q4	0.00%

IV. OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

This section addresses the quarterly requirements for STC 67 regarding outreach and other initiatives to ensure access to care. The Dental Stakeholder Update addresses STC 40(c) and the Medicaid Managed Care Advisory Committee meeting update also addresses STC 67.

A. ENROLLMENT BROKER AND PLAN ACTIVITIES

The State's Enrollment Broker, MAXIMUS, performs various outreach efforts to educate potential clients about their medical and dental enrollment options. During the 2015 D4 Demonstration period (July-September 2015), MAXIMUS sent 306,740 enrollment mailings to potential STAR and STAR+PLUS clients, and 229,296 mailings to potential Dental Program clients. MAXIMUS field staff completed 27,289 home visit attempts for these programs and 145,080 phone call attempts. Additionally, MAXIMUS completed 6,561 field events, which included enrollment events, community contacts, presentations, and health fairs. The full report is available in Attachment L.

The State's managed care contracts also require health and dental plans to conduct provider outreach efforts and educate providers about managed care requirements. Plans must conduct training within 30-days of placing a newly contracted provider on active status. Training topics that promote access to care include:

- Covered services and the provider's responsibility for care coordination;
- The plan's policies regarding network and OON referrals;
- Texas Health Steps benefits; and
- The State's Medical Transportation Program.

To promote access to care, health and dental plans must update their provider directories on a quarterly basis and online provider directories at least twice a month. Plans also must mail member handbooks to new members no later than five days after receiving the State's enrollment file and to all members at least annually and upon request. The handbooks must describe how to access primary and specialty care.

Through the member handbooks and other educational initiatives, plans must instruct members on topics such as:

- How managed care operates;
- The role of the primary care physician or main dentist;
- How to obtain covered services;
- The value of screening and preventative care; and
- How to obtain transportation through the State's Medical Transportation Program.

B. DENTAL STAKEHOLDER MEETING

HHSC hired a new dental director in quarter 4 and is evaluating when dental stakeholder meetings will resume. It is anticipated that the meetings will resume in February 2016. HHSC staff continues to answer questions submitted to its dental stakeholder email box.

C. MEDICAID MANAGED CARE ADVISORY COMMITTEE

The State Medicaid Managed Care Advisory Committee (SMMC) serves as the central source for stakeholder input on the implementation and operation of Medicaid managed care. The following link is the SMMC website address which lists the members and affiliations: http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/smmcac.shtml.

The SMMC met Sept 18, 2015 and discussed the work of a "phone tree" subcommittee formed during the April SMMC. The focus of the subcommittee is to investigate barriers experienced by members with intellectual and developmental disabilities and STAR+PLUS members in using MCO call centers. The SMMC received an update that the phone tree subcommittee had met with MCO representatives about their call center systems. The SMMC recommended the work of the phone tree subcommittee continue.

During the September SMMC meeting, there was also discussion about the possible restructuring of the SMMC in which the members expressed interest that the SMMC be allowed to continue.

Executive Commissioner Chris Traylor joined the meeting to express his gratitude to the committee while encouraging continued support and input and thanking them for their hard work. As part of the process called for in S.B. 200, approved by the 84th Texas Legislature, the HHS Transformation Office established a workgroup to review and draft rules pertaining to advisory committees that are either new or are being reestablished. HHSC will post the rules to the Texas Register April 1, 2016. The earliest the SMMC is expected to reconvene would be July 2016.

D. PUBLIC FORUM

In accordance with STC 14, Post Award Forum, HHSC afforded the public with several opportunities to provide comment on the progress of the Demonstration.

During DY4Q1, HHSC held the quarterly HHSC Stakeholder Forum on October 13, 2014. The date, time and location of the Stakeholder Forum were published on the HHSC website at least 30 days prior to the date of the forum. The HHSC Stakeholder Forum is open to the public. HHSC staff presented an overview of progress to date on the demonstration waiver and took questions and feedback from those in attendance. An archived recording of the forum is posted on the HHSC website.

During DY4Q3, the Medical Care Advisory Committee (MCAC) met on June 9, 2015. The date, time and location of the MCAC were published on the HHSC website on May 22, 2015. HHSC staff provided an overview of the 1115 extension application submission process and key dates and explained that the extension application would focus on three key areas: DSRIP programs, the Uncompensated Care pool and Medicaid managed care. Staff also notified the committee members and public attendees about the 1115 extension application stakeholder meetings that would be held across the state during the month of July. Members of the MCAC provided comments and questions related to DSRIP projects and allocation of funding, and metrics for mental health quality measures. No members of the public provided comment during the meeting.

During DY4Q4, HHSC held a series of public meetings on different dates and in different locations about the 1115 extension application to ensure that members of the public and interested stakeholders had ample opportunity to provide comments well in advance of submission of the application to CMS. HHSC posted the date, time and location of the meetings on the HHSC website in June. The meeting information was also included in a detailed public notice posted on the HHSC website, on July 2, 2015, the abbreviated public notice of intent (PNI) in the Texas Register on July 3, 2015, and through the HHSC Public Meetings and Events Gov Delivery list on July 10, 2015. HHSC released a draft 1115 Waiver Extension on July 2, 2015 and opened a public comment period on the extension that ran from Monday, July 6, 2015 through Wednesday, August 5, 2015. There were 11,790 recipients of this notice. HHSC held

public meetings at Houston, Edinburg, Tyler, Austin, San Antonio, Dallas, El Paso, and Amarillo. A total of 786 people attended the public hearings, with 150 individuals completed registration forms at the eight in-person hearings indicating their intent to provide comments.

Registered attendees provided oral testimony following the staff presentation and some individuals submitted only written comments to HHSC staff. Once public testimony was completed, if additional time remained, HHSC and HMA staff stayed at the hearing until the time of the meeting conclusion as published in the public hearing notice to accommodate any individuals who arrived within the posted timeframe.

In addition to the eight public meetings, HHSC hosted a webinar on July 23, 2015 and provided the same overview and opportunity to comment as provided in the face to face meetings. Approximately 200 individuals logged into the webinar and seven provided comments.

HHSC solicited additional public feedback about the DSRIP and UC requests in the draft extension application via an online survey. The survey was posted on the Renewal Waiver webpage of the HHSC website during the comment period from July 6th through August 5th. HHSC provided notice about the survey during the monthly Regional Healthcare Partnership Anchor call on July 10th. A total of 17 comments were submitted to the online survey.

By the end of the public comment period, HHSC had received 196 comments covering a broad range of topics. The broad participation at the public meetings and the numerous comments submitted during the public comment period demonstrate the importance of the 1115 waiver to individuals and organizations across the state of Texas. HHSC staff documented, reviewed and carefully considered each comment, many of which were supportive of the waiver and contained ideas for program improvements.

E. INDEPENDENT CONSUMER SUPPORTS SYSTEM (ICSS) PLAN

HHSC submitted a plan to CMS on May 1, 2014, describing the structure and operation of the Independent Consumer Supports System (ICSS) that aligns with the core elements provided in STC 20. The Texas ICSS consists of the HHSC Medicaid/CHIP Division, the Office of the Ombudsman (OO), the State managed Enrollment Broker (EB, MAXIMUS) and community support from the Aging and Disability Resource Centers (ADRCs). HHSC and CMS held a phone call on January 6, 2015, to discuss the ICSS plan. In response to that discussion HHSC resubmitted the report to CMS with additional information on February 9, 2015. HHSC will provide relevant updates regarding ICSS in this section of the report each quarter.

1. Office of the Ombudsman

Compared to the third quarter of 2015, the Ombudsman Managed Care Assistance Team (OMCAT) averaged a call abandonment rate of 8% and a call volume decrease of 5%, or 560 calls. The team anticipates an increase in abandoned calls over the next few months due to vacancies. Rider 46 in the new state budget directs OO to prepare information that identifies a Medicaid managed care organization's performance related to nursing facility consumer complaints. The information will be distributed to managed care consumers annually.

2. Aging and Disability Resource Center (ADRC)

Local-level ADRC staff continue to participate in training activities to ensure consistent information and referral protocols. Trainings conducted this quarter included sessions regarding maintaining professionalism while providing services and information about the Medicare Improvements for Patients and Providers Act (MIPPA). In addition, the ADRC staff was trained in the new Long-term Services and Supports (LTSS) screen, which functions as an intake, assessment and referral tool. The following is a list of dates and trainings:

August 17-21: LTSS Screen (multiple dates and times)

September 1: Staying within Your Boundaries

September 22: MIPPA

In August 2015, DADS gathered input from stakeholders on how to improve the ADRC system. DADS hosted five in-person listening forums throughout the state as well as two statewide webinars. DADS also gathered stakeholder feedback from a number of other venues, including an ADRC State Advisory Committee meeting, an ADRC Coalition meeting and a designated email address. There was good representation at each event, with some forums having upward of 70 attendees. Through these meetings and comments, DADS obtained substantive and comprehensive insight on what improvements could be made to the ADRC system to ensure the Texas No Wrong Door system continues to be successful.

F. HHSC MANAGED CARE INITIATIVES

Effective March 1, 2015, under the Dual Demonstration, HHSC began testing an innovative delivery model that combines health services for people with both Medicaid and Medicare coverage into one plan. The Texas plan involves a three-party agreement between a Medicare-Medicaid health plan, the State, and the federal Centers for Medicare and Medicaid Services (CMS), to provide individuals with the full array of Medicaid and Medicare services. The demonstration includes full-dual eligible adults (age 21 and above) who currently receive their Medicaid benefits through the STAR+PLUS managed care program. The goal of the project is to better coordinate the care that participants receive. The demonstration has been implemented for all dual-eligible members, in the following six counties: Bexar, Dallas, El Paso, Harris,

Hidalgo and Tarrant. For more information about the Demonstration, including Frequently Asked Questions (F.A.Q.'s), please visit the HHSC Demonstration's webpage at: http://www.hhsc.state.tx.us/medicaid/managed-care/dual-eligible/.

For more information on all upcoming managed care initiatives, please visit the Expansion of Medicaid Managed Care webpage on the HHSC website: http://www.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml

V. COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA

The State manages enrollment in a 24-month window that includes one prospective month and 23 prior period adjustment months. During successive processing cycles, this allows the State to verify prior enrollments and implement adjustments to them as necessary. The types of adjustments include revisions for newborns, deaths, change of service delivery areas and the addition of Medicare eligibility or eligibility attributes.

The State continues to conduct the quarterly MCO encounter financial reconciliation process for 2015 SFQ4. The State will contact each plan that did not achieve the financial reconciliation threshold, and advise them of the necessary steps to achieve contract compliance and, ultimately, certification.

VI. OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENTS/ISSUES

This section addresses STC 67, regarding operational issues identified during the quarter. It also addresses pending lawsuits that may potentially impact the Demonstration, and new issues identified during the reported quarter.

A. UPDATE FROM PRIOR QUARTER

HHSC has not identified any ongoing issues in the relevant subject matter sections of this report.

B. LITIGATION UPDATE

Below is a summary of pending litigation and the status. HHSC Legal is unaware of any threatened litigation affecting healthcare delivery.

Legacy Community Health Services, Inc., v. Janek (official capacity) and Texas Children's Health Plan. Filed on January 7, 2015, in the U.S. District Court for the Southern District of Texas. Plaintiff Legacy is a Federally Qualified Health Center (FQHC) and a Medicaid provider that was in Texas Children's Health Plan's (TCHP's) provider network. TCHP notified Legacy in December 2014 that Legacy was to be terminated as a provider in TCHP's plan. Legacy brought suit against both TCHP and HHSC's Executive Commissioner, alleging that HHSC's method of paying FQHCs is contrary to federal law. FQHCs are guaranteed an encounter rate calculated under a methodology prescribed under 42 U.S.C. §1396a(bb). HHSC ensures compliance with this provision by requiring MCOs to pay FQHCs the full encounter rate, and includes funds for such payments in the capitated rate paid to MCOs. Legacy asserts that HHSC must make supplemental ("wrap") payments directly to FQHCs. District Judge Keith Ellison

conducted a hearing on January 28, 2015, and denied Legacy's request for a preliminary injunction. Legacy non-suited TCHP, but continues to maintain its claims against HHSC. Both Legacy and HHSC have filed motions for summary judgment. The Court could rule early in 2016.

Texas Children's and Seattle Children's Hospital v. Burwell (official capacity), Tavenner (official capacity), and CMS. Filed on December 5, 2014, in the U.S. District Court for the District of Columbia. District Judge Emmet Sullivan granted a preliminary injunction request by Plaintiffs, and required CMS to discontinue enforcing its policy published as "FAQ Number 33" and involving the inclusion of revenues associated with patients having coverage under both Medicaid and private insurance. The court also expressly prohibited CMS from taking action to recoup past Disproportionate Share Hospital (DSH) program overpayments based on a state's compliance with FAQ No. 33.

HHSC notes that the same issue was litigated in state court. In 2013, Texas Children's Hospital (TCH) sued HHSC in state court alleging that by following CMS's FAQ 33, HHSC had improperly altered its method of calculating uncompensated care, adversely affecting TCH's disproportionate share and uncompensated care payments. That lawsuit was dismissed on March 29, 2014. However, TCH and co-plaintiff Seattle Children's now assert substantially the same theory against CMS in federal court litigation. Although HHSC is not a direct party to this federal litigation, HHSC recognizes that the outcome of this case could have a significant bearing on the hospital disproportionate share and uncompensated care payment programs. Until the issue is resolved with clarity, the litigation may result in delays and uncertainty concerning the appropriate method of making the uncompensated care calculations for future payments and for recouping past DSH and uncompensated-care overpayments.

Filed in 1993, *Frew, et al. v. Traylor, et al*. (commonly referred to as *Frew*), was brought on behalf of children birth through age 20 enrolled in Medicaid and eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. The class action lawsuit alleged that the Texas EPSDT program did not meet the requirements of the federal Medicaid Act. The Texas EPSDT program, known as Texas Health Steps (THSteps), provides comprehensive and preventive medical and dental services for children through age 20 enrolled in Medicaid. The parties resolved the *Frew* litigation by entering into an agreed consent decree, which the court approved in 1996. The decree sets out numerous state obligations relating to THSteps. It also provides that the federal district court will monitor compliance with the orders by the Texas Health and Human Services Commission (HHSC) and the Texas Department of State Health Services (DSHS) and that the federal district court will enforce the orders if necessary. In 2000, the court found the State defendants in violation of several of the decree's paragraphs. In 2007, the parties agreed to 11 corrective action orders to bring the state into compliance with the consent decree and to increase access to THSteps' services. The corrective action orders touch

upon many program areas, and generally require the State to take actions intended to ensure access to or measure access to Medicaid services for children. The Texas Medicaid program must consider these obligations in many policy and program decisions for Medicaid services available for persons from birth through 20 years of age.

