Medicaid Managed Care in Texas: A Review of Access to Services, Quality of Care, and Cost Effectiveness.

February, 2015

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Executive Summary

Over the past 20 years managed care has revolutionized the delivery of Medicaid health care services in Texas. As a result of managed care Texas Medicaid is far more accountable than its predecessor fee-for-service (FFS) model. The Texas managed care model was designed to achieve public sector policy objectives through use of private sector models and incentives. Through such a model, Texas is better able to manage costs, quality and access and offer a health care delivery system that is rooted in the local community.

Texas Medicaid Managed Care Overview

There are 19 Medicaid managed care organizations (MCOs) that serve more than 3 million Texans and almost 85% of all Texans enrolled in Medicaid. Texas uses several risk-based capitated managed care programs to serve Medicaid populations that include children, pregnant women, seniors and persons with physical, behavioral, and intellectual and developmental disabilities.

Texas began transitioning from traditional Medicaid (fee-for-service) in 1993. The legislature enabled the development of the State of Texas Access Reform (STAR) program. There are several STAR models.

- STAR - covers children, newborns, pregnant women and some families
- STAR+PLUS — covers people who have disabilities or are ages 65 or older. People in STAR+PLUS receive Medicaid basic medical services and long-term services through a health plan
- STAR Health — covers children who receive Medicaid coverage through the Texas Department of Family and Protective Services. One Medicaid plan provides both medical and dental services for all children in STAR Health
- NorthSTAR - provides behavioral health and substance abuse services to almost 400,000 persons in Dallas and contiguous counties only. The program services both Medicaid and low income persons
- STAR Kids – will cover children on Supplemental Security Income (SSI) and other children with disabilities beginning September 2016
- Dental MCO - covers children in Medicaid and CHIP

There are a number of benefits that distinguish managed care from the inefficient FFS model. In general managed care offers the following advantages:

- Provides Medicaid members with a **medical home**. Members have an established primary care provider (PCP) and a network of specialists to meet their medical needs
- MCOs are **accountable** for health outcomes, quality of care, appropriate utilization of services and cost effectiveness
- Focuses on **preventive care and continuity of care.** Health plans save money by avoiding unnecessary hospitalizations, complications and institutionalizations
- Offers increased flexibility to develop **innovative,** community-based solutions
- **Provides value-added services**, such as extra vision or dental benefits, 24-hour nurse hotlines, transportation assistance, and weight loss programs

- MCOs **outreach** to members to assess their need for health care and long-term services and provide **person-centered service coordination**
- **Enables rigorous oversight**, including numerous audits, contractual requirements, performance guarantees and penalties to enhance accountability, transparency and outcomes

Table 1: Comparing FFS and Capitated Managed Care

	Fee-for-service	Risk-based Capitation
Overview	Non-capitated, non-risk model with no care or service coordination	Capitated, risk-based model. MCOs are held accountable for health and LTSS outcomes and the overall cost of the service plan
Provider Contracting	Providers contract with the state	Providers contract with the managed care organization
Reimbursement	Providers are reimbursed according to FFS rates for each service	Providers are reimbursed a negotiated rate between the MCO and provider with pay-for-performance incentives
Provider Network and Referrals	Medicaid beneficiaries must find their own doctors and other service providers that will accept Medicaid	Medicaid MCO members choose a PCP and must get referrals for certain types of specialists
Service and Care Coordination	Limited to persons in disease management or Waiver programs	MCO provides Service/Care Coordinators for any member with a need for coordination or on request

Growth in Medicaid Managed Care

Following the successful implementation of the STAR program in 1993, the Legislature directed the Health and Human Services Commission (HHSC) to expand managed care for the aged, blind and disabled (ABD) Medicaid population. These populations were traditionally excluded from managed care or "carved out" and served through FFS. Texas sought to bring these individuals into managed care for both their acute care and long-term services and supports (LTSS) through the STAR+PLUS capitated managed care program. In 1998, STAR+PLUS was launched as a pilot program for the aged and disabled in Harris County.

Over the years numerous studies and evaluations have concluded that the Texas Medicaid managed care program was indeed meeting its promise to improve access, reduce cost, and improve quality of care. Expanding Medicaid managed care has been a key Texas strategy for reforming its Medicaid program. Over the last 20 years the population in Medicaid managed care has increased from 58,000 members to over 3 million members.

Value Based Purchasing

Value Based Purchasing (VBP) is a strategy to contract, measure, report, and reward excellence in health care delivery. Texas is a national leader in VBP approaches for Medicaid managed care. As one of the largest health care

payers in the state, the Texas Medicaid program is in a powerful position to help drive improvements as a purchaser. Effective value-based purchasing is an external motivator for providers to lead continuous improvement in health care delivery.

In 2014, HHSC implemented the Pay-for-Quality Program that includes an at-risk pool that is four percent of the MCO capitation rate. The quality of care measures used in this initiative are a combination of process and outcome measures which include select potentially preventable events as well as other measures specific to the program's enrolled populations.

Medicaid Managed Care Successes

Texas Medicaid MCOs have excelled in meeting and exceeding contractual standards for performance and quality improvement. Some of the highlighted successes include:

- An average of **93% of child and adolescent members reporting having a PCP** and **90% visiting their PCP** during the year
- Surpassed national performance expectations on **child well visits and childhood immunizations**
- **No Interest List wai**t to access community based waiver services
- **High level of customer satisfaction** with 83% of child members reporting overall positive experience with their health plan
- **Cost savings** for the state of 7.9% over fee for service

Success with Promoting Independence and Person-centered care planning

STAR+PLUS is the managed care program for seniors and persons with disabilities. Many of these people have chronic and complex conditions and require assistance with activities of daily living. In the past often the only option for these people was to enter a nursing facility. STAR+PLUS has been very successful in assisting persons to move back to the community and keeping them out of nursing facilities in the first place. The following page offers some success stories provided by advocates for persons with disabilities to demonstrate that even individuals who have been in a facility for many years can successfully and happily move to the community.

Improvements in Quality of Care

STAR Program Quality Improvement. Assessed against national quality standards, the Texas STAR managed care program provides some encouraging results with children. (Rates noted below represent hospitalization for ambulatory sensitive conditions.)

- Asthma: Rates declined 22% from 2009 to 2011
- Diabetes Short-Term Complications: Rates declined from 25.18 per 100,000 in 2009 to 18.58 per 100,000 in 2011, a 26% decrease
- Gastroenteritis: Rates decreased approximately 37% from 2009 to 2011. Moreover, rates of gastroenteritis in 2011 (45 per 100,000) fell

substantially below HHSC Dashboard Standards (146 per 100,000)

- Urinary Tract Infection: Rates decreased by nearly 20% from 2009 to 2011. The 2011 rates (31) were significantly lower than the HHSC Dashboard Standard of 53 per 100,000

STAR+PLUS Quality Improvement. Quality of care has improved for adults with disabilities under STAR+PLUS.