In 2013, the U.S. district court vacated two of the eleven corrective action orders: (1) Check Up Reports and Plans for Lagging Counties, and (2) Prescription and Non-Prescription Medications, Medical Equipment, and Supplies, and related paragraphs of the consent decree, after finding that the state defendants had complied with the required actions. The *Frew* Plaintiffs appealed the second order (regarding Prescription and Non-Prescription Medications, Medical Equipment, and Supplies) to the Fifth Circuit Court of Appeals. On March 5, 2015, the Fifth Circuit affirmed the district court's order vacating the corrective action order and related paragraphs of the consent decree, holding that the state had satisfied its obligations related to training Medicaid-enrolled pharmacists about EPSDT-covered pharmacy items. The *Frew* Plaintiffs have filed a petition for writ of certiorari in the U.S. Supreme Court, seeking to have the Fifth Circuit's order reversed. The U.S. Supreme Court has requested a brief in opposition from the State, which is due in January 2016.

In 2014, the parties jointly agreed to vacate a corrective action order related to Toll-Free Numbers and the related paragraph of the consent decree, for several Medicaid-related toll-free lines operated by the state and its contractors. The district court granted the parties' joint motion and vacated the toll-free numbers orders for all but one remaining helpline: a medical transportation line operated by one of the state's full-risk broker transportation contractors.

On January 20, 2015, the district court vacated a corrective action order related to an Adequate Supply of Health Care Providers and several paragraphs of the consent decree relating to an adequate supply of healthcare providers. The Court found that the State had satisfied the terms of those orders by taking realistic and viable measures to enhance recipients' access to care through ensuring an adequate supply of healthcare providers (both primary care and specialists) by using targeted recruitment efforts, increasing reimbursement rates, and using best efforts to maintain updated lists of providers for recipients and other providers. The *Frew* Plaintiffs have appealed the January 2015 ruling to the Fifth Circuit, and oral argument on this appeal is in January 2016.

On September 28, 2015, the district court vacated two of the remaining corrective action orders: (1) Transportation Program, and (2) Health Care Provider Training, and related paragraphs of the consent decree, after finding that the state defendants had complied with the required actions.

C. NEW ISSUES

HHSC has not identified any new issues in the relevant subject matter sections of this report, other than those already reported in previous sections. There were no issues outside of the general categories typically reported and HHSC does not anticipate any significant issues or activities in the near future that affect healthcare delivery.

D. CLAIMS SUMMARY

This section addresses the requirements of STC 39(b) for biannual claims summary reporting, including the timeliness and accuracy of claims processing, and possible fraud and abuse detected.

1. Claims Adjudication

HHSC's managed care contracts include the following claims adjudication standards for clean claims:

- 98% must be adjudicated within 30 days;
- 98% of appealed claims must be adjudicated within 30 days; and
- 99% must be adjudicated within 90 days.
- 98% of pharmacy claims must be adjudicated within 18 or 21 days for electronic and paper claims, respectively.

Attachment V is a summary of the health and dental plans' 2015 SFQ3 through SFQ4 claims adjudication results. For these quarters, STAR and STAR+PLUS MCOs reported results for acute care, behavioral health, vision services, and pharmacy claims. Additionally, STAR+PLUS MCOs also reported results for long-term services and supports claims. Dental plans reported results for all dental claims. Both dental plans met the claim adjudication standards for clean claims in 2015 SFQ3 and SFQ4. All plans met the 98% standard for the pharmacy claims adjudicated within 18-21 days for electronic and paper claims. Almost all MCOs met the claims processing standards with a few exceptions listed below in bold red font which represent plans that did not meet the standards for clean claims and appealed claims. HHSC staff is in the process of developing an appropriate remedy for the MCOs that are not in compliance with the claims adjudication standards identified below.

STAR Acute Care Claims SFY2015							
MCO	**Service Area**	**Acute Care Claims**					
		% Clean Adj. w/in 30 Days		% Appealed Adj. w/in 30 Days		% Clean Adj. w/in 90 Days	
		(98% Std.)		(98% Std.)		(99% Std.)	
		15Q3	**15Q4**	**15Q3**	**15Q4**	**15Q3**	**15Q4**
Amerigroup	Harris	99.51%	99.88%	98.95%	98.57%	99.73%	99.97%
Amerigroup	Jefferson	99.53%	99.90%	98.59%	**95.04%**	99.77%	100.00%
Amerigroup	Lubbock	98.76%	99.88%	98.51%	**87.76%**	99.40%	100.00%
Christus	Nueces	**91.91%**	**88.89%**	**0.00%**	**0.00%**	100.00%	99.87%
Driscoll	Hidalgo	99.92%	99.76%	98.85%	**11.84%**	100.00%	100.00%
Driscoll	Nueces	99.91%	99.50%	98.09%	**14.79%**	100.00%	99.99%
Scott and White	MRSA Central	99.98%	99.97%	**91.02%**	99.39%	99.96%	99.87%
Sendero	Travis	99.96%	99.96%	**90.91%**	**93.33%**	100.00%	100.00%

STAR Behavioral Health Claims SFY2015							
MCO	Service Area	Behavioral Health Services Organization's Claims					
		% Clean Adj. w/in 30 Days (98% Std.)		% Appealed Adj. w/in 30 Days (98% Std.)		% Clean Adj. w/in 90 Days (99% Std.)	
		15Q3	15Q4	15Q3	15Q4	15Q3	15Q4
Amerigroup	Harris	99.81%	99.93%	99.00%	97.91%	99.97%	100.00%
Amerigroup	Lubbock	99.02%	99.85%	**50.00%**	**90.91%**	100.00%	100.00%
Amerigroup	MRSA NE	99.86%	99.86%	97.87%	100.00%	100.00%	100.00%
Amerigroup	MRSA West	99.87%	99.90%	**96.67%**	**96.55%**	99.95%	100.00%
Christus	Nueces	**90.43%**	**84.40%**	**0.00%**	**0.00%**	100.00%	100.00%
Driscoll	Hidalgo	99.93%	99.84%	100.00%	**40.00%**	100.00%	100.00%
Driscoll	Nueces	99.95%	99.62%	100.00%	**60.00%**	100.00%	99.99%
Superior	Bexar	99.91%	99.41%	N/A	**50.00%**	100.00%	99.89%
Superior	Hidalgo	99.81%	99.17%	N/A	**71.43%**	100.00%	100.00%
Superior	MRSA Central	99.48%	99.21%	**0.00%**	100.00%	100.00%	99.98%
Superior	MRSA NE	99.76%	99.69%	N/A	**60.00%**	99.98%	99.99%
Superior	Nueces	99.71%	99.47%	N/A	**25.00%**	99.97%	99.85%
Superior	Travis	99.80%	99.66%	N/A	**50.00%**	100.00%	100.00%
United	Hidalgo	99.95%	99.96%	100.00%	**0.00%**	100.00%	100.00%
United	Jefferson	99.96%	99.86%	100.00%	**0.00%**	100.00%	100.00%

STAR Vision Services Claims SFY2015							
MCO	Service Area	Vision Services Organization's Claims					
		% Clean Adj. w/in 30 Days (98% Std.)		% Appealed Adj. w/in 30 Days (98% Std.)		% Clean Adj. w/in 90 Days (99% Std.)	
		15Q3	15Q4	15Q3	15Q4	15Q3	15Q4
Driscoll	Hidalgo	100.00%	100.00%	**81.82%**	100.00%	100.00%	100.00%
El Paso 1st	El Paso	100.00%	100.00%	**85.71%**	N/A	100.00%	100.00%
Superior	Bexar	100.00%	100.00%	**93.33%**	100.00%	100.00%	100.00%
Superior	El Paso	100.00%	100.00%	**88.89%**	100.00%	100.00%	100.00%
Superior	Hidalgo	100.00%	99.99%	**85.53%**	100.00%	100.00%	100.00%
Superior	MRSA Central	100.00%	100.00%	**92.31%**	100.00%	100.00%	100.00%
Superior	Travis	100.00%	100.00%	**93.55%**	100.00%	100.00%	100.00%

STAR+PLUS Acute Care Claims SFY2015							
MCO	Service Area	Acute Care Claims					
		% Clean Adj. w/in 30 Days		% Appealed Adj. w/in 30 Days		% Clean Adj. w/in 90 Days	
		(98% Std.)		(98% Std.)		(99% Std.)	
		15Q3	**15Q4**	**15Q3**	**15Q4**	**15Q3**	**15Q4**
Amerigroup	El Paso	98.57%	99.72%	98.86%	97.94%	99.77%	99.98%
Amerigroup	Harris	98.57%	99.78%	97.61%	98.19%	99.30%	99.98%
Amerigroup	Jefferson	98.62%	99.86%	98.60%	**95.86%**	99.33%	99.99%
Amerigroup	Lubbock	**97.03%**	99.76%	98.70%	99.21%	98.29%	99.98%
Amerigroup	MRSA West	**97.41%**	99.79%	98.26%	98.17%	98.65%	99.98%
Amerigroup	Tarrant	98.51%	99.72%	98.41%	98.35%	99.13%	99.96%
Amerigroup	Travis	97.90%	99.85%	97.85%	98.25%	98.53%	99.98%
Cigna-HealthSpring	Hidalgo	**95.27%**	97.85%	100.00%	**95.94%**	99.87%	100.00%
Cigna-HealthSpring	MRSA NE	**83.65%**	**93.48%**	100.00%	**88.13%**	**96.82%**	99.96%
Cigna-HealthSpring	Tarrant	**90.93%**	97.61%	99.84%	**95.08%**	99.16%	100.00%
Superior	Hidalgo	99.24%	99.78%	100.00%	97.92%	99.98%	99.96%
Superior	MRSA Central	99.60%	99.78%	100.00%	**97.92%**	99.97%	99.96%

STAR+PLUS Behavioral Health Services Claims SFY2015							
MCO	Service Area	Behavioral Health Services Organization's Claims					
		% Clean Adj. w/in 30 Days (98% Std.)		% Appealed Adj. w/in 30 Days (98% Std.)		% Clean Adj. w/in 90 Days (99% Std.)	
		15Q3	15Q4	15Q3	15Q4	15Q3	15Q4
Amerigroup	El Paso	99.82%	99.90%	**94.44%**	**96.55%**	99.96%	100.00%
Amerigroup	Lubbock	99.20%	99.94%	**95.45%**	100.00%	100.00%	100.00%
Amerigroup	Tarrant	99.70%	99.90%	**87.18%**	**96.55%**	99.87%	100.00%
Cigna-HealthSpring	Hidalgo	97.75%	98.51%	N/A	N/A	100.00%	99.83%
Cigna-HealthSpring	MRSA NE	**88.43%**	**92.97%**	100.00%	**95.45%**	**97.27%**	100.00%
Cigna-HealthSpring	Tarrant	**91.08%**	98.40%	N/A	100.00%	**98.36%**	100.00%
Superior	Bexar	99.56%	98.74%	N/A	**25.00%**	100.00%	99.78%
Superior	MRSA West	99.46%	99.61%	N/A	**50.00%**	100.00%	100.00%
Superior	Nueces	99.53%	98.56%	**75.00%**	**30.00%**	100.00%	99.70%
United	MRSA NE	98.46%	**92.33%**	100.00%	100.00%	99.05%	**93.30%**
United	Travis	99.96%	99.89%	97.60%	100.00%	100.00%	100.00%

STAR+PLUS Long-Term Care Claims SFY2015							
MCO	Service Area	Long Term Care Organization's Claims					
		% Clean Adj. w/in 30 Days		% Appealed Adj. w/in 30 Days		% Clean Adj. w/in 90 Days	
		(98% Std.)		(98% Std.)		(99% Std.)	
		15Q3	**15Q4**	**15Q3**	**15Q4**	**15Q3**	**15Q4**
Amerigroup	Tarrant	99.81%	98.76%	97.53%	**96.59%**	99.93%	99.75%
Amerigroup	Travis	99.88%	99.99%	**95.83%**	**97.26%**	99.90%	100.00%
Cigna-HealthSpring	MRSA NE	**92.19%**	**96.91%**	100.00%	**96.91%**	99.86%	99.93%
Cigna-HealthSpring	Tarrant	97.89%	98.61%	100.00%	100.00%	99.95%	99.96%

2. Provider Fraud and Abuse

The state's managed care contracts require health and dental plans to form special investigative units that refer suspected cases of fraud, waste, or abuse to the HHSC Office of Inspector General (OIG). Attachment R is a summary of the referrals that STAR, STAR+ PLUS and Dental Program plans sent to the OIG during the annual reporting period, 2015 SFQ1 through SFQ4.

In SFQ1 and SFQ2, MCOs forwarded 41 suspected cases of fraud, waste, or abuse to the OIG. More than half of these referrals related to non-appropriate billing, billing for services not rendered, and program non-compliance. OIG returned 16 of the cases to the MCO for the determination of appropriate action and launched a full scale investigation for 14 cases received. The remaining cases were referred to federal OIG for investigation, or the appropriate licensing board. Dental plans forwarded 31 suspected cases of fraud, waste, or abuse to the OIG. Most of the cases related to inappropriate billing and program non-compliance. OIG issued a full scale investigation or transferred information to existing full scale cases for 18 of the 31 cases. The remaining cases were returned to the MCO and one was closed upon receipt.

During SFQ3 and SFQ4 MCOs forwarded 45 suspected cases of fraud, waste or abuse to the OIG. More than half of these referrals were for non-appropriate billing . OIG returned 31 of the cases to the MCO for the determination of appropriate action and launched a full scale investigation for 6 of the 31 cases received. The remaining cases were referred to Medicaid Fraud Control Unit (MFCU) or transferred to IG Litigation. Dental plans forwarded 17 suspected cases of fraud, waste, or abuse to the OIG. Most of the cases related to inappropriate billing, billing for services not rendered and solicitation. OIG issued a full scale investigation or transferred information to existing full scale cases for 6 of the 17 cases. The remaining cases were returned to the MCO.

VII. ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

This section describes the State's action plan for addressing issues identified in the quarterly report as required by STC 67.

1. Managed Care Issues

Issues identified during the quarter have been addressed within the relevant subject matter sections of this report.