- Diabetes Short-Term Complications rate decreased 31% between 2009-2011
- Bacterial Pneumonia rate decreased 19% between 2009-2011
- Urinary Tract Infection rate declined 31% between 2009- 2011

Consumer Stories Provided by Individuals in STAR+PLUS

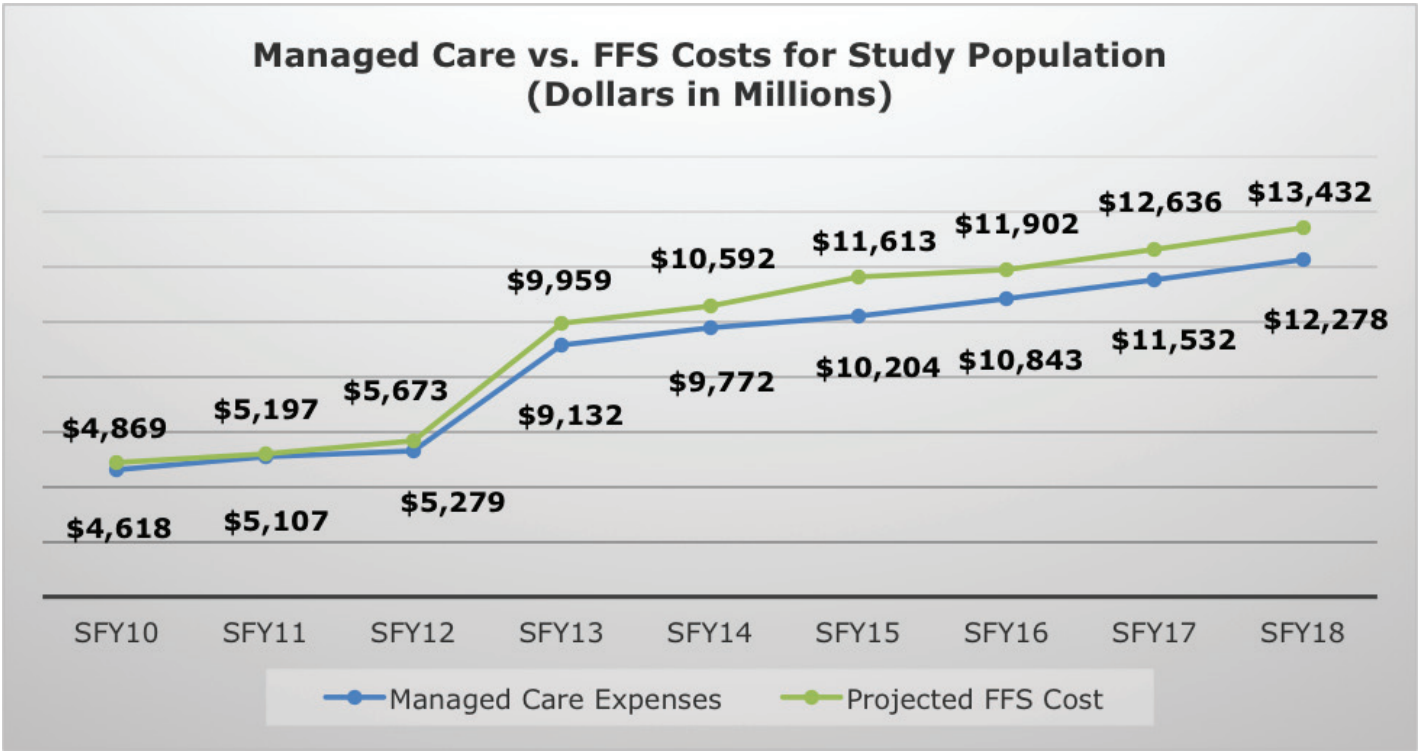
Loretta W.	Ms. W, 52 years old, born with cerebral palsy, is a widow with no children. She had been living in a nursing facility for many years. Ms. W. requires a wheelchair for mobility and major support for her activities of daily living. Her STAR+PLUS service coordinator made it possible for her to relocate from the nursing facility by arranging community-based services including finding her public housing through a Section 8 housing voucher. She now lives in the community and participates in community activities.
Victor M.	Mr. M. is a 56 year old who suffered a spinal cord injury in 1988. Mr. M. is dependent on his wheelchair for mobility and attendant services for supporting his activities of daily living. STAR+PLUS provides 54 hours of attendant services per week. Prior to enrollment in STAR+PLUS, Mr. M was in a nursing facility for many years until his STAR+PLUS service coordinator assisted him in relocating to his own apartment. The STAR+ service coordinator arranged for Mr. M. to receive a housing voucher to ensure his community living.
Nelson P.	Mr. P. is 58 years old with a cyst on his spine since 1974. He uses a wheelchair for mobility. His STAR+PLUS service coordinator coordinated all community services to ensure that Mr. P. could fully participate in his community. Both his Medicare and Medicaid services are also coordinated under the program. The service coordinator helped secure the housing voucher so he could live in his own apartment and helped with setting up consumer-directed services so Mr. P. could hire his own direct service attendant.

Cost Savings in Medicaid Managed Care

In addition to improving quality, a major goal of Medicaid managed care is to control costs associated with providing health care to the covered population. An analysis of costs under the STAR, STAR+PLUS, and DMO programs completed by Milliman shows that cost trends in these programs have been below expected trends in a fee-for-service environment. Milliman has estimated that savings for the populations and services included in its study were nearly $3.8 billion or 7.9% of projected costs over the six years from SFY 2010 through SFY 2015.

The chart on the following page provides an analysis of the managed care costs versus predicted FFS costs from SFY10 to SFY18. The major driver producing the cost saving is the managed care impact on reducing the cost trends below expected FFS costs.

Chart A: Managed Care vs. FFS Costs



Moving Forward with Medicaid Managed Care

MCOs are the platform for Texas to pursue payment reform and alignment of financial incentives. If Texas is to realize the investment it has made through the Health Care Transformation and Quality Improvement Program Waiver (1115 Waiver), there must be increased engagement with managed care. The MCOs and HHSC should continue to build upon the quality initiatives and innovative reforms promoted by the Texas legislature.

In the short term, Texas Medicaid will launch two new managed care models for complex populations, Medicare-Medicaid dual eligibles and children with disabilities, to better integrate and coordinate the community long term care needs of these complex populations with their acute care at a manageable cost. As the state moves forward with bringing together the coordination of all of the health services for these individuals under one entity, it is imperative **that the regulatory environment and federal and state Medicaid policies are aligned to support key managed care principles.**

Further service integration within managed care will reduce Texas Medicaid costs and increase quality. Texas has taken important steps in this direction by carving in behavioral health, pharmacy and LTSS services into managed care. By having all benefits administered by a single managed care plan, members are able to receive all their healthcare and support needs through one individualized plan of care.