2. Litigation

Plans for addressing pending litigation are considered confidential client information, but HHSC will keep CMS informed of any significant court orders or decisions.

3. Other

There were no fiscal or systems issues, or legislative activity that occurred in 2015 SFQ4. The state does not anticipate any such activity in the near future that affects healthcare delivery.

VIII. FINANCIAL/BUDGET NEUTRALITY DEVELOPMENT/ISSUES

This section addresses the quarterly reporting requirements in STCs 49, 65 and 67 regarding financial and budget neutrality development and issues. Details on the budget neutrality calculations can be found in Attachment P.

There were no significant development issues or problems with financial accounting, budget neutrality and the CMS 64 or budget neutrality report for 2015 SFQ4.

IX. MEMBER MONTH REPORTING

The tables below address the quarterly reporting requirements regarding eligible member month participants in compliance with STC 53.

Eligibility Groups Used in Budget Neutrality Calculations (2015 D4)

Eligibility Group	Month 1 (Jul 2015)	Month 2 (Aug 2015)	Month 3 (Sept 2015)	Total for Quarter Ending Sept 2015
Adults	286,084	288,943	286,149	861,176
Children	2,591,053	2,602,748	2,623,919	7,817,721
AMR	364,211	365,604	366,098	1,095,914
Disabled	427,836	429,547	429,760	1,287,143

Eligibility Groups Not Used in Budget Neutrality Calculations (2015 D4)

Eligibility Group	Month 1 (Jul 2015)	Month 2 (Aug 2015)	Month 3 (Sept 2015)	Total for Quarter Ending Sept 2015
Adults in MRSA	-	-	-	-
Foster Care	32,930	32,993	33,031	98,953
Medically Needy	142	143	140	424
CHIP-Funded	268,149	268,754	269,312	806,215
Adoption Subsidy	46,014	46,249	46,485	138,747
STAR+PLUS 217-Like HCBS	11,993	11,021	10,691	33,706

X. CONSUMER ISSUES

This section addresses quarterly reporting requirements in STCs 22, 39(a) and 39(b) and 67 regarding complaints and calls to HHSC Health Plan Management (HPM) staff and the Office of the Ombudsman's Medicaid Managed Care Helpline (MMCH), as well as complaints and appeals received by plans. This section covers the trends discovered and steps taken to resolve complaints and prevent future occurrences.

The State tracks customer service issues, such as member and provider hotline performance, member complaints and appeals and provider complaints through the managed care quarterly reports.

Attachments M, N, and O include supporting data for this section.

A. HOTLINE CALL VOLUME AND PERFORMANCE

This subsection includes quarterly data regarding call center volumes and plan. As addressed in prior quarterly reports, the State's health and dental plans consolidate all Medicaid and CHIP calls for reporting purposes.

Attachments M1 through M4 detail the total calls received as well as performance standards for all MCOs and DMOs. Calls to the MCO member hotlines increased by 1.2% and to the MCO provider hotlines increased by about 5% in 2015 SFQ4. Calls to the behavioral health crisis hotline decreased by 12.5%. In the Dental Program, calls to the member hotlines increased by approximately 9% and to the provider hotlines increased by approximately 12% in SFQ4.

The following table shows the number of hotline calls received per 1,000 members in the last four quarters. The rate of member hotline calls received per 1,000 members increased from 2015 SFQ3 to 2015 SFQ4 across most MCO plans and both DMO plans.

Member Hotline Calls Received per 1,000 Members (2015 SFQ1 - 2015 SFQ4)

MCO	Member Hotline per 1,000 Members			
	SFY15			
	Q1	Q2	Q3	Q4
Aetna*	492	448	482	500
Amerigroup*	194	178	191	219
BCBS*	260	255	217	282
CHC*	183	181	200	207
Christus*	298	263	786	1,039
Cigna-HealthSpring	911	762	658	832
Community 1st*	106	110	176	232
Cook Children's*	187	174	184	2
Dentaquest	76	72	81	95
Driscoll*	161	152	156	152
El Paso 1st*	172	167	167	182
FirstCare*	142	134	133	130
MCNA	102	97	106	130
Molina*	325	334	370	456
Parkland*	220	226	268	271
Scott & White	346	327	316	360
Sendero*	202	217	214	197
Seton*	431	345	422	687
Superior*	232	217	214	242
Texas Children's*	85	96	109	119
United*	478	437	413	487
Statewide (excludes dental program)	**231**	**219**	**231**	**258**

*Enrollment and Hotline data includes CHIP program

Both DMOs and most MCOs met the following performance standards in 2015 SFQ4 for their member, provider and behavioral health hotlines:

- 99% of all calls must be answered by the fourth ring;
- ≤ 1% busy signal rate for all calls;
- 80% of all calls must be answered by a live person within 30 seconds;
- ≤ 7% call abandonment rate; and
- ≤ 2 minute average hold time.

The following MCOs failed to meet the standards listed above for 2015 SFQ4. HHSC staff is in the process of developing appropriate remedies for the following MCOs.

Member Hotline:

- 56% of Christus member hotline calls were answered by the fourth ring.
- 74.95% of FirstCare member hotline calls were answered by a live person within 30 seconds.
- 73.27% of Superior member hotline calls were answered by a live person within 30 seconds.

Provider Hotline:

- Christus had slightly more than the 7% maximum call abandonment standard for the provider hotline, with 7.08% of provider calls abandoned in 2015 SFQ4.
- 97.69% of Texas Children provider hotline calls were answered by the 4th ring.

Behavioral Health Crisis Hotline:

- Scott & White failed to meet two requirements for the behavioral health hotline:
    - 75% of calls were answered by a live person within 30 seconds, and
    - 22.58% of calls were abandoned. MCO is subject to liquidated damages. MCO continues to work with subcontractor Tejas on their Corrective Action Plan to bring this metric to standards.

B. COMPLAINTS AND APPEALS RECEIVED BY PLANS

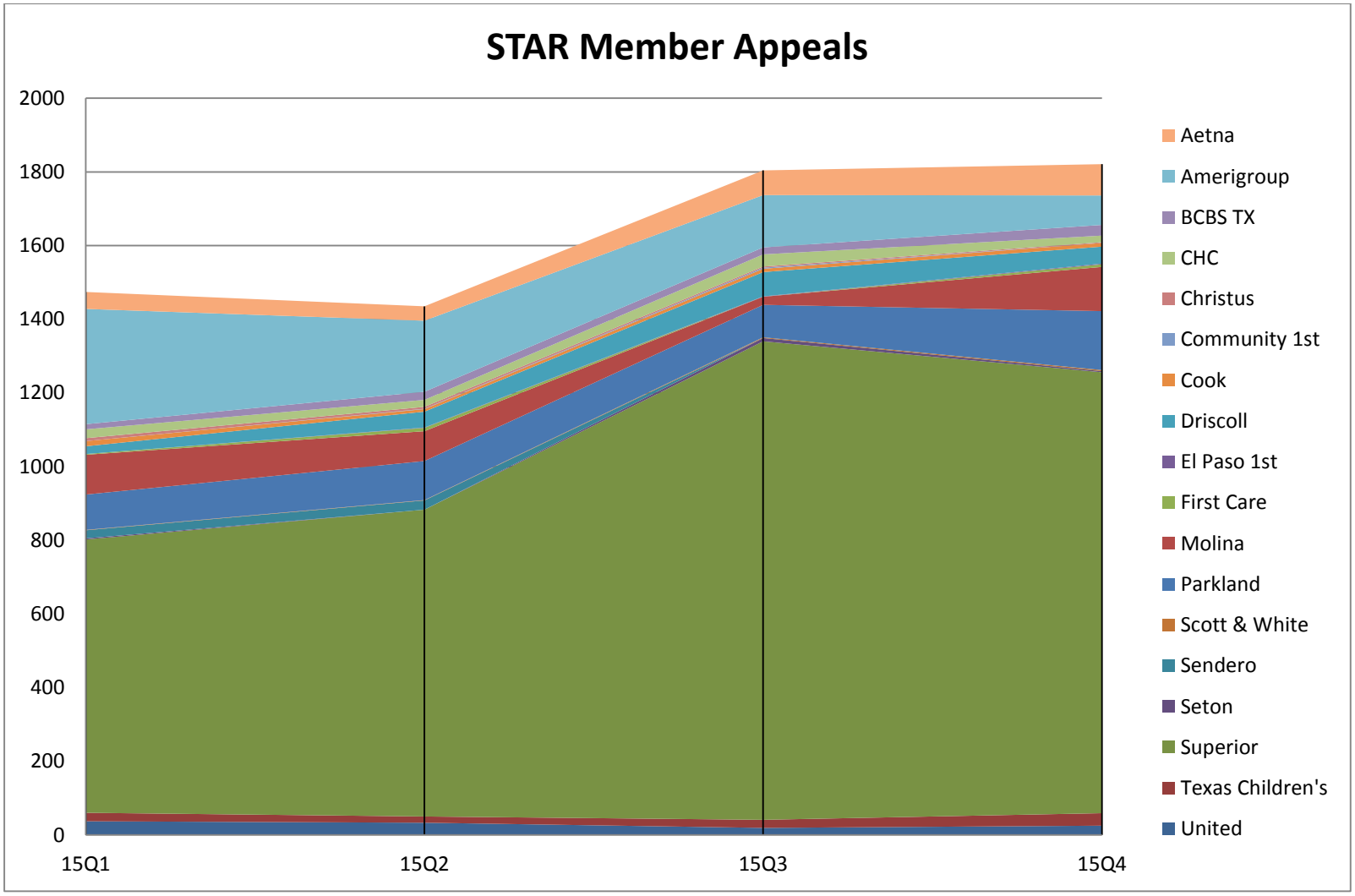
This subsection addresses the reporting requirements Attachment N shows the number of member complaints and appeals and provider complaints resolved by MCOs and DMOs.

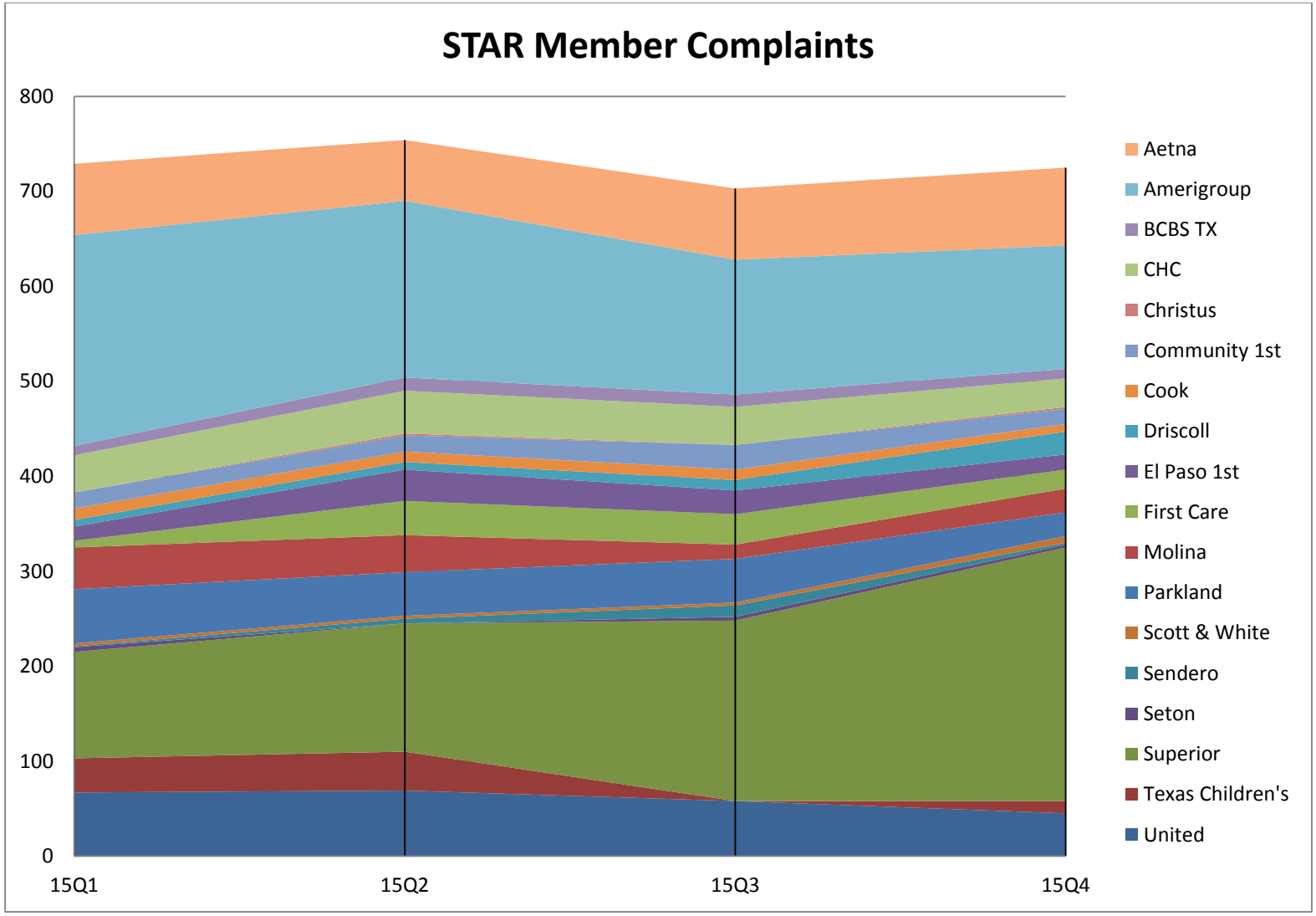
1. STAR and STAR+PLUS

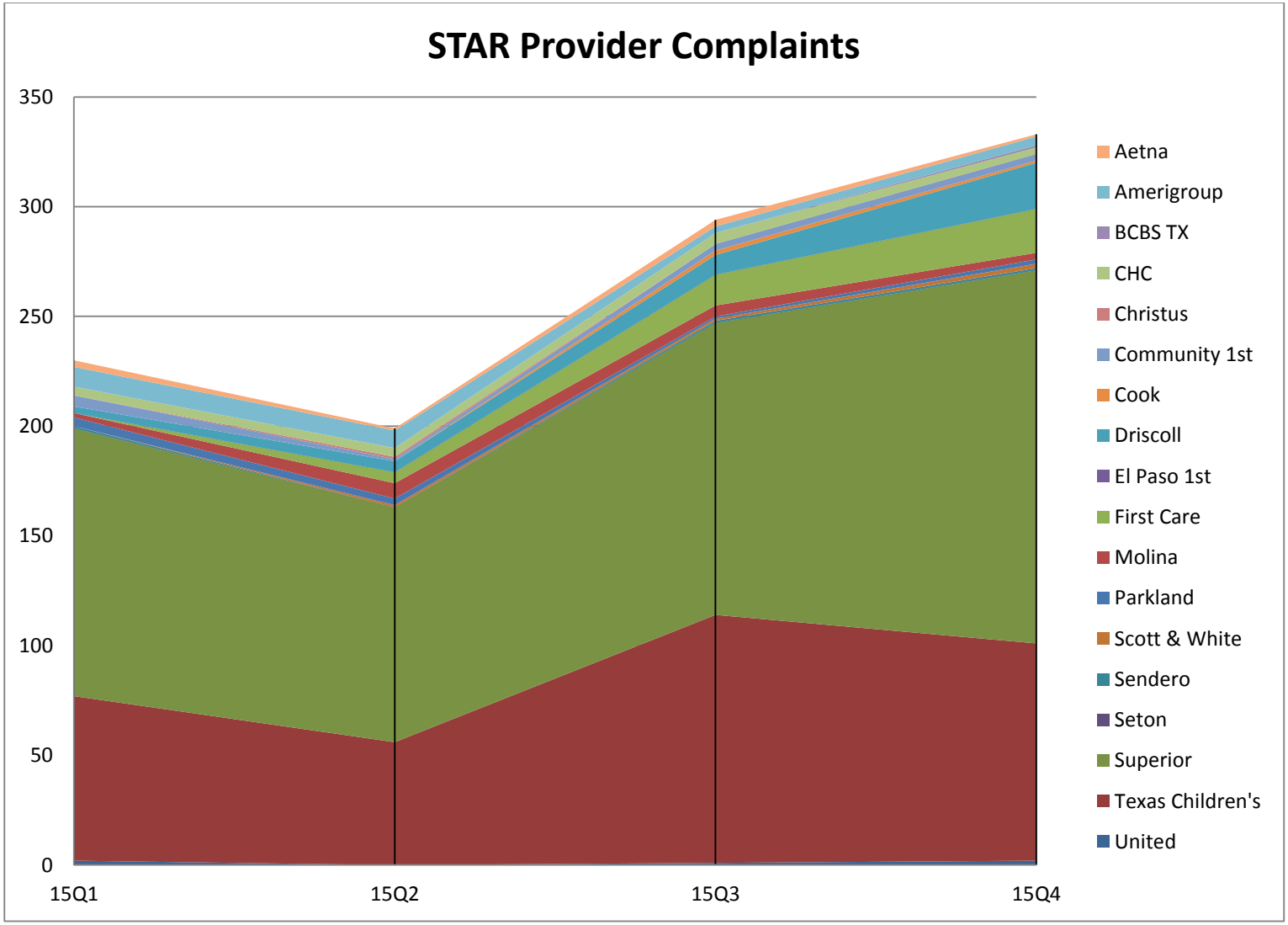
There were small fluctuations from 2015 SFQ3 to 2015 SFQ4 in the total number of member complaints and member appeals received by STAR and STAR+PLUS plans (less than 4% change). Provider complaints for STAR+PLUS increased by only 3.93%; however, provider complaints for STAR increased by 13%, as shown in the figures below. STAR plans collectively reported 725 member complaints, 1,821 member appeals and 333 provider

complaints in SFQ4. STAR+PLUS plans reported 1,122 member complaints, 1,508 member appeals and 397 provider complaints in SFQ4. Amerigroup and Superior comprise approximately 48% of the STAR member complaints, which is slightly higher than their market share of 44%. Amerigroup and United make up approximately 51% of the STAR+PLUS member complaints and comprise about 47% of the market share. The STAR+PLUS MCOs received significantly more member complaints and appeals per 1,000 members than the STAR MCOs.

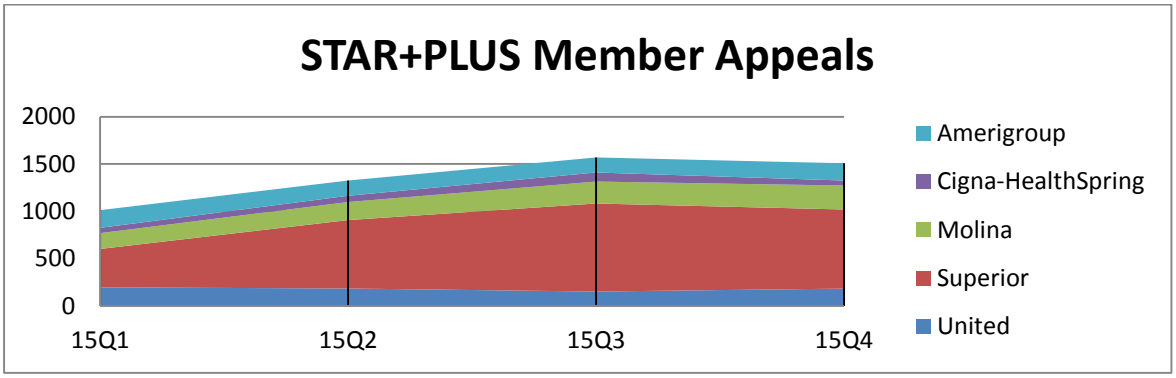
Complaints and Appeals Received by STAR MCOs (2015 SFQ1 – 2015 SFQ4)

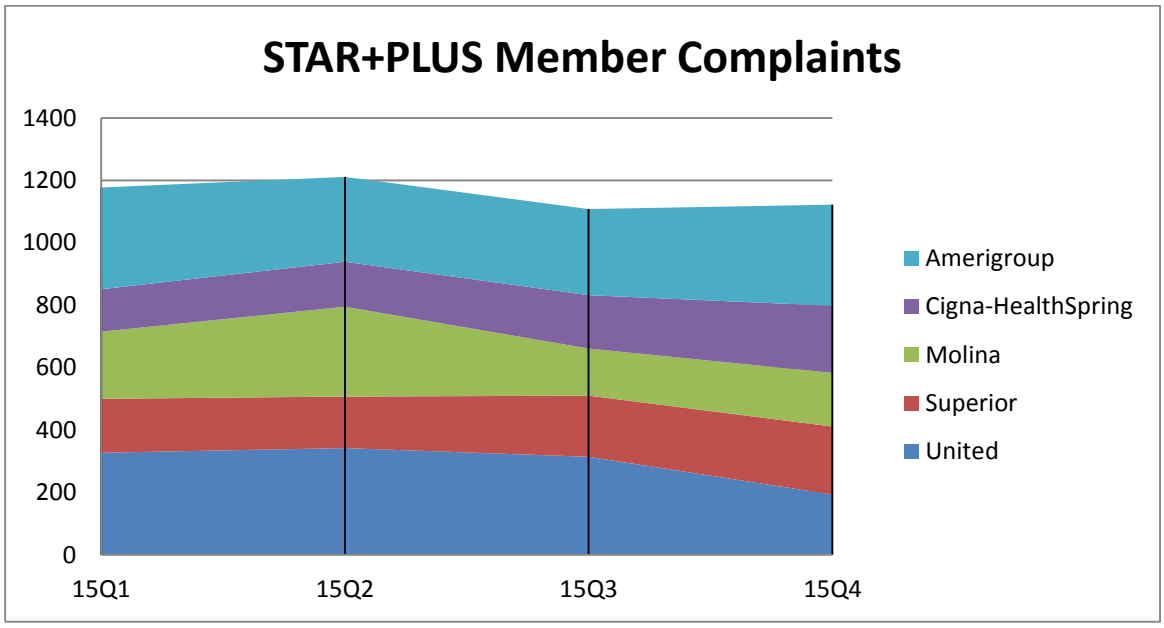


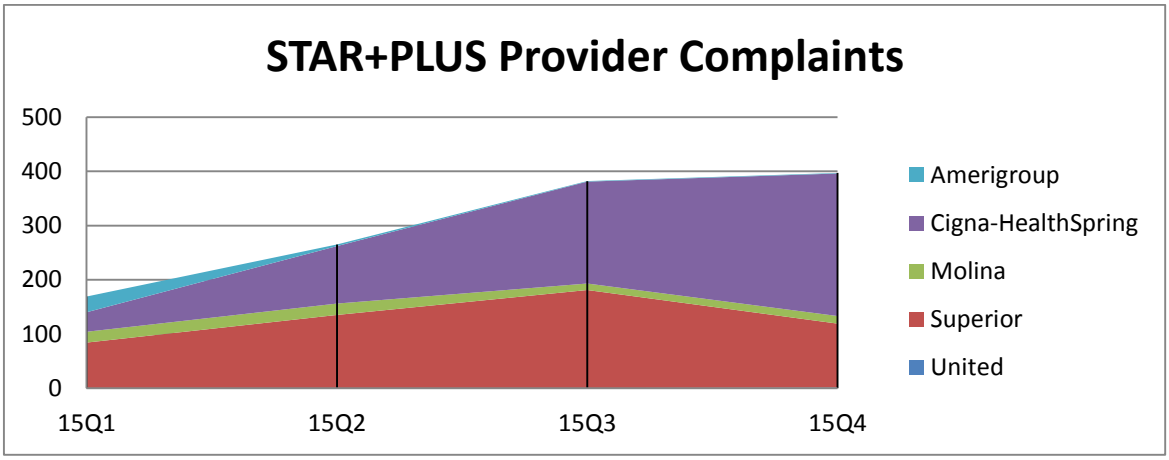

STAR Member Complaints
800
700
600
500
400
300
200
100
0
15Q1
15Q2
15Q3
15Q4
Aetna
Amerigroup
BCBS TX
CHC
Christus
Community 1st
Cook
Driscoll
El Paso 1st
First Care
Molina
Parkland
Scott & White
Sendero
Seton
Superior
Texas Children's
United


STAR Provider Complaints
350
300
250
200
150
100
50
0
15Q1
15Q2
15Q3
15Q4
Aetna
Amerigroup
BCBS TX
CHC
Christus
Community 1st
Cook
Driscoll
El Paso 1st
First Care
Molina
Parkland
Scott & White
Sendero
Seton
Superior
Texas Children's
United

Complaints and Appeals Received by STAR+PLUS MCOs (2015 SFQ1 – 2015 SFQ4)







The State's managed care contracts require plans to track and monitor the number of complaints and appeals resolved within 30 days of receipt and require the plans achieve a benchmark of 98% compliance in each service delivery area.

STAR

- All STAR MCOs in all service delivery areas with member complaints resolved 100% within 30 days.
- Two STAR MCOs failed to meet the timely resolution benchmark for member appeals in 2015 SFQ4. HHSC staff is in the process of developing appropriate remedies for the following MCOs:
  - BCBS TX in the Travis SDA
  - United in the Harris and Hidalgo SDAs
- Only two STAR MCOs failed to meet the timely resolution standard for provider complaints. HHSC staff is in the process of assessing liquidated damages.
  - Amerigroup resolved one of the two received provider complaints within 30 days.
  - BCBS TX did not resolve their one provider comment in 30 days.

STAR+PLUS

- All STAR+PLUS MCOs in all service delivery areas resolved at least 98% of member complaints within 30 days.
- Three STAR+PLUS MCOs failed to meet the standard for member appeals. HHSC staff is in the process of assessing liquidated damages.
  - Cigna Health-Spring in Tarrant SDA
  - Superior in Lubbock SDA
  - United in Harris Jefferson, Nueces, Travis, MRSA NE and MRSA Central SDAs

2. Dental Program

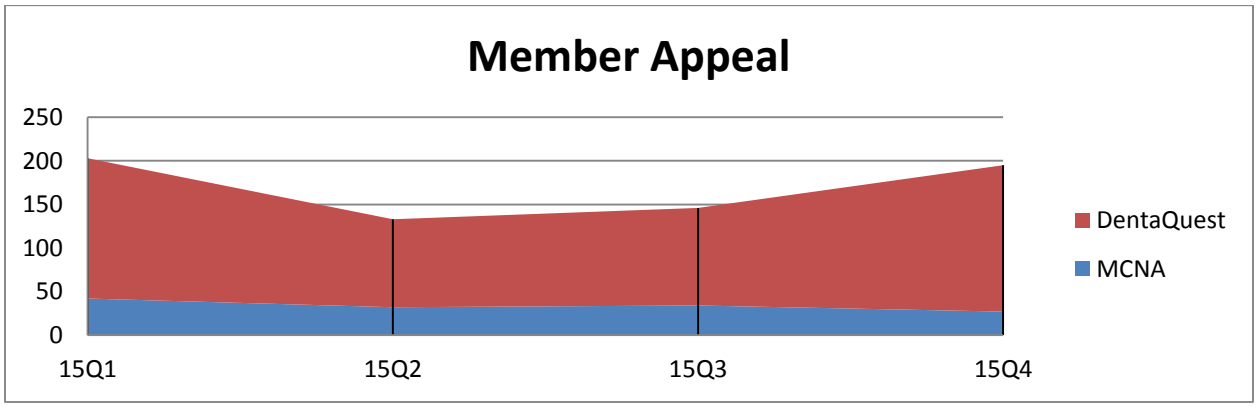
Dental member complaints increased by 19% from 213 in 2015SFQ3 to 254 in 2015SFQ4 and member appeals increased by 34% from 146 in 2015SFQ3 to 195 in 2015SFQ4. These percent changes are magnified because the total numbers of dental member complaints and appeals are small. Provider complaints decreased slightly from 28 in 2015SFQ3 to 25 in 2015SFQ4.