To operate effectively and provide the state budget predictability, the MCOs and HHSC must establish **a rate setting process that is collaborative and transparent.** This includes incorporation of trends based on policy and benefit changes and the addition of new treatment modalities (e.g. Sovaldi in 2014) to provide a basis for establishing actuarially sound rates.

While Medicaid is a complex program, those complexities should not translate into administrative burdens for providers, consumers and health plans. What makes the MCO model effective is its ability to deviate from the heavily controlled federal Medicaid rules to provide benefits and services that recognize the needs and personal choices of the consumer. HHSC should pursue opportunities to **reduce administrative complexity wherever possible**.

Finally, the **ability to innovate** is critical to being able to provide the best services to Medicaid members while at the same time being responsible partners to the Texas Medicaid program. The Texas Medicaid MCOs have brought many best practices to the communities they serve.

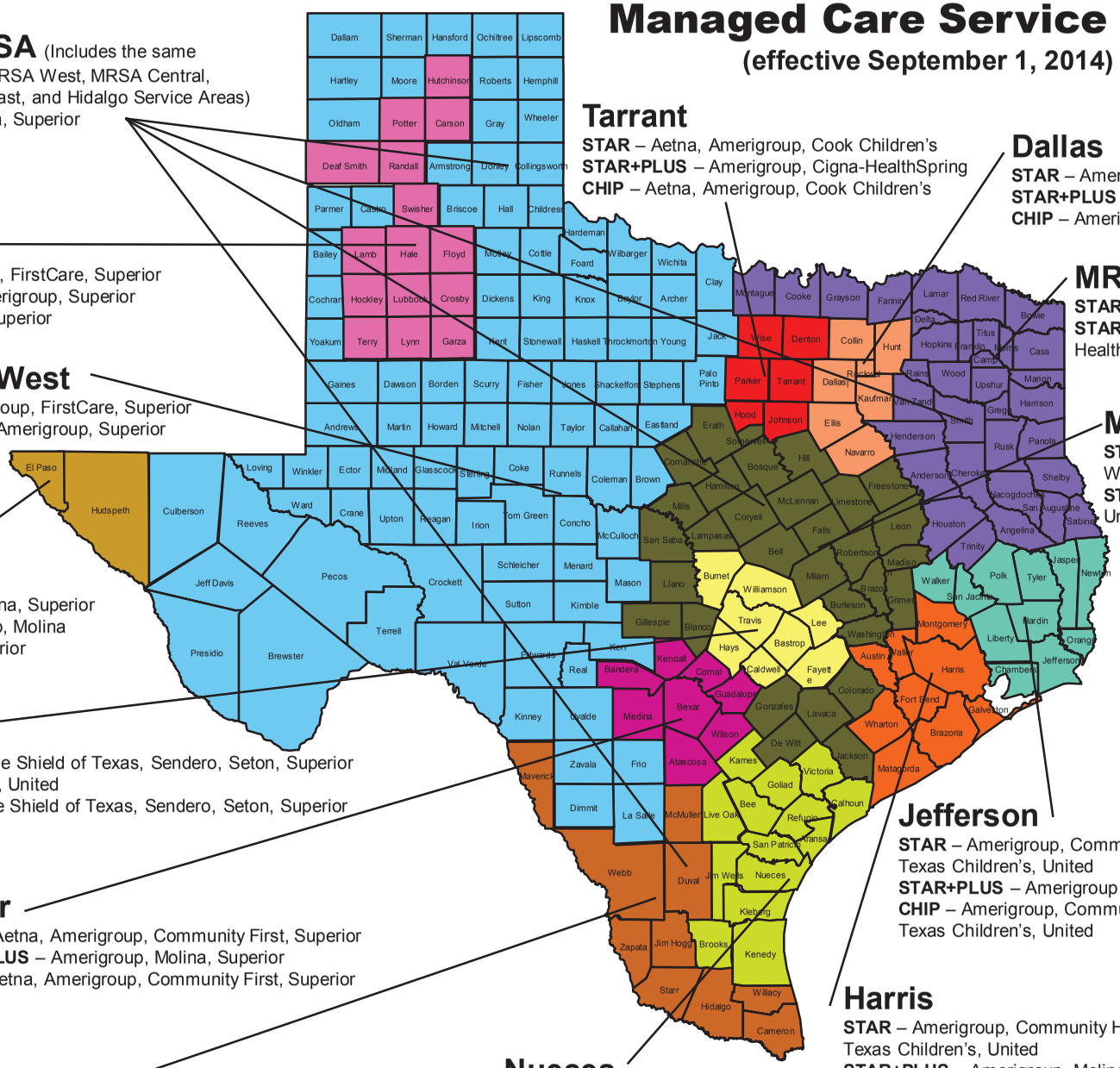
Innovations can occur more easily under a managed care approach because of flexibility to pay for and provide services in different ways. MCOs can use cost savings from keeping persons out of the hospital or emergency department to fund new service delivery approaches that address particular populations like superutilizers or homeless populations.

Map of Texas Medicaid Managed Care Programs

The map on the following page summarizes the Medicaid managed care service delivery areas including the managed care programs and the MCOs delivering services in those areas.

Managed Care Service Areas

(effective September 1, 2014)



CHIP RSA (Includes the same counties as MRSA West, MRSA Central, MRSA Northeast, and Hidalgo Service Areas)

CHIP – Molina, Superior

Tarrant

STAR – Aetna, Amerigroup, Cook Children's
STAR+PLUS – Amerigroup, Cigna-HealthSpring
CHIP – Aetna, Amerigroup, Cook Children's

Dallas

STAR – Amerigroup, Molina, Parkland
STAR+PLUS – Molina, Superior
CHIP – Amerigroup, Molina, Parkland

Lubbock

STAR – Amerigroup, FirstCare, Superior
STAR+PLUS – Amerigroup, Superior
CHIP – FirstCare, Superior

MRSA – Northeast

STAR – Amerigroup, Superior
STAR+PLUS – Cigna-HealthSpring, United

MRSA – West

STAR – Amerigroup, FirstCare, Superior
STAR+PLUS – Amerigroup, Superior

MRSA – Central

STAR – Amerigroup, Scott & White, Superior
STAR+PLUS – Superior, United

El Paso

STAR – El Paso First, Molina, Superior
STAR+PLUS – Amerigroup, Molina
CHIP – El Paso First, Superior

Travis

STAR – Blue Cross and Blue Shield of Texas, Sendero, Seton, Superior
STAR+PLUS – Amerigroup, United
CHIP – Blue Cross and Blue Shield of Texas, Sendero, Seton, Superior

Jefferson

STAR – Amerigroup, Community Health Choice, Molina, Texas Children's, United
STAR+PLUS – Amerigroup, Molina, United
CHIP – Amerigroup, Community Health Choice, Molina, Texas Children's, United

Bexar

STAR – Aetna, Amerigroup, Community First, Superior
STAR+PLUS – Amerigroup, Molina, Superior
CHIP – Aetna, Amerigroup, Community First, Superior

Harris

STAR – Amerigroup, Community Health Choice, Molina, Texas Children's, United
STAR+PLUS – Amerigroup, Molina, United
CHIP – Amerigroup, Community Health Choice, Molina, Texas Children's, United

Hidalgo

STAR – Driscoll, Molina, Superior, United
STAR+PLUS – Cigna-HealthSpring, Molina, Superior

Nueces

STAR – Christus, Driscoll, Superior
STAR+PLUS – Superior, United
CHIP – Christus, Driscoll, Superior

Texas Medicaid Managed Care Organizations Innovations Showcase

Managed care allows for flexibility in developing new models of service delivery that are not permitted in fee-for-service Medicaid. Throughout the report are showcased innovations implemented by the Texas Medicaid MCOs to improve community access to services, reduce unnecessary hospitalizations, improve the quality of members' lives, and pay providers for improved performance.

- **Cigna HealthSpring** implemented an intensive behavioral health intervention that reduces the overall costs for the top 5% most expensive members by 40%. This program serves members with schizophrenia, bipolar disorder, substance abuse disorder, and personality disorder. Its motto is, "Do whatever it takes to allow the member to live as independently as possible".
- **Molina Health Care** members are offered accredited disease management programs to improve quality of life and experience fewer emergency room visits and hospitalizations.
- **Texas Children's Health Plan** identified significant access issues in its population leading to the establishment of TCHP Women and Children's Clinics with the Baylor College of Medicine. These two staff model clinics serve TCHP members exclusively in medically underserved communities.
- 20 counties served by **Driscoll Health Plan** in South Texas have no child and adolescent psychiatrists. Driscoll developed an initiative to better serve their members including education for PCPs in behavioral health concerns in children and convened a joint project with UTMB and Behavioral Health Services of Nueces County (BHSNC) to implement the Tele-Psych Clinic.
- **Parkland Community Health Plan** has collaborated with local community based efforts to improve asthma care for all ages. PCHP initiated home visits by respiratory therapists for the most severe asthmatics; these staff are certified asthma educators who augment traditional telephonic disease management. This program has resulted in statistically significant decreases in ER visits and admissions for asthma.
- **Community First Health Plan** served a 10-year old member with a diagnosis of Bipolar Disorder who has had nine inpatient hospitalizations in 6 months due to aggressive behaviors and suicidal ideation. The member received intensive targeted case management and rehabilitative services and has been closely followed by the health plan RN with subsequent inpatient hospitalization.
- **Superior Health Plan's** Integrated Diabetes Program was implemented in 2011 and focused on care management intervention upon discharge for foster care children with multiple diabetic admissions. This intervention reduced the Diabetes Short-Term Complications Admission rates by 45% and 30-day readmission rates after diabetes-related inpatient stays from 55.7% to 14.1%.
- **Seton Health** partnered with two large PCP groups to use technology to better support members during care transitions and to decrease unnecessary hospital admissions/readmissions and recurring emergency room [ER] visits. Using Seton's access to census information from its system hospitals, these groups receive daily lists of their members with recent hospital admissions, ER visits, and deliveries.
- **Community First Health Plan** has implemented a provider payment incentive program for primary care providers and prenatal care providers. The program pays providers who avoid or reduce potentially preventable expenditures relating to asthma. To date, over 200 providers are enrolled and provide care for 92,043 members.
- **Blue Cross Blue Shield of Texas** has introduced an enhanced payment to providers for post-partum visits. An email from Capital OB/GYN Associates of Texas wrote "I couldn't be more pleased and excited with the news … "
- **UnitedHealthcare** launched an initiative that identifies members who are chronically homeless and assigns a housing case manager to move them to stable housing. Working with ECHO (Austin homeless coalition) and the Houston Homeless Coalition, United Pilot Program will include engagement in housing needs assessment, assignment of a housing case manager, immediate enrollment with PCP, and a dedicated service coordinator.
- **Amerigroup** has implemented a unique In-Home Program that offers in-home medical services including: provider visits, x-rays and laboratory tests and includes monitoring long-term treatment of chronic illnesses such as Diabetes, CHF, COPD and Hypertension. The program greatly benefits Members who may be homebound or have significant barriers to getting to their PCP's office.
- **DentaQuest's** industry leading Preventistry program has increased the number of high-risk children receiving preventive fluoride treatments and sealants. From 2012 to 2013, sealant usage increased 10% while restoration costs dropped by 30% in 2013.

Table 2: Texas Managed Care Enrollment Numbers

STAR Enrollment

Health Plan	Service Area	Enrollment
Aetna Better Health	Tarrant, Bexar	63,357
Amerigroup	Lubbock, MRSA-West, MRSA-Central, MRSA-Northeast, Dallas, Tarrant, Bexar, Harris, Jefferson	519,206
Blue Cross and Blue Shield of Texas	Travis	18,173
CHRISTUS Health Plan	Nueces	6,760
Community First Health Plans	Bexar	94,396
Community Health Choice	Harris, Jefferson	206,785
Cook's Children	Tarrant	84,754
Driscoll Children's Health Plan	Hidalgo, Nueces	111,006
El Paso First Premier Plan	El Paso	56,830
FirstCare STAR	Lubbock, MRSA-West	88,603
Molina Healthcare of Texas	Dallas, El Paso, Hidalgo, Harris, Jefferson	95,151
Parkland HEALTHfirst	Dallas	166,178
Right Care from Scott and White Health Plans	MRSA-Central	38,083
Sendero Health Plans	Travis	10,149
Seton Health Plan	Travis	13,211
Superior HealthPlan	Lubbock, MRSA-West, MRSA-Central, MRSA-Northeast, El Paso, Travis, Bexar, Hidalgo, Nueces	657,408
Texas Children's Health Plan	Harris, Jefferson	283,358
UnitedHealthcare Community Plan	Hidalgo, Harris, Jefferson	104,816
Total		2,618,224

STAR+PLUS Enrollment

Health Plan	Service Area	Enrollment
Amerigroup	Lubbock, MRSA-West, Tarrant, El Paso, Travis, Bexar, Harris, Jefferson	118,647
Cigna-HealthSpring	MRSA-Northeast, Tarrant, Hidalgo	25,121
Molina Healthcare of Texas	Dallas, El Paso, Bexar, Hidalgo, Harris, Jefferson	90,780
Superior Health Plan	Lubbock, MRSA-West, MRSA-Central, Dallas, Bexar, Hidalgo, Nueces	111,301
UnitedHealthcare Community Plan	MRSA-Central, MRSA-Northeast, Travis, Nueces, Harris, Jefferson	66,094
Total		411,943

Medicaid and CHIP Dental Services Enrollment

DentaQuest	1,436,397
MCNA Dental	1,155,053
Total	2,591,450

STAR Health Enrollment

Superior Health Plan	31,087

Chapter 1
Overview of Managed Care in Texas

Medicaid managed care plans serve more than 3 million Texans and almost 85% of all Texans enrolled in Medicaid.