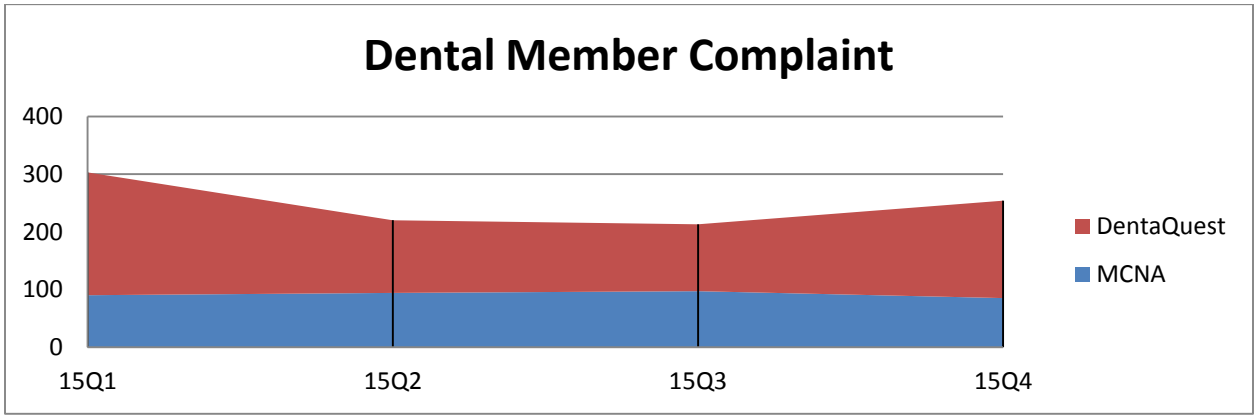
Complaints and appeals are reported in aggregate for each statewide dental plan. Each DMO has over one million members enrolled across the State; therefore, the number of complaints and appeals as compared to enrollment is very small. In 2015 SFQ4, there were about .09 dental member complaints and .07 dental member appeals per 1,000 dental members. Likewise, the

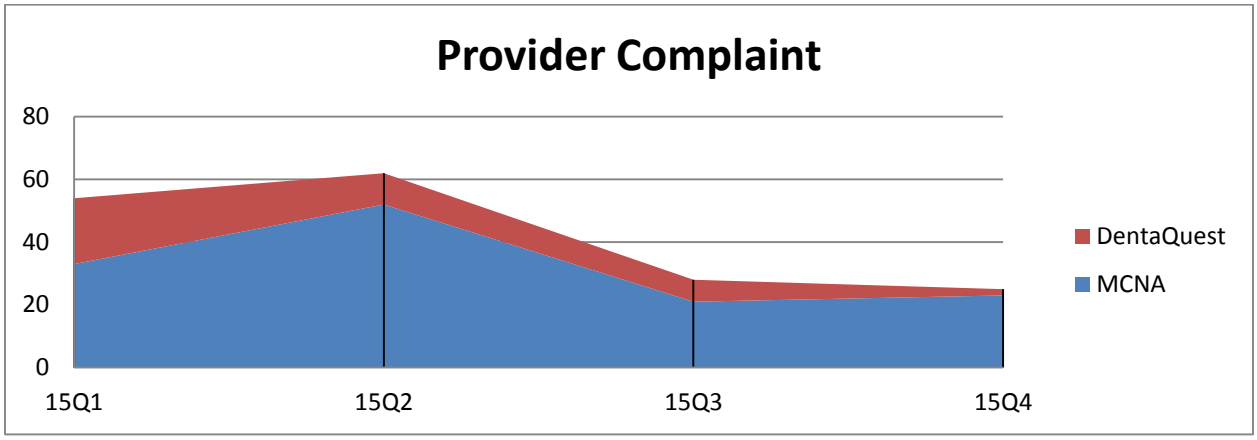
quarterly changes in complaints and appeals per 1,000 members also represent tiny fluctuations with complaints per 1,000 members down by .01 and appeals per 1,000 members up by .02.

The State's managed care contracts require dental plans to track and monitor the number of complaints and appeals resolved within 30-days of receipt and require 98% compliance with this benchmark. MCNA and DentaQuest met all performance standards for the timely resolution of complaints and appeals in 2015 SFQ4, with the exception of DentaQuest member complaints (95% resolved in 30 days).

Complaints and Appeals Received by DMOs (2015 SFQ1 – 2015 SFQ4)







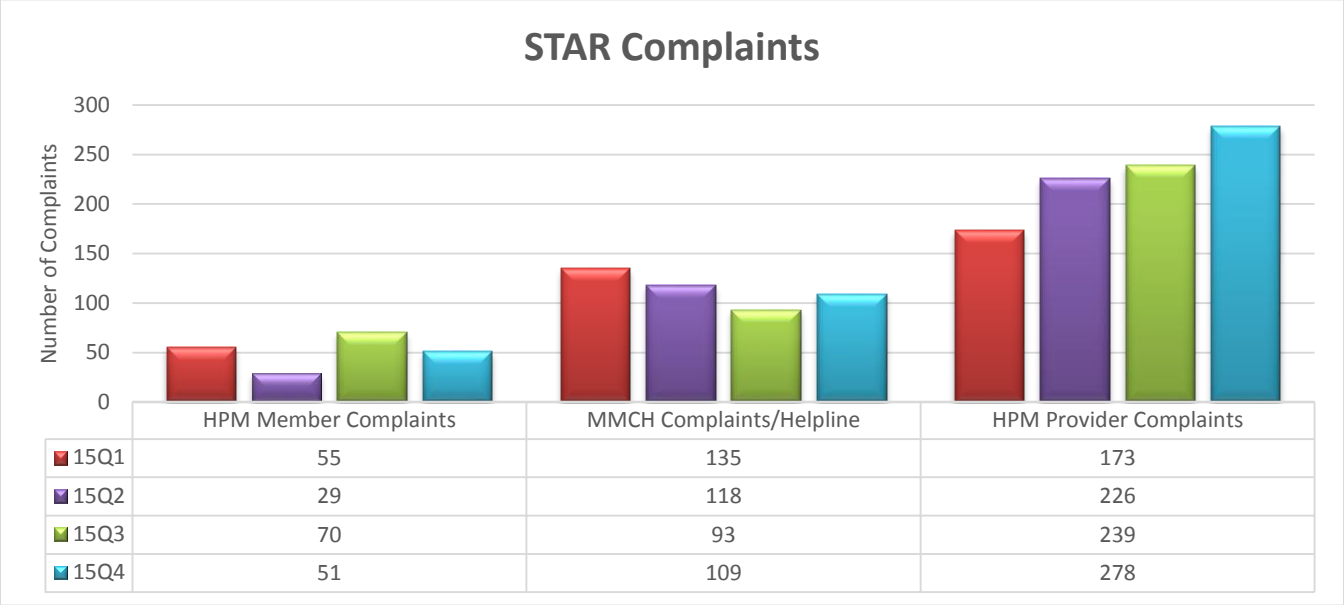
C. COMPLAINTS RECEIVED BY THE STATE

In addition to monitoring complaints received by plans, HHSC also tracks the number and types of complaints submitted to the State. Members and providers can submit complaints to the HHSC HPM team. Members can also call in to submit complaints through the Office of the Ombudsman via the Medicaid Managed Care Helpline (MMCH). After investigating each complaint, staff determines whether or not it is substantiated. (Substantiated complaints are those where there is a clear indication that agency policy was violated or agency expectations were not met (e.g. paying at an incorrect rate or a member not receiving medically necessary benefits)).

1. STAR

In the STAR program, the number of member complaints received by HHSC decreased by 27.1% (from 70 complaints to 51 complaints) and the number of member complaints received by MMCH increased by 17.2% (from 93 complaints to 109 complaints) from 2015 SFQ3 to 2015 SFQ4. The majority of helpline complaints reported during SFQ4 were related to billing problems, inadequate/outdated provider information and prescription unknown and prescription not showing active. HHSC received 13 contacts on behalf of members from legislative representatives. The most frequent member complaints received by HHSC and MMCH were issues with member claims and billing. The number of provider complaints received by HHSC increased by 16.3% in 2015 SFQ4. The most common provider complaint received by HHSC was denied claims.

Complaints to the State Regarding STAR (2015 SFQ1 - 2015 SFQ4)

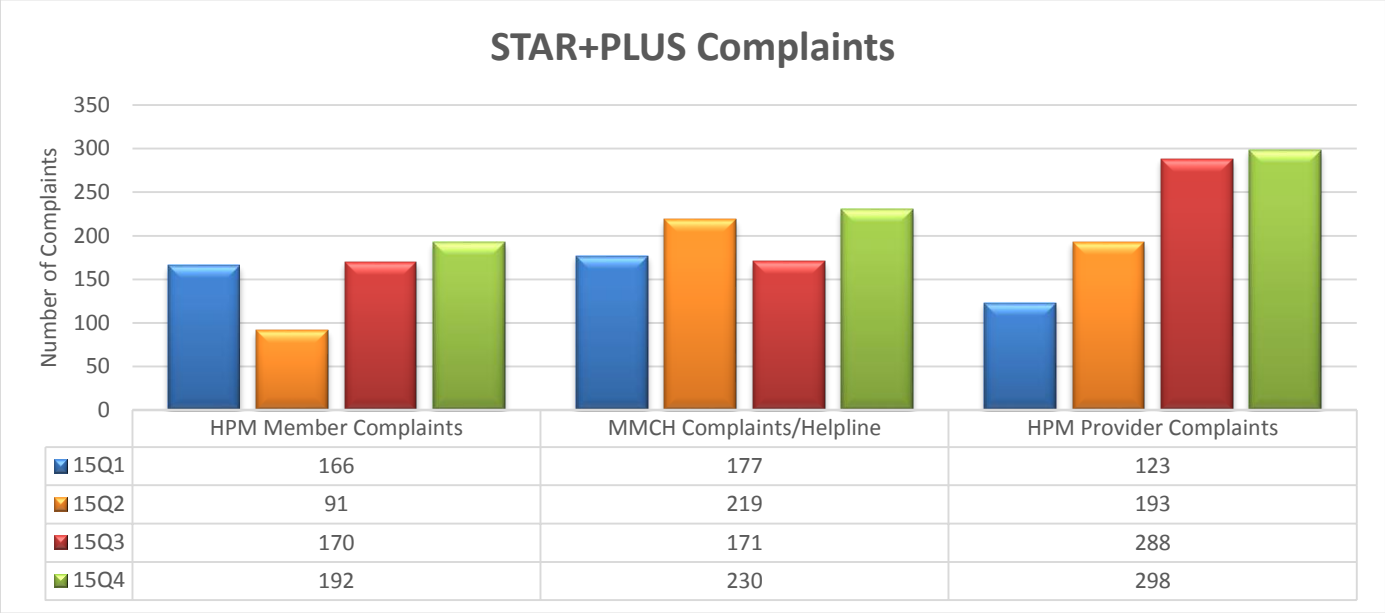


	HPM Member Complaints	MMCH Complaints/Helpline	HPM Provider Complaints
15Q1	55	135	173
15Q2	29	118	226
15Q3	70	93	239
15Q4	51	109	278

2. STAR+PLUS

Across the STAR+PLUS program, the number of member complaints received by MMCH increased by 34.5% (from 171 complaints to 230complaints) in SFQ4 and the member complaints received by HHSC increased by 12.9% (from 170 complaints to 192 complaints). HHSC received 45 contacts on behalf of members from legislative representatives. The most frequent member complaints received by MMCH and HHSC were issues related to access to durable medical equipment (DME), access to long term services and supports, billing problems and prescription eligibility. The number of provider complaints increased by 3.5% in 2015 SFQ4.

Complaints to the State Regarding STAR+PLUS (2015 SFQ1 - 2015 SFQ4)



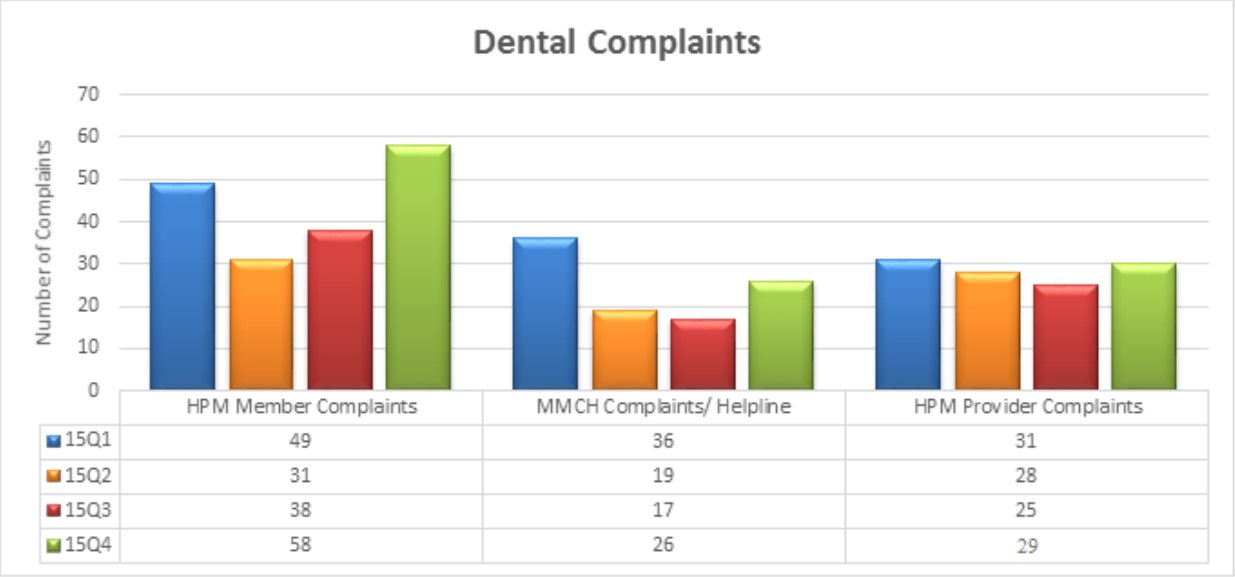
	HPM Member Complaints	MMCH Complaints/Helpline	HPM Provider Complaints
15Q1	166	177	123
15Q2	91	219	193
15Q3	170	171	288
15Q4	192	230	298

The following paragraph addresses STC 22. In order to monitor performance and quality during the STAR+PLUS expansion to the MRSAs, HHSC tracked complaints received from members and providers in the STAR+PLUS MRSAs. Of the total of 192 STAR+PLUS member complaints received by HHSC, 32 came from members in the MRSAs. Of the total 230 STAR+PLUS complaints received by MMCH, 46 came from members in the MRSAs. Of the 298 provider complaints received in STAR+PLUS, 62 had to do with the MRSAs. The most common provider complaint issue had to do with denied claims.

3. Dental Program

Across the Dental Program, the number of member complaints received by MMCH increased by 52.9% and the number of member complaints received by HHSC increased by 52.6% in 2015 SFQ4. The most common member complaints dealt with incorrect eligibility or enrollment information. The most common provider complaint was denied claims. Provider complaints increased by 16% from 2015 SFQ3 to 2015 SFQ4.