Texas uses several risk-based capitated managed care programs for Medicaid populations that include children, pregnant women, seniors and persons with physical, behavioral, and intellectual and developmental disabilities.

Medicaid managed care programs include STAR, STAR+PLUS, STAR Health, NorthSTAR, STAR Kids and Dental MCO.

Medicaid managed care has consistently improved the health status of its members via increased access to care, service coordination and innovative programs.

Expanding Medicaid managed care has been a key Texas strategy for improving its Medicaid program.

Medicaid is a joint federal and state program that provides health care and long-term services and supports (LTSS) for nearly 70 million people in the United States including pregnant women, children, adults, and individuals with disabilities regardless of age. Nearly 3.7 million Texans receive coverage for medical care and LTSS through Medicaid, including over 57 percent of the births in our state.

Texas continually focuses on improving its Medicaid program to improve the health status of Texans through increased access and care coordination while effectively controlling costs. Expansion of Medicaid managed care has been critical to achieving these goals.

Medicaid Fee-for-Service

In 1967, Texas began administering its Medicaid program exclusively as a fee-for-service (FFS) service delivery model for all of its acute services and LTSS. FFS is also referred to as Traditional Medicaid. In FFS, the state contracts directly with health care and LTSS providers and reimburses them directly for each service delivered. Texans with Medicaid FFS can receive services from any doctor, specialist or LTSS provider that is willing to accept Medicaid reimbursement without a referral. However, they often have difficulty finding a doctor/provider and are not required to have a PCP or medical home because there is no guaranteed network of doctors and providers. Providers are paid based on the volume of services provided (not the value of those services) and there is no formalized internal review of delivered services. Also, FFS does not guarantee an appointment within a certain timeframe or have any accountable, quantifiable quality measures.

With Medicaid enrollment growing, Texas considered other service delivery models that would enhance access to doctors/providers, coordinate services, improve overall quality, and help ensure the sustainability of the program.

Medicaid Managed Care

Texas Medicaid has used two types of managed care: Risk-based capitated managed care and Primary Care Case Management (PCCM). PCCM was used as an early model in the development of the managed care approach. The PCCM model was discontinued in favor of risk based capitation.

Overview of Texas Medicaid Managed Care Programs

Texas has implemented a number of risk-based capitated managed care programs for the various Medicaid populations and Medicaid services. The Medicaid managed care programs include STAR, STAR+PLUS, STAR Health, NorthSTAR, STAR Kids and Dental Managed Care. An overview of each of these programs is included on the following page.

Table 3: Comparing FFS and Capitated Managed Care

	Fee for service	Risk-based Capitation
Program	Traditional Medicaid	STAR STAR+PLUS STAR Health STAR Kids Dental MCO
Overview	Non-capitated, non-risk model with no care or service coordination	Capitated, risk-based model where the MCOs are held responsible for health and LTSS outcomes and the overall cost of the service plan Includes specified service coordinators
Provider Contracting	Providers contract with the state	Providers contract with the managed care organization
Reimbursement	Providers are reimbursed according to FFS rates established by the state for each service	Providers are reimbursed a negotiated rate between the MCO and provider
Provider Network and Referrals	Medicaid beneficiaries must find their own doctors and other service providers that will accept Medicaid Self-referrals allowed	Medicaid MCO members choose a PCP and must receive referrals for certain types of specialists Must see in-network providers unless authorized for out-of-network services

STAR is Medicaid managed care for children, newborns, pregnant women and some families and children.

STAR

STAR (State of Texas Access Reform) is Texas' largest Medicaid managed care program and serves children, newborns, pregnant women, and some families. STAR provides risk-based, capitated Medicaid coverage for primary and acute medical services. In 1993, STAR was implemented in selected locations of the state and continually expanded until, as part of the Medicaid 1115 transformation waiver, the Centers for Medicare and Medicaid Services (CMS) approved the statewide expansion of STAR in 2011.[1] As of 2014, more than 2.6 million Texans are enrolled in STAR.[2]

STAR MCOs emphasize preventive health care in order to keep members healthy and reduce utilization of more costly care. PCPs play an essential role by providing a medical home for each STAR member. The PCP coordinates medical care and referrals to specialty care when needed. STAR members receive the same benefits as FFS enrollees as well as additional value-added services provided by MCOs. Value-added services are not included in the capitation rate, but MCOs provide additional preventive care services such as extra vision and transportation services, 24 hour nurse lines, health and wellness care classes, gym memberships or sports physicals. These extra value-added services help improve members' health while simultaneously generating savings for the MCOs and ultimately the Medicaid program.

STAR+PLUS provides acute, primary, behavioral health and LTSS to seniors and persons with disabilities and provides medical services to persons with IDD.

STAR+PLUS

In 1995, the Texas Legislature directed the creation of STAR+PLUS, a risk-based capitated managed care product that integrates acute care and LTSS for seniors and for persons with a physical disability 21 years and older. The goal of integration was to create a cost-effective, coordinated service delivery model that improves access to services and emphasizes preventive health and community based service and supports. Care coordination and integration can be particularly impactful for this population, who are generally heavy utilizers of healthcare and community support services. In 1998, STAR+PLUS began as a pilot program with 55,000 enrollees in Harris County. Over the next 16 years, the program expanded and became statewide in 2014 with close to 500,000 managed care members.

STAR+PLUS MCOs provide and coordinate both acute care and LTSS for STAR+PLUS members who are eligible for Medicaid only. Many in the STAR+PLUS eligible population are dually eligible for Medicare and Medicaid. For dually-eligible individuals, Medicare provides and pays for acute care services while the STAR+PLUS MCOs coordinate and provide LTSS.

Service Coordinators. STAR+PLUS MCOs employ service coordinators who work with members, their families and support systems to develop an individualized plan of care that integrates the member's medical, behavioral, and LTSS services. Service coordinators assess the member's needs and then initiate a care plan that best meets the needs of the member. Often, service coordinators will authorize non-Medicaid services that will improve the member's health or functioning on a case-by-case basis. For example, service coordinators commonly facilitate obtaining and installing air conditioners for asthmatic members or other members whose healthcare would otherwise be compromised by the summer heat.

No waiting list for Nursing Facility Waiver Services. Individuals participating in STAR+PLUS with a nursing facility level of need are able to access the former Community Based Alternatives (now called STAR+PLUS Waiver) services without a waiting list. As a result, many more Texans have avoided costly institutions and receive services and supports where they live.[3] These results are discussed more thoroughly in Chapter 3, Access to Care.

New Initiatives within STAR+PLUS. As the state continues to expand managed care, STAR+PLUS remains at the center of many of these new initiatives. In September 2014, individuals with intellectual and developmental disabilities (IDD) were "carved-in" and now receive acute care services through STAR+PLUS. In March 2015, individuals residing in a nursing facility will receive full Medicaid coverage under STAR+PLUS. Also planned for March 2015 is implementation of the Dual Eligible Demonstration together with CMS. Individuals eligible for both Medicare and Medicaid will be enrolled in the same plan for all their health and support care services. The demonstration will allow Texas to share in the Medicare savings generated by keeping dual eligibles out of the hospital and emergency room by providing better services in the community. The demonstration will be implemented in six counties.

STAR Health serves over 31,000 children statewide in foster care through one MCO.

STAR Health

STAR Health is a statewide risk-based capitated Medicaid managed care program designed to address the healthcare needs of children and young adults in foster care and beyond by delivering integrated physical and behavioral health services, centralized service management and service coordination, and effectively managed healthcare data and information for children in foster and kinship care. The children and young adults in STAR Health have many physical, developmental, and mental health needs that may result from or be exacerbated by other issues such as parental neglect, abuse, parental substance abuse or mental illness, and unstable family care.[4] The goal is to give each of these children and young adults healthcare services that are coordinated, comprehensive, easy to find, and uninterrupted when the child moves. The 79th Texas Legislature passed S.B. 6 in 2005 which directed HHSC and the Department of Family and Protective Services (DFPS) to develop a statewide health care delivery model for all Medicaid children in foster care. STAR Health was implemented on April 1, 2008.

Children and young adults eligible to participate in STAR Health are (1) children and young adults in DFPS conservatorship, (2) young adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement, (3) young adults aged 18 through the month of their 21st birthday who are participating in the Former Foster Care Children (FFCC) program or are participating in the Medicaid for Transitioning Foster Care Youth (MTFCY) Program due to ineligibility for the FFCC program, and (4) young adults aged 21 through the month of their 23rd birthday who are participating in the Former Foster Care for Higher Education (FFCHE) Program due to ineligibility for the FFCC program.

The STAR Health MCO provides members with comprehensive and integrated physical health, behavioral health, vision, and dental benefits. STAR Health members also receive service coordination, service management, and value-added services as well as a 24/7 nurse hotline for foster care parents, caregivers and caseworkers. Moreover, the STAR Health MCO, Superior Health Plan, provides a web-based electronic health record called Health Passport, which allows users to view key member contacts as well as a member's allergies, medications, medical and behavioral health (BH) service history over the entire span of a member's participation in STAR Health (and up to two years of the member's claims history in other HHSC programs), lab results, service plans (including initial and updated Healthcare Service Plans (HCSP), Psychotropic Medication Utilization Reviews (PMUR), and other clinical information. Through role-based access, the secure information in Health Passport can be accessed by health care providers, caregivers, medical consenters, and Department of Family and Protective Services (DFPS) staff, as authorized. Health Passport facilitates continuity of care as children in foster care transition between placements. As of September 2014, approximately 31,000 children in foster care are enrolled in STAR Health.[5]

STAR Kids

STAR Kids will serve children on SSI and other children with disabilities beginning September 2016.

In 2013, S.B. 7 expanded managed care for a new population. STAR Kids will launch in September 2016 as a statewide, risk-based capitated comprehensive managed care program serving children and youth with disabilities who receive SSI and children who receive Medicaid benefits through the Medically Dependent Children Program. STAR Kids will provide comprehensive benefits including primary and specialty care, hospital care, prescription drugs, preventive care, and personal care services. STAR Kids will also include LTSS state plan services such as personal care services, private duty nursing, and behavioral health services. STAR Kids will provide extensive service coordination to best integrate benefits and enhance continuity of care and access to health care and community based services.

STAR Kids is expected to: 1) improve quality and continuity of care, 2) improve access to care through the use of health homes, 3) prepare youth for adulthood, 4) improve coordination of care, and 5) realize cost-effectiveness and cost-containment.

Children enrolled through other DADS 1915(c) waiver programs will receive acute care through STAR Kids. Currently, HHSC is evaluating proposals from plans who desire to participate in STAR Kids.

NorthSTAR

NorthSTAR provides behavioral health and substance abuse services to almost 400,000 persons in Dallas and contiguous counties.

NorthSTAR is a publicly-funded managed care program that delivers mental health and chemical dependency services to the eligible residents of Dallas, Ellis, Collin, Hunt, Navarro, Rockwall and Kaufman counties. NorthSTAR is administered by the Department of State Health Services (DSHS). It provides a comprehensive mental health/substance abuse benefit package for all eligible individuals, and access to benefits is determined by clinical need, not funding source. The programs covers both Medicaid eligible and low-income persons that meet certain eligibility requirements.

The state contracts with one behavioral health organization (BHO) to manage member services. Members may choose any appropriate contracted provider for their behavioral healthcare needs. The North Texas Behavioral Health Authority serves as the local behavioral health (mental health and substance abuse) authority for the entire NorthSTAR service area, and its functions include planning, oversight, single portal authority functions, as well as a local problem solving resource that includes ombudsman services.

There are no plans to expand NorthSTAR as the direction has been to integrate physical and behavioral health services within a single MCO to facilitate better coordination and service delivery.

Dental Managed Care

Dental Services for children in Medicaid and CHIP are provided through two Dental Managed Care Organizations.

Under the provisions of the Texas 1115 Waiver, effective March 1, 2012, HHSC changed the service delivery model for Medicaid dental services from a FFS model to a capitated managed care model. Most children and youth age 20 and younger eligible for Medicaid or CHIP receive dental services through a managed care dental plan. Texas currently contracts with two dental plans that

provide services across the state.

General or pediatric dentists or federally qualified health centers (FQHCs) contract directly with the Dental MCOs to serve as a dental home to eligible children/youth. The dental home is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referrals for care.

HHSC Rider 54, 82nd Legislature, Regular Session, 2011 required that HHSC evaluate the impact of providing dental services through a capitated managed care model. The report *Capitated Managed Care Model of Dental Services Report*[6] noted a decrease in dental utilization after implementation of the Dental MCO, however most was attributed to the significant drop in orthodontics, which was to be expected given the previous problems with over-authorization of this service.[7] The report also noted "premium levels have remained constant and HHSC has achieved cost savings related to the implementation of a Dental MCO service delivery model. In addition to the cost savings, the State of Texas has realized increased revenues due to the premium tax revenue collected from Dental MCOs for the 2012 corresponding time period. The tax revenues received and cost savings achieved have made the rollout of the Dental MCO system a success."

CHIP Coverage

CHIP covers children in families who have too much income or too many assets to qualify for Medicaid.