Complaints to the State Regarding the Dental Program (2015 SFQ1 - 2015 SFQ4)



	HPM Member Complaints	MMCH Complaints/ Helpline	HPM Provider Complaints
15Q1	49	36	31
15Q2	31	19	28
15Q3	38	17	25
15Q4	58	26	29

XI. QUALITY ASSURANCE/MONITORING ACTIVITY

A. DY4 QUARTER 4 UPDATE

HHSC releases MCO report cards to help members of STAR and STAR+PLUS identify and select a MCO. During SFQ4, HHSC completed final review and approval of the report cards for 2015. Similar to the last round of report cards, a separate report card by program has been developed for each service delivery area to provide information on the performance of each MCO with respect to outcome and process measures. Results allow members to easily compare MCOs on quality measures. The 2015 reports cards will be made available to members on the HHSC website in January and will be included in the enrollment packets sent to all newly eligible members in February. The measures will continue to be reviewed and updated annually.

The MCOs submitted their 2014 Performance Improvement Progress reports (PIP) and Texas's External Quality Review Organization (EQRO) reviewed and scored these. HHSC and the EQRO provided technical assistance to health plans that scored 5 or more points below the average PIP progress report score.

HHSC received the EQRO's Administrative Interview evaluations and participated in the teleconferences and local site visits. The agenda items included:

- Identification and dissemination of best practices

- Provider incentives and value based payment
- Network adequacy

The EQRO provided HHSC with summaries of the calls and meetings.

During Q4, HHSC, together with the National Association of States United for Aging and Disabilities (NASUAD) and the EQRO, facilitated a day-long training of the interviewers the EQRO will be using to conduct the National Core Indicators-Aging and Disabilities (NCI-AD) survey. These EQRO subcontractors began conducting the survey in August 2015. The survey process is ongoing and will be completed in the spring of 2016.

HHSC received the annual quality of care reports and potentially preventable events (PPE) data from the EQRO for measurement year 2014. These results were loaded onto the Texas Healthcare Learning Collaborative website. Texas's EQRO has also begun providing monthly PPE data to the health plans.

B. ANNUAL UPDATE

1. Incentive/Disincentive Programs

HHSC will keep the same measures in 2016 for the Pay for Quality (P4Q) program.

HHSC continues to implement capitation rate reductions for MCOs based on performance of hospitals on potentially preventable readmissions (PPR) and potentially preventable complications (PPC). The revised capitation rate is calculated by factoring in an adjustment based on hospitals that had an actual to expected ratio of potentially preventable readmissions and complications above 1.10 (statewide risk adjusted norm is 1.00). In accordance with the HHSC rules, MCOs were provided a list of hospital PPR and PPC performance for FY2013 which MCOs could use to adjust their network provider payments.

2. Public Reporting

As part of its quality strategy, HHSC is working to strengthen public reporting and to increase transparency and accountability of services and care being provided under the Texas Medicaid system. This is congruent with legislative initiatives from the 83rd Legislative Session, 2013 that mandate or suggest increasing public reporting, regarding Medicaid managed care quality.

As mentioned above in the quarter 4 quality assurance update, HHSC continues to develop MCO report cards to help members of STAR, STAR+PLUS, and CHIP identify and select a health plan.

HHSC has developed a dedicated Medicaid quality website to provide information on quality initiatives and projects that are currently occurring at HHSC. The Medicaid quality website serves as a central location for the public and other stakeholders to access information related to Medicaid quality with the aim of promoting transparency. The intent of this website is to consolidate and increase the availability of information related to Medicaid quality. For additional information, please visit the Medicaid and CHIP Quality and Efficiency Improvement webpage: http://www.hhsc.state.tx.us/hhsc_projects/ECI/index.shtml.

The Texas Healthcare Learning Collaborative Portal is an interactive website that presents quality of care data graphically. The measures presented report members' access to and utilization of preventive care, the occurrence of potentially avoidable hospitalizations, and effectiveness of care and treatment for behavioral and respiratory conditions. Data can be looked at by plan, program, and service delivery area. HHSC made the portal available to the public during SFQ4. For additional information, please visit the portal: www.thlcportal.com .

3. Quality Improvement Initiatives

New nursing facility quality measures were included in HHSC's 2015 quality performance indicator dashboard standards for STAR+PLUS.

HHSC has revised its performance improvement project (PIP) process in an effort to improve the quality of MCO PIPs. Changes included making all future PIPs two-year projects, requiring at least one collaborative PIP (with another MCO, DMO or DSRIP provider), and requiring the incorporation of all EQRO recommendations unless an exemption is requested and granted. HHSC also revised its PIP templates to facilitate more detailed reporting and is providing individualized technical assistance calls for all MCOs that score 5% or more below average on at least one of their PIPs. HHSC held a webinar on the changes and conducted extensive technical assistance.

Texas's EQRO, on behalf of HHSC, has begun fielding appointment availabilities for primary care services, behavioral health services, prenatal care, and vision care as outlined in the managed care contracts between HHSC and the MCOs. Samples of providers were pulled from current provider directories submitted to HHSC by the Texas STAR, CHIP, and STAR+PLUS MCOs. Posing as new patients, the EQRO calls providers in order to assess the availability of appointments.

The National Association of States United for Aging and Disabilities (NASUAD), in collaboration with the Human Services Research Institute (HSRI) and the National Association of State Directors of Developmental Disabilities Services (NASDDDS), has developed the NCI-AD survey. The intent of this survey is to obtain feedback from older adults and individuals with physical disabilities accessing publicly funded long-term services and supports on their

experience receiving those services. Texas has elected to participate in this project, which will include members of the STAR+PLUS program.

XII. DEMONSTRATION EVALUATION

This section addresses the quarterly reporting requirements in STC 67, regarding evaluation activities and issues.

A. OVERVIEW OF EVALUATION

This quarterly report reflects evaluation activities from July 1, 2015 through September 30, 2015.

The Program includes two interventions:

> **Intervention I**: The expansion of the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide, creating a new children's dental program, while carving-in prescription drug benefits (Evaluation Goals 1-4); and
>
> **Intervention II**: The establishment of two funding pools that will assist providers with uncompensated care costs and promote health system transformation (Evaluation Goals 5-11).

The Program evaluation will examine the implementation and impact of the Program through a set of annual performance measures through year four of the demonstration period. The principal focus of the demonstration evaluation will be on obtaining and monitoring data on performance measures for short-term (process measures) and intermediate (health outcomes) of the Program. The performance measures will be used to assess the extent to which the Program accomplishes its goals, track changes from year to year, and identify opportunities for improvement.

This report identifies:

1) The current quarter's evaluation activities;
2) any challenges or issues encountered; and
3) planned evaluation activities in the next quarter.

B. SUMMARY OF EVALUATION ACTIVITIES

Joint Evaluation Activities (HHSC and Texas A&M): Interventions I & II

HHSC's Office of Strategic Decision Support's evaluation team ("HHSC SDS") and the Texas A&M School of Public Health, including its subcontractors the University of Louisville School of Public Health and Information Sciences and the University of Texas School of Public Health

(collectively referred to as "Texas A&M"), attended monthly meetings and continued discussions regarding evaluation activities, including data collection, data requests, analysis, and preliminary results.

HHSC Evaluation Activities: Interventions I & II

General Evaluation Activities

1. HHSC SDS evaluation staff attended project meetings and scheduled monthly CMS calls.
2. HHSC SDS attended Regional Healthcare Partnership (RHP) anchor calls.
3. HHSC SDS finalized the overall Interim Report, including editing and copyediting of the various sections of the document. The report was sent to HHSC Waiver Operations and was submitted to CMS on September 30, 2015 as an attachment to the waiver renewal application.
4. HHSC Research Specialist Angie Cummings left her position in July to pursue another opportunity. In her place, HHSC Research Specialist Alison Little has joined the waiver evaluation team. Her biographical sketch is below.

   Alison Little serves as an Evaluation Research Specialist for Strategic Decision Support in the Financial Services Division of the Texas Health and Human Services Commission. Alison began working at Strategic Decision Support in September 2012 and joined the team evaluating the 1115(a) waiver in August 2015. Prior to joining the waiver evaluation team, she has been responsible for evaluation activities for the Texas Lifespan Respite Care Program as well as of several legislatively mandated programs and services and Commissioner-directed programs. She earned a Master of Public Policy degree from the University of California, Berkeley in 2005. She also earned a Certificate in Public Health Leadership from the University of Texas at Austin and the University of Texas School of Public Health in 2012. Besides her work as an evaluator, she has experience with project management, grant management, and case management for individuals with disabilities.

5. HHSC recruitment and selection of two Research Specialist V candidates is ongoing. Initial and second interviews were conducted in July and August. Final candidates were selected in September, and offers are being processed.
6. HHSC SDS attended the 2015 DSRIP Statewide Learning Collaborative Summit in Austin, TX on August 27th and 28th. HHSC SDS also presented two posters at the poster sessions highlighting the formal evaluation:

- *Transforming the Health Care System: Implementation Strengths and Challenges in Texas' Healthcare Transformation and Quality Improvement Program 1115(a) Medicaid Waiver* and
- *Using Network Analysis to Understand Regional Differences in Collaboration Resulting from the Texas 1115(a) Medicaid Waiver.*

Intervention I

1. HHSC SDS finalized the sections on Evaluation Goals1-4 for the Interim Report.
2. HHSC SDS continued to document an Intervention I evaluation plan protocol for the Final Report, which includes stratification methodology.
3. HHSC SDS continued to identify and collect data for Intervention I due to state legislative or federal changes while expanding the Interim Report analyses to include Program demonstration years (DYs) 2014-2015.
    a. Fee-for-service claims and Managed Care encounters
    b. Eligibility files

Intervention II

HHSC SDS continued to review and finalize the Interim Evaluation report chapters provided by Texas A&M relating to Intervention II.

Integrating Primary Care into Behavioral Health Settings for Adults with Severe and Persistent Mental Illnesses (SPMI)

1. HHSC SDS participated in monthly meetings hosted by UT School of Public Health to collaborate and provide feedback on the evaluation project. Texas A&M School of Public Health, the Meadows Mental Health Policy Institute, and the Texas Council of Community Centers also attended.
2. In September, HHSC SDS reviewed and provided feedback on an abstract from Texas A&M team members titled "Providing Primary Care in Community Mental Health Center Settings" for submission to *Health Affairs*.

Texas A&M Evaluation Activities: Intervention II

Evaluation Goal (EG) 5

1. Given the delay in relevant uncompensated care data from HHSC, Texas A&M continued to develop an alternate data analytic strategy for Evaluation Goal (EG) 5.

Evaluation Goals 6-8

1. In July, Texas A&M finalized the subcontract with the University of Texas School of Public Health and provided project data files and funding to continue supporting EG 6-8 project activities.
2. During this reporting period, three new team members joined the EG 6-8 evaluation team at The University of Texas School of Public Health: Maame Asafo-Adjei, half-time graduate assistant; Ellen Breckenridge, faculty associate; and Mónica Siañez, post-doctoral fellow. Their biographical sketches are below.

   Maame Asafo-Adjei will complete her Masters in Public Health in Management, Policy, and Community Health in May 2016. At the end of September, Maame joined the team as an administrative graduate assistant. During the summer of 2015, she completed a public health practicum as a Program Specialist I in the Institute of Health Care Quality and Efficiency at the Texas Health and Human Services Commission. Prior to attending UT School of Public Health, she earned a BS in Health Sciences from Drexel University in 2012, and worked as an Outpatient Clinical Coordinator at The Children's Hospital of Philadelphia. Maame has experience with data management and analytics, as well as program planning, implementation, and evaluation skills.

   Ellen Breckenridge is a faculty associate in the Department of Management, Policy, and Community Health and serves as Project Manager and Co-Investigator for both the Evaluation Goal 6-8 and Behavioral Health Integration Projects. Prior to joining the waiver evaluation team in August, she was Assistant Project Manager in the Coordinating Center for Clinical Trials and was responsible for curriculum development and evaluation activities for the Office of Academic Affairs at the UT School of Public Health. She earned a PhD in History and Sociology of Science from the University of Pennsylvania in 1990, a JD in Health Law from the University of Houston Law Center in 2008, and a Masters of Public Health in Management, Policy, and Community Health from the UT School of Public Health in 2010. Besides her work in qualitative and quantitative research in the biomedical and social sciences, she has experience with research ethics, protection of human research subjects, compliance, project management, and publications management.

   Mónica Siañez is a postdoctoral fellow in the Department of Management, Policy, and Community Health. Mónica joined the evaluation team full-time in mid-August 2015. Prior to joining the waiver evaluation team, she earned a DrPH from UT School of Public Health in 2015 and an MPH in Epidemiology from Columbia University in 2008. As a consultant to the Hispanic Health Disparities Research Center Environment Core at the University of Texas, El Paso, she conducted data cleaning, data preparation, and analyses for a child health project. She has also worked as an epidemiologist/evaluator for an HIV surveillance program at the Houston Department of Health and Human Services. Besides

her work as an epidemiologist, data manager, and program evaluator, she has considerable experience with community-based research and social science research methods, gained while working with multiple programs at the University of California, Davis and the Stanford University School of Medicine.

3. New team members and two research interns completed team building activities and training in requisite qualitative research skills at a week-long intensive workshop at the University of North Carolina at Chapel Hill, and applied these skills to begin "cycle 2" (more inferential) coding of EG 6 – 8 qualitative data.
4. In collaboration with HHSC SDS, the evaluation team refined EG 6-8 to streamline the case study component and incorporate broader quantification of project performance across the state.
5. The Public Policy Research Institute at the Texas A&M completed 28 of the wave 2 phone surveys with patients at the two sites with later start dates.
6. At suggestion of HHSC SDS, the evaluation team prepared to conduct a patient phone surveys in a new cohort across Texas in early 2016. This new cohort will be drawn from client lists provided by DSRIP project staff.
7. The evaluation team revised instrument case study instruments for wave 3 data collection.

Evaluation Goal 9

1. Texas A&M drafted and submitted a manuscript on EG9 findings for publication in the *American Journal of Public Health*, which declined the submission; the team is now preparing the paper for submission to another journal.
2. Texas A&M planned for T2 data collection, scheduled to begin in November.

Evaluation Goal 10-11

1. Texas A&M developed ideas for manuscripts incorporating findings from EGs 10 & 11 and how it relates to other current literature.
2. Texas A&M continued to work on RHP-specific summaries of findings from the stakeholder survey.

Integrating Primary Care into Behavioral Health Settings for Adults with SPMI

1. In August, new team member Ellen Breckenridge (see details above under EG 6-8) began working as project manager and co-investigator for the primary care integration project.
2. The Texas Department of State Health Services and study site participants met in August to discuss quantitative measures of integrated care impact.