The Children's Health Insurance Program (CHIP) covers children who do not qualify for Medicaid but whose families cannot afford private insurance. To qualify for CHIP, children must be under age 19, uninsured for at least 90 days, have family income at or below 200% FPL and live in a family that passes an asset test if family income is above 150% FPL. As of August 2013, CHIP covered more than 600,000 children in Texas but that dropped down to 350,000 a year later as the ACA directed that children up to 133% FPL be covered by Medicaid.

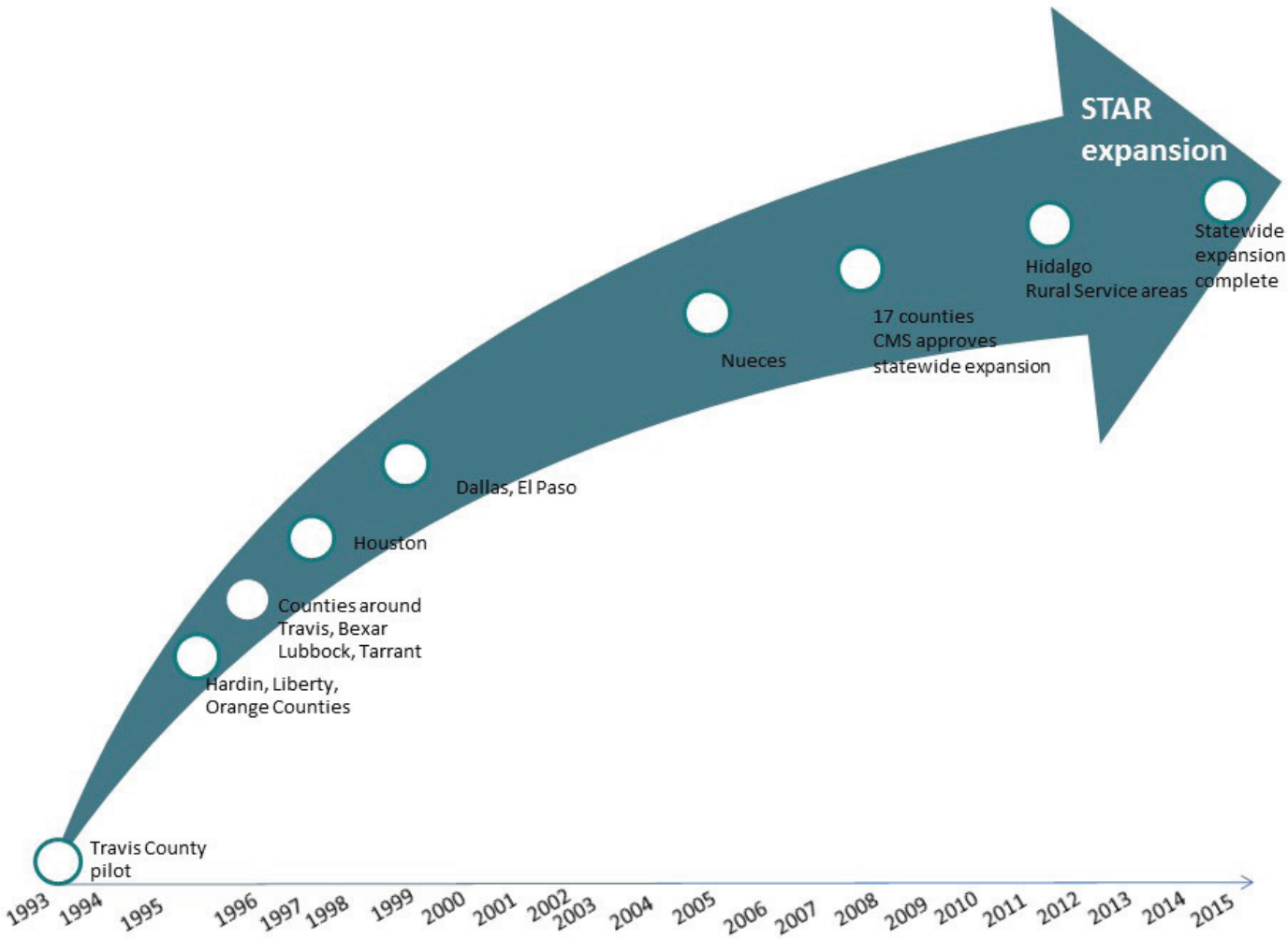
Like Medicaid, CHIP is jointly funded between the state and federal government. The federal matching rate for CHIP is higher than Medicaid. For FY14, Enhanced Federal Medical Assistance Percentage for CHIP was 71.04% versus 58.69 for regular FMAP for Medicaid.

CHIP Members Cost Share. Most CHIP families pay an annual enrollment fee of either $30 or $50 to cover all children in the family. CHIP also requires co-pays up to $75 on a sliding scale for doctor visits, prescription drugs, inpatient hospital care, and non-emergency care provided in an emergency room setting.

History of Managed Care in Texas

Currently, most of the state's Medicaid populations are enrolled in capitated managed care. Texas continues to expand Medicaid managed care to cover additional services and populations as a key strategy to improve access, quality and sustainability. In order to understand the critical role of managed care in improving the Texas Medicaid program, the following section covers the state's history of managed care from its inception (1993) to the most recent statewide managed care expansion plans (2014).

Chart B: STAR Expansion 1993-2014



The Early Years

In order to improve quality and access to care while controlling rising costs, the Texas Legislature directed the HHSC to implement a cost-effective delivery model for pregnant women and children (the Temporary Assistance for Needy Families population) in Medicaid in 1991. The Legislature approved managed care pilot programs in several areas of the state which was named the STAR (State of Texas Access Reform) program. The STAR initiative implemented capitated Medicaid managed care in Travis County for acute care services. The state also began a Primary Care Case Management (PCCM) pilot in Chambers, Jefferson, and Galveston Counties. Based on these initial successes, additional managed care pilots added Hardin, Liberty, and Orange counties. Beginning in 1995, STAR continued to expand to urban areas, including Bexar, Lubbock, Tarrant and Harris County service areas.

Based on the STAR program's success in improving access, the 74th Legislature (1995) directed the HHSC to expand managed care for the aged, blind and disabled (ABD) Medicaid population. These Medicaid populations were

traditionally excluded from managed care or "carved out" and served through FFS. Texas sought to bring these individuals into managed care for both their acute care and LTSS through the STAR+PLUS capitated managed care program. In 1998, STAR+PLUS was launched as a pilot program for the aged and disabled in Harris County. During this time, the state continued its STAR program expansion into the Dallas and El Paso areas.

In 1999, the Legislature placed a moratorium on the expansion of managed care. It directed HHSC to evaluate managed care's impact on cost, quality, and access to care. This evaluation, known as the Medicaid Managed Care Report[8], covered a 15 month period between 1999 and 2000, and demonstrated favorable outcomes regarding provider access, cost savings, and member satisfaction.