3. Follow-up surveys were sent to key informants at the selected study sites to solicit information about which quantitative DSRIP Category 3 outcome measures should be used in analyses of integrated care impact.
4. Key informants discussed the results of that survey in a conference call in September, and chose outcome and control measures to include in the study.
5. Members of the Texas A&M evaluation team, with feedback from HHSC SDS, submitted an abstract titled "Providing Primary Care in Community Mental Health Center Settings" to *Health Affairs* for consideration for a special issue on behavioral health to be published in June, 2016. Over 200 submissions were received and of those 20 were selected for submission. As *Health Affairs* declined the submission, the team began drafting the paper for submission to a different journal.

Challenges or Issues Encountered

1. There was a one month delay in obtaining IRB approval from Texas A&M, which delayed wave 2 patient phone interviewing at the last two sites for EG 6 – 8. However, the impact on the evaluation is negligible as only cohort 2 patient phone survey data will be used for the Final Report.

C. ACTIVITIES PLANNED IN NEXT QUARTER

(October 1, 2015 through December 31, 2015)

1. HHSC SDS will attend project meetings and monthly CMS calls, as well as RHP anchor calls.
2. HHSC SDS and Texas A&M will continue to meet at least monthly to collaborate and provide feedback on each other's evaluations.

Intervention I

1. HHSC SDS will continue to gather data for Intervention I for the Final Report.
2. HHSC SDS will continue to develop Intervention I evaluation plan protocol which includes stratification methodology for inclusion.
3. HHSC SDS will extend offers to qualified candidate(s) for the open Research Specialist positions.

Intervention II

1. Texas A&M will review the revised EG 5 evaluation with HHSC SDS.
2. Texas A&M will provide HHSC SDS a revised evaluation plan on EG 6-8.

3. HHSC SDS will have planning meetings with Texas A&M to discuss the development of those sections of the final evaluation report related to EG 5 and EG 6-8.
4. Texas A&M will begin wave 3 site visits and phone interviews for EG 6-8 including follow-up phone interviews (1-year post original data collection) of key informants at each site.
5. Texas A&M will prepare for phone survey in new cohort to be conducted in following quarter.
6. Texas A&M will begin planning for the final report based on HHSC SDS input, External Advisors' suggestion, and current study progress.
7. Manuscript preparation will continue.
8. Preparation will continue for collecting the final round of inter-organizational network data for EG 9. The data collection period will begin on November 1, 2015.

Integrating Primary Care into Behavioral Health Settings for Adults with SPMI

1. Texas A&M, HHSC SDS, the Meadows Mental Health Policy Institute, and the Texas Council of Community Centers will continue to collaborate and provide feedback on the behavioral health project.
2. Texas A&M will meet on November 5, 2015 with study site participants as convened by the Texas Council of Community Centers to discuss outcome measures.

XIII. REGIONAL HEALTHCARE PARTNERSHIP PARTICIPANTS

This section addresses the quarterly and annual reporting requirements in STC 67 and 68.

A. ACCOMPLISHMENTS

1. Major DSRIP Activities during Demonstration Year 4 Quarter 1 (10/01/2014-12/31/2014)

In DY4Q1, HHSC designed a Category 3 Baseline reporting template. Baseline reporting templates specific to each of the 20 RHPs were posted on the HHSC website for providers to complete and submit during the October 2014 reporting of DY3 measures (hereafter referred to as "October DY3 reporting," unless otherwise noted), in order to earn payment for the DY3 Category 3 process milestone. During the review of baseline template submissions, HHSC staff provided a significant amount of technical assistance to providers who submitted requests for alternate achievement levels, reported low volume denominators, had low or high baseline performance compared to benchmarks, and/or did not submit the appropriate forms. Category 3 baseline review continued into DY4Q2.

In DY4Q1, HHSC continued reviewing the nearly 2,000 RHP plan modification and technical change requests submitted by DSRIP providers in July and August of DY3 Q4. These change requests included changes to project narratives and to project milestones/metrics in DYs 4 and 5. HHSC comments and preliminary determinations were provided to DSRIP providers in November 2014, and providers were asked to respond to HHSC comments in December 2014.

Preparing for and processing October DY 3 reporting was a large focus of DY4Q1. The web-based reporting system that had been in development for several months was implemented successfully for DY3 October reporting. Providers were able to complete their reporting in the online database and upload their documentation to support metric achievement. HHSC staff held three webinars to assist with October DY3 reporting and posted the recorded videos and presentations on the HHSC website. HHSC also developed a provisional approval process in order to complete preliminary review of milestones and metrics reported in October 2014 during the 30 days allowed for HHSC and CMS review. CMS worked with HHSC to add language to the Program Funding and Mechanics (PFM) Protocol to specify that HHSC and CMS may determine that a subset of not less than half of the projects and metrics will be reviewed during the 30 days after the reporting period.

In DY4Q1, HHSC sent formal anchor contracts for reporting administrative costs, which are required for participation by anchors in administrative cost claiming. HHSC conducted a technical assistance session in October 2014 for anchors participating in administrative claiming to discuss timelines, cost principles, the Percent of Effort spreadsheet and the cost template. These documents were all posted on the HHSC website. The due date for the DY2 anchor cost claiming report was November 30, 2014. Anchors could also submit their DY3 costs with the DY2 invoice or carry them forward to the next invoice period.

HHSC continued working with Myers & Stauffer, LLP, the independent assessor conducting the midpoint assessment and ongoing compliance monitoring. Six hundred and seventy-seven projects were selected for the midpoint assessment review based on the following: a) project options that were requested to be reviewed by CMS (1.10, 2.4, 2.5 and 2.8 and projects that were approved under "other" project option); b) projects flagged by HHSC during approval, plan modification and reporting reviews; and c) projects selected via random sampling. Myers & Stauffer began with in-depth desk reviews and also conducted on-site visits with selected providers.

Finally, during DY4Q1, HHSC worked with CMS to resolve the deferral related to private hospital UC financing arrangements in three regions that underwent a CMS DSRIP Financial Management Review.

HHSC continued stakeholder communications in DY4Q1 through webinars, biweekly Anchor calls, Executive Waiver Committee meetings, and companion documents. HHSC conducted

webinars to provide technical assistance to DSRIP providers for reporting Quantifiable Patient Impact (October 1, 2014), for assistance with Category 3 baseline reporting (October 2, 2014) and general reporting guidance for October DY3 reporting, including how to use the new DSRIP automated reporting system (October 6, 1014).

2. Major DSRIP Activities during Federal Fiscal Quarter 2/2015 (01/01/2015-03/31/2015)

For project metrics achieved in DY3 (including DY2 carryforward metrics), DSRIP providers received about $1.76 billion in January 2015. This included those metrics that were provisionally approved during the October reporting review. Also in Q2, the first payments for Anchor administrative costs were made.

During DY4Q2, HHSC continued review of baseline Category 3 data submitted during the October 2014 reporting period. HHSC identified and began to follow-up with 671 projects needing technical assistance or clarification of baseline measurement, prioritizing assistance for the projects with outcomes eligible for DY4 metric achievement reporting in April 2015 (hereafter referred to as "April DY4 reporting").

In DY4Q2, HHSC finalized review of the nearly 2,000 RHP plan modification and technical change requests that were submitted by DSRIP providers in July and August of 2014. This included determinations by the independent assessor, Myers & Stauffer, LLP, who provided additional review of some change requests. Updated project narratives and milestones/metrics workbooks that reflect approved change requests were posted on the HHSC waiver website. With the change requests finalized, HHSC began working with RHP Anchors to draft a process for submission of updated RHP Plans.

In DY4Q2, HHSC continued working with Myers & Stauffer on the midpoint assessment and ongoing compliance monitoring of the 677 projects selected for review. Myers & Stauffer continued with in-depth desk reviews and also conducted on-site visits with the selected providers. HHSC worked with providers to make changes to their narratives and milestones/metrics based on Myers & Stauffer's findings.

A major initiative during DY4Q2 was the launching of the Clinical Champions Workgroup. This workgroup is made up of clinical, quality and operational experts, who will help HHSC assess the transformational potential and impact of active DSRIP projects, identify best practices by project area, support HHSC in discussions of waiver renewal/extension and inform the clinical and quality aspects of future DSRIP protocol development. Clinical Champions nominations were solicited from Executive Waiver Committee member entities and other stakeholders. The Clinical Champions began meeting monthly in January 2015 with support from HHSC staff.

On March 9, 2015, HHSC leadership met with key CMS staff to discuss the renewal/extension of the 1115 Transformation Waiver and ways to address CMS's concerns raised in the September

2014 UC deferral letter regarding IGT financing for private hospitals. Also in March, HHSC submitted to CMS the Transition Plan for Funding Pools as required by the waiver's terms and conditions (STC 48). The Transition Plan addressed the state's experience with the DSRIP pool, actual UC trends in the state and investment in value-based purchasing and other payment reform options.

HHSC continued stakeholder communications in DY4 Q2 through biweekly Anchor calls and Executive Waiver Committee meetings. On February 12, 2014, HHSC presented to the Executive Waiver Committee updates on DSRIP and Uncompensated Care, and led a discussion on waiver renewal, including the development of the Transition Plan for Funding Pools discussed above.

3. Major DSRIP Activities during Demonstration Year 4 Quarter 3 (04/01/2015-06/30/2015)

April 2015 was the first opportunity for providers to report achievement of DY4 metrics along with reporting metrics carried forward from DY3. Provider reports were due April 30, and HHSC began reporting review in May 2015 and completed it in mid-June 2015. Providers were sent reporting feedback in June and given three weeks to respond to requests for additional information to support achievement of 101 metrics.

During the April 2015 reporting period DSRIP providers reported achievement of 21.7 percent of the 9,677 DY3-DY4 Category 1-4 milestones and metrics. HHSC approved 93.6 percent of the reported milestones/metrics. Based on available intergovernmental transfer funds (IGT), $2.9 million was collected in Monitoring IGT and $700,276,608 was paid for DSRIP in July 2015. The total DY1 - DY4 DSRIP payments to date is about $5.2 billion.

During DY4Q3, HHSC continued to review baseline Category 3 data submitted during the October reporting period. Technical assistance (TA) was prioritized to address questions and concerns related to April 2015 reporting first. After the April 2015 reporting period closed to providers HHSC continued to work with providers to resolve outstanding baseline TA flags. Baselines reported in April 2015 were reviewed in the same manner as baselines reported in October 2014 for DY3, being either approved as reported or flagged for technical assistance.

Anchors were able to report administrative costs on May 15, 2015 using the HHSC and CMS approved cost template spreadsheet. This submission period was the last opportunity for anchors to submit costs for DY2. Anchor administrative cost payments were made in August 2015 during DY4Q4.

During DY4Q3, HHSC developed policies and processes to enable 3-year projects to submit change requests (plan modifications and change requests) for DY5 only. This change request process began in July during DY4Q4.

HHSC continued working with Myers & Stauffer during DY4Q3 on the midpoint assessment, including review of 3-year projects, and ongoing compliance monitoring. As part of the mid-point assessment, HHSC requested that projects that met or exceeded their DY5 Quantifiable Patient Impact (QPI) goal with DY3 QPI achievement increase their DY5 QPI goals. HHSC contacted these providers in May 2015 with the updated QPI goals. Providers were not able to maintain their current DY5 QPI goals, but could propose an alternate goal that was higher than their DY3 QPI achievement for HHSC review and approval.

During DY4Q3, Myers & Stauffer began Component 2 of their monitoring work, which is compliance monitoring for validation of data submitted by performing providers as the basis for their milestone/metric achievement and subsequent DSRIP payments. This validation began with a review of Category 3 baselines from a random sample of baselines of projects not working with HHSC on a baseline correction or clarification. All projects that have reported metrics are eligible for review.

Providers were able to submit project withdrawals without recoupment of funds during the midpoint assessment window HHSC and CMS agreed upon, which ended May 1st 2015. If a project withdraws from DSRIP after May 1 2015, any DSRIP payments made after that date are subject to recoupment according to the Program Funding and Mechanics Protocol (PFM).

RHP Plans were updated in DY4Q3, which included new RHP certification forms signed by each DSRIP performing provider, anchoring entity and UC hospital. Anchors also updated their RHP websites to include information on their process for selecting 3-year projects, which occurred after the original RHP Plans were submitted, as well as information for stakeholders who are interested in getting involved in RHP activities. HHSC also updated its waiver website with updated RHP Plan information, including most recent Category 1 & 2 project narratives, Category 1 & 2 workbooks for 4-year and 3-year projects, Category 3 outcome selections for all projects, and 2013 RHP level potentially preventable event (PPE) data, as well as a QPI summary for all RHPs and links to all updated RHP websites. HHSC also developed a matrix for categorizing RHP projects by project type, which each provider completed for their projects. The statewide summary file of project types was also posted on the HHSC website.

The work of the Clinical Champions Workgroup (CCW), supported by HHSC staff, continued during DY4Q3. This workgroup is made up of clinical, quality and operational experts, who will help HHSC assess the transformational potential and impact of active DSRIP projects, identify best practices by project area, support HHSC in discussions of waiver renewal/extension and inform the clinical and quality aspects of future DSRIP protocol development. The CCW developed a Transformational Impact Summary to gather supplemental information on DSRIP projects demonstrating early successes as well as a rubric to assess the transformational impact of these projects. The rubric captured factors deemed by the CCW as indicative of success such as sustainability planning, outcome oriented design, use of evidence based models, impact to

triple aim and potential for duplication. The CCW received a total of 492 voluntary submissions from projects for review through this peer assessment process.

HHSC continued conversations with stakeholders about waiver renewal/extension during Q3. During the May Executive Waiver Committee meeting, HHSC led a discussion of waiver renewal key DSRIP issues. A draft waiver renewal document from that meeting was posted on the HHSC waiver website, along with a link to a survey for stakeholders to give preliminary feedback on key issues in the document.

HHSC continued stakeholder communications in DY4Q3 through biweekly Anchor calls and Executive Waiver Committee meetings. On May 14, 2015, HHSC presented to the Executive Waiver Committee updates on DSRIP and Uncompensated Care, and led a discussion on waiver renewal/extension. On April 7th, HHSC conducted webinars to provide technical assistance for DY4 reporting (DY4 General Reporting Guidance, Quantifiable Patient Impact, and Category 3 & 4 Reporting Guidance).

4. Major DSRIP Activities during Demonstration Year 4 Quarter 4 (7/01/2015 - 9/30/2015)

In DY4Q4, HHSC staff continued conducting Category 3 technical assistance via email and telephone calls for baselines reported in October DY3 and flagged as needing baseline clarification or assistance in determining DY4 and DY5 goals. HHSC staff also began reviewing Category 3 baselines submitted during the April DY4 reporting period and notified providers of any needed baseline clarifications or technical assistance.

During DY4Q4, HHSC reviewed the additional information requested by HHSC and reported by providers to support achievement of metrics reported in April 2015 and approved 97 percent of these milestones/metrics. Payments for those metrics will be included in the January 2016 payment period. Based on available intergovernmental transfer funds (IGT), $2.9 million was collected in Monitoring IGT and $700,276,608 was paid for DSRIP metrics achieved in April by July 31, 2015.

The compliance monitor, Myers and Stauffer, LLC, continued their review of Category 3 baselines. The initial sample of baselines was taken from outcomes with no outstanding HHSC flags for baseline clarification or technical assistance. Providers were requested to submit additional documentation to Myers and Stauffer when necessary. Providers were also able to voluntarily request that their outcomes be reviewed by the compliance monitor.

In DY4Q4 Myers and Stauffer also began the first phase of the compliance monitoring of Category 1 and 2 metrics. Close to 100 projects were included in this phase. For these projects Myers and Stauffer will review selected process milestones, Quantifiable Patient Impact (QPI)

metrics and Medicaid Low Income Uninsured (MLIU) information. Myers and Stauffer also completed their Mid-Point Assessment for 3-year projects during DY4Q4.

In DY4Q4, DSRIP providers had an opportunity to submit change requests for plan modifications and technical changes for 3-year projects. These requests are to make changes and updates to project narratives and milestones and metrics. Staff developed a change request form, which providers completed and submitted with a revised project narrative, as appropriate.

During DY4Q4, HHSC staff supported the ongoing work of the Clinical Champions workgroup, which reviewed projects that submitted a Transformational Impact Summary. These summaries provide information on projects that are implementing promising practices and have data to show the transformational impact on their health systems. Findings from this process were shared at the Statewide Learning Collaborative Summit in August (detailed below). The Clinical Champions also helped inform the preliminary development of the streamlined project menu for replacement projects in the waiver renewal period.

HHSC staff worked in DY4Q4 to develop a DSRIP Tableau Dashboard. This dashboard is a searchable statewide DSRIP database that presents Category 1-3 data in summaries and graphs. It allows users to filter projects based on RHP, Provider Name, Provider Type, Project Option, Primary Project Type, and Category 3 outcome. The dashboard link is posted on the HHSC waiver website.

HHSC continued work on developing proposals for DSRIP program changes and updated protocols for the waiver extension period, in particular the transition year immediately after Demonstration Year 5, which ends September 30, 2016. As part of this process, HHSC began reviewing identified projects for possible changes for waiver renewal, including whether they should be continued during the next waiver period.

HHSC continued stakeholder communications in Q4 through responses to technical assistance requests, biweekly Anchor calls, an Executive Waiver Committee meeting, companion documents, and webinars. Webinars were held on July 2, 2015 to provide technical assistance to DSRIP providers on 3-year project change requests and on September 30, 2015 on DSRIP extension planning and proposed changes to protocols. HHSC also held a Statewide Learning Collaborative Summit, discussed more fully below.

5. Major Uncompensated Care (UC) Program Activities During DY4

July 2015

- HHSC issued combined Disproportionate Share Hospital/ Uncompensated Care (DSH/UC) DY4 applications to providers

August 2015

- Completed DY4 DSH/UC applications received from providers

October 2015

- HHSC issued Texas Physician Uncompensated Care (TXPUC) applications to providers
- HHSC processed a 2015 DY4 Advance UC Payment totaling approximately $1,614,441,815

November 2015

- Posted Advance UC Payment information to HHSC website in accordance with state appropriations Rider 80 requirements
- Completed TXPUC applications received from providers
- HHC processed an off-cycle UC payment of $345,016

December 2015

- HHSC completed the processing of all DY4 DSH/UC applications
- Completed the calculation of hospital specific limits (HSLs) and verification by providers and their consultants
- HHSC processed an off-cycle UC payment of $3,196,717

Upcoming UC Program Events for DY4

February 2016

- DY4/FFY2015 Final Payment

6. Statewide Learning Collaborative Summit

On August 27-28, 2015, HHSC held a two-day Statewide Learning Collaborative Summit in Austin. The purpose of the Summit was to share best practices from DSRIP projects, highlight effective systems of care and discuss next steps as we look to the future of the 1115 Healthcare Transformation Waiver. Attending the conference in person were approximately 500 people representing a wide variety of providers and projects across all 20 RHPs as well as other DSRIP stakeholders, and there was live stream web video capability for up to 1,000 others to view remotely.

Speakers included Timothy Hill, Deputy Director, CMS Center for Medicaid and CHIP Services; David Lakey, MD, Associate Vice Chancellor for Population Health at the University of Texas System, who gave a population health perspective on the 1115 Waiver extension/renewal; Clay

Johnston, MD, PhD, Dean of the Dell Medical School at the University of Texas at Austin, who spoke about supporting rapid cycle health innovation; and Betsy Shenkman, PhD, from the University of Florida Institute for Child Health Policy, who spoke about next steps to further integrate the quality strategy in Medicaid to analyze outcomes on a regional level to measure performance towards advancing program improvements.

There were also moderated panels on developing systems of care; improving outcomes by coordinating among payers and providers (moderated by Mark McClellan, MD, PhD, Director of the Brookings Institute's Healthcare Innovation and Value Initiative); and alignment with managed care from multiple perspectives. Summit participants also had the opportunity to attend smaller breakout sessions including peer-to-peer learning and networking by DSRIP project types; conducting meaningful and effective program evaluation; collecting and using data more effectively; and health information exchanges. There was also a Poster Session for innovative DSRIP projects to highlight their progress and successes.

7. Summary of RHP Milestone Achievement in DY4

Each of the 20 RHPs submitted an annual report to HHSC by December 15, 2015, that outlines the activities and achievements of the RHP for DY4. Those reports will be made available to CMS for review. HHSC also is providing a high-level summary of performance achievement by each RHP based on the two DY4 reporting periods – April 2015 and October 2015. This data is included in Attachment W. Please note that the eligible payment amounts are contingent on available intergovernmental transfer (IGT) funds, so actual payments likely will be a little lower than eligible payments.

As required in the Program Funding and Mechanics Protocol, each Anchoring Entity submitted a DY4 Annual Report by December 15, 2015. The reports include a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings. The required data on the progress made for all metrics is contained in the attachment of the Summary of DY4 Reporting by RHP. A compressed file of all of the DY4 Anchor Annual Reports for all RHPs is included in Attachment W.

8. Projected DY5 DSRIP Payments

While HHSC's Financial Services staff will provide the official estimates of potential DSRIP payments to CMS for each quarter, based on April and October 2015 reporting, HHSC estimates that DSRIP providers will earn over $1 billion in DY5 DSRIP funds. This uses the same percentages as in DY4 reporting in which 15 percent of funding was approved in April 2015; an

additional 58 percent of funding was approved by October 2015. It does not include DY4 metrics carried forward into DY5, so the total payment amounts for July 2016 (based on April 2016 reporting) and January 2017 (based on October 2016 reporting) likely will be higher that what is reflected below.

RHP	DSRIP Allocation DY5	Estimated April 2016 Reporting	Estimated October 2016 Reporting
RHP 1	$117,254,535	$17,588,180	$68,007,630
RHP 2	$106,970,297	$16,045,545	$62,042,772
RHP 3	$621,670,292	$93,250,544	$360,568,770
RHP 4	$127,556,048	$19,133,407	$73,982,508
RHP 5	$201,604,147	$30,240,622	$116,930,405
RHP 6	$323,924,613	$48,588,692	$187,876,275
RHP 7	$194,871,479	$29,230,722	$113,025,458
RHP 8	$28,891,856	$4,333,778	$16,757,276
RHP 9	$447,121,451	$67,068,218	$259,330,442
RHP 10	$308,388,633	$46,258,295	$178,865,407
RHP 11	$37,221,524	$5,583,229	$21,588,484
RHP 12	$116,034,422	$17,405,163	$67,299,965
RHP 13	$21,857,200	$3,278,580	$12,677,176
RHP 14	$74,302,056	$11,145,308	$43,095,192
RHP 15	$144,279,333	$21,641,900	$83,682,013

RHP 16	$42,221,881	$6,333,282	$24,488,691
RHP 17	$24,299,140	$3,644,871	$14,093,501
RHP 18	$33,089,172	$4,963,376	$19,191,720
RHP 19	$29,249,200	$4,387,380	$16,964,536
RHP 20	$27,765,119	$4,164,768	$16,103,769
Total	**$3,028,572,397**	**$454,285,859**	**$1,756,571,990**

B. POLICY, ADMINISTRATIVE AND FINANCIAL DIFFICULTIES

The Texas DSRIP program continued to evolve during DY4, encountering many policy and administrative challenges as HHSC, CMS, RHP anchors, and DSRIP providers worked to implement a DSRIP program that is very different than any other state's DSRIP program.

The volume and variety of providers (over 300) and projects (1,452) means Texas' DSRIP program is extremely complex. The overarching challenge facing HHSC continues to be managing a large, diverse program with aggressive timelines and limited resources. The HHSC waiver team now has 19 full-time positions dedicated to DSRIP and a number of other staff within the agency playing key support roles for DSRIP. HHSC also relies heavily on a number of contractors to support DSRIP, including Deloitte Consulting, Health Management Associates, Cooper Consulting, and Myers and Stauffer, LLC.

ENCLOSURES/ATTACHMENTS

Attachment A – Health and Dental Plans by Service Area. The attachment includes a table of the health and dental plans by service areas.

Attachment B -- Enrollment Summary. The attachment includes annual and quarterly Dental, STAR and STAR+PLUS enrollment summaries.

Attachments C1-C3 – Network Summary and Methodology. The attachments summarize STAR and STAR+PLUS network enrollment by managed care organizations, service areas, and provider types. It also includes a description of the methodology used for provider counts and terminations.

Attachment D – Out-of-Network Utilization. The attachment summarizes Dental, STAR and STAR+PLUS out-of-network utilization.

Attachment E – HHSC GeoMapping. The attachment shows the state's GeoMapping analysis for STAR and STAR+PLUS plans.

Attachment G – HHSC Pharmacy GeoMapping Summary. The attachment includes the State's pharmacy GeoMapping results.

Attachment H – HHSC Dental GeoMapping Summary. The attachment includes the results of the State's GeoMapping analysis for dental plans.

Attachment I1-I2 –MCO GeoMapping Summary. The attachment includes the STAR and STAR+PLUS plans' self-reported GeoMapping results for PCP and specialists.

Attachment J – MCO Pharmacy GeoMapping Summary. The attachment includes the STAR and STAR+PLUS plans' self-reported GeoMapping results for pharmacy.

Attachment K – DMO Children's Medicaid Dental Services GeoMapping Summary. The attachment includes the dental plans' self-reported GeoMapping results.

Attachment L – Enrollment Broker Report. The attachment provides a summary of outreach and other initiatives to ensure access to care.

Attachments M1-M4 – Hotline Summaries. The attachments provide data regarding phone calls and performance standards of MCO and DMO Member and Provider Hotlines.

Attachments N – Complaints and Appeals to MCOs. The attachment includes Dental, STAR and STAR+PLUS complaints and appeals received by plans.

Attachment O – Complaints to HHSC. The attachment includes information concerning Dental, STAR and STAR+PLUS complaints received by the State.

Attachment P – Budget Neutrality. The attachment includes actual expenditure and member-month data as available to track budget neutrality. This document is updated with additional information in each quarterly report submission.

Attachment Q – Members with Special Healthcare Needs Report. The attachment represents total MSHCN enrollment in STAR and STAR+PLUS.

Attachment R – Provider Fraud and Abuse. The attachment represents a summary of the referrals that STAR, STAR+PLUS, and Dental Program plans sent to the OIG.

Attachments V1-V3 –Claims Summary. The attachment is a summary of the managed care organizations' claims adjudication results

Attachment W – DSRIP Reporting by RHP. The attachments includes a summary of the demonstration year 4 DSRIP reporting by RHP and annual reports from all anchors

Attachment X - DSRIP Project Summary October DY4. The attachment includes a summary of the accomplishments, progress on core components, and CQI (Continuous Quality Improvement) for each DSRIP project as reported in October 2015.

STATE CONTACTS

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ACRONYM LIST

AAA	area agency on aging
ADRC	Aging and Disability Resource Centers
APHA	American Public Health Association
BIP	Balancing Incentive Program
CAHPS	Consumer Assessment of Health Providers and Systems
CAP	corrective action plan
CFC	Community First Choice
CMS	Centers for Medicare & Medicaid Services
DADS	Department of Aging and Disability Services
DMO	dental managed care organization
DSH	Disproportionate Share Hospital
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
DY	demonstration year
EB	enrollment broker
EG	evaluation goal
ENT	otolaryngologist
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
ER	emergency room
ERS	emergency response services
FQHC	Federally Qualified Health Center
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission
HHSC	Health Plan Management
HSRI	Human Services Research Institute
ICF-IID	intermediate care facility for individuals with intellectual disabilities or a related condition
ICHP	Institute for Child Health Policy
ICSS	Independent Consumer Supports System
IGT	intergovernmental transfer
IMD	institution for mental disease
LD	liquidated damages
LTCO	long-term care ombudsman
MACPAC	Medicaid and CHIP payment and Access Commission
MAGI	modified adjusted gross income
MCO	managed care organization
MMCH	Medicaid Managed Care Helpline
MRSA	Medicaid rural service area
NASDDDS	National Association of State Directors of Developmental Disabilities Services
NASHP	National Academy for State Health Policy

NASUAD	National Association of States United for Aging and Disabilities
NCI-AD	National Core Indicators-Aging and Disabilities
OON	out-of-network
P4Q	Pay-For-Quality
PBM	Pharmacy Benefits Manager
PIP	performance improvement project
PCP	primary care provider
PFM	Program Funding and Mechanics
RHP	Regional Healthcare Partnerships
SDA	service delivery area
SDS	HHSC Strategic Decision Support
SFQ	State Fiscal Quarterly
SMMC	State Medicaid Managed Care Advisory Committee
SPMI	severe and persistent mental illness
STCs	Special Terms and Conditions
TCH	Texas Children's Hospital
TCHP	Texas Children's Health Plan
THSteps	Texas Health Steps
UC	uncompensated care