Medicaid Managed Care Expansion Increases

Based on the favorable outcomes published in the Medicaid Managed Care Report, the state resumed managed care expansion in 2001.[9]

In 2003, the Legislature directed HHSC to implement managed care using the PCCM model in the nearly 200 rural counties that did not have a capitated managed care model. In 2005, PCCM expanded its presence into the remaining counties and entered into a number of STAR counties in the Southeast Region. During this period, every county had STAR, PCCM or both.

The Texas Legislature (in 2005) also began examining the challenges faced by children in foster care. Children in foster care often experience more trauma resulting in more complex needs.

In 2006, Texas began shifting to capitated managed care when an external evaluation showed it was a more cost-effective choice.[10] By December 2006, PCCM was available only in the Southeast Region—Jefferson, Chambers, Orange, Hardin, and Liberty counties. In the same year, Texas expanded STAR to the Nueces service area.

Additionally, foster care children often move several times and do not establish a sense of permanence. FFS does not provide the care and service coordination that makes a difference to this population and thus, the 79th Legislature directed HHSC to develop a delivery model that comprehensively met the health needs of children in foster care. In April 2008, STAR Health was implemented to serve children and youth in foster care.

Issue with Hospital Supplemental Payments and Managed Care. In 2007, hospital providers expressed concern with the further expansion of STAR+PLUS due to potential loss of significant supplemental federal funds. This supplemental reimbursement program (known as upper payment limit or UPL program) was vital to hospitals. The move to managed care threatened many of these supplemental FFS payments. While the State proposed expanding STAR+PLUS, hospital systems raised concerns regarding the loss of supplemental payments for hospital services. As a result, the 80th Legislature (2007) directed HHSC to "carve-out" hospitals from STAR+PLUS.

In September 2011, STAR expanded to 17 additional counties while STAR+PLUS expanded to 10 additional counties. Both programs also expanded into the newly established Jefferson service area.

Statewide Expansion

The state of Texas significantly changed its Medicaid program in 2011 with its approved 1115 Medicaid Transformation Waiver. The 1115 Transformation waiver is complex and provides the state with many opportunities: allows for hospitals to be carved back into managed care by preserving supplemental funding; it creates short-term dedicated funding for innovative demonstration pilots; it changed the STAR+PLUS program from a (b)(c) waiver structure to the 1115 waiver which provides additional flexibility; and allowed for the further expansion of managed care. Additionally, HHSC eliminated PCCM and replaced it with STAR in a separate action in 2011.

In 2012, Texas underwent its largest expansion of Medicaid managed care. The following activities occurred: (1) STAR expanded into two new regions, Hidalgo and the Medical Rural Service Areas, effectively implementing STAR statewide; (2) STAR+PLUS expanded into El Paso, Lubbock and Hidalgo Service Areas; and (3) Texas implemented a statewide model for managed Medicaid dental services for children and carved pharmacy services into managed care.

The 83rd Legislature continued to expand the state's managed care programs with S.B. 7 and 58 (83rd Legislature, Regular Session, 2013). S.B. 7 made comprehensive changes to the managed care system especially in the area of quality requirements. S.B. 58 required the carve-in of mental health targeted case management and mental health rehabilitation services into managed care.

As directed by S.B 7, STAR+PLUS was expanded statewide on September 1, 2014. This expansion includes not only additional geographic regions, but includes additional populations. Medicaid-eligible Texans with intellectual and developmental disabilities (IDD) began receiving acute, primary and behavioral health services through the STAR+PLUS program in 2014. The goal is to improve the quality of care and promote care in the least restrictive, most integrated setting. Approximately 56,800 nursing facility residents will transition to STAR+PLUS.

To assist with the transition for nursing facility providers, S.B. 7 requires MCOs to pay claims no later than ten calendar days after the submission of a clean claim. The MCO's clean claim criteria will meet the criteria currently used by DADS. HHSC will set the minimum reimbursement rate paid to nursing facilities under STAR+PLUS, including the staff rate enhancement. HHSC will establish a portal through which nursing facilities may submit claims to participating MCOs. Providers may choose to utilize the MCOs' claims portals as well. And, unlike the standard MCO 95-day filing deadline, nursing facilities will continue to have a one year claims filing deadline.

STAR Kids

S.B. 7 directed HHSC to implement a Medicaid managed care program for children and young adults with disabilities, including children and youth under age 21 who receive SSI or home and community-based waiver services. STAR Kids will provide services for those enrolled in the Medically Dependent Children Program and Texas State Plan services for those enrolled in other 1915(c) waiver programs. STAR Kids will eventually incorporate all services provided through the Youth Empowerment Services (YES) waiver. Services not provided through STAR Kids include nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and children with SSI in foster care will continue to receive services through STAR Health.

The STAR Kids program will be implemented on September 1, 2016. Because it is so critical to have significant outreach and preparation by the MCOs to serve this population, the Request for Proposal responses have already been submitted by health plans.

Pilot programs for IDD Home and Community Based Waiver

S.B. 7 required HHSC to test capitated service delivery models for provision of Intermediate Care Facility and Home and Community Based waiver services to provide integrated service coordination together with acute care services. The pilot providers must have a process in place to prevent inappropriate institutionalizations and accept the financial risk of failure. Participation in the pilots by persons with IDD will be voluntary.

Community First Choice

Beginning June 1, 2015, STAR+PLUS and STAR Health plans will provide personal attendant and habilitation services for people with disabilities under the federal option called Community First Choice. Individuals on a 1915(c) waiver interest list and others who meet eligibility and coverage requirements will receive community based services including: personal assistance with activities of daily living, habilitation services to help the individual learn how to care for themselves, emergency response systems to alert others when there is a medical need, and support for consumer directed services.

Medicare-Medicaid Integration Demonstration

Under the CMS Financial Alignment Demonstration, Texas is one of 15 states that have been approved to integrate Medicare and Medicaid funding for dual eligibles. Beginning in March 2015, the demonstration will be implemented in 6 Texas counties.

The objectives of the demo are to (1) promote member independence in the community, (2) eliminate cost shifting between Medicare and Medicaid, and (3) allow the state to gain share Medicare savings realized through improvements in care coordination and prevention of unnecessary ER and inpatient hospital admissions. The demonstration project will cover six counties:

Geographic Area for Medicare-Medicaid Demonstration

Counties	Number of Members	Health Plans
Bexar	26,452	Amerigroup, Molina, Superior
Dallas	27,941	Molina, Superior
El Paso	19,645	Amerigroup, Molina
Harris	47,160	Amerigroup, Molina, United
Hidalgo	27,090	Health Spring, Molina, Superior
Tarrant	16,986	Amerigroup, Health Spring

The dual eligible members are already enrolled in the MCOs for their Medicaid benefits. In March 2015 they will be enrolled into the same plan for their Medicare benefits. Members can opt out of the Medicare enrollment at any time. Chart C below and Table 4 on the following page show how managed care enrollment has grown with each managed care expansion.

Chart C: Managed Care Enrollment 1993-2015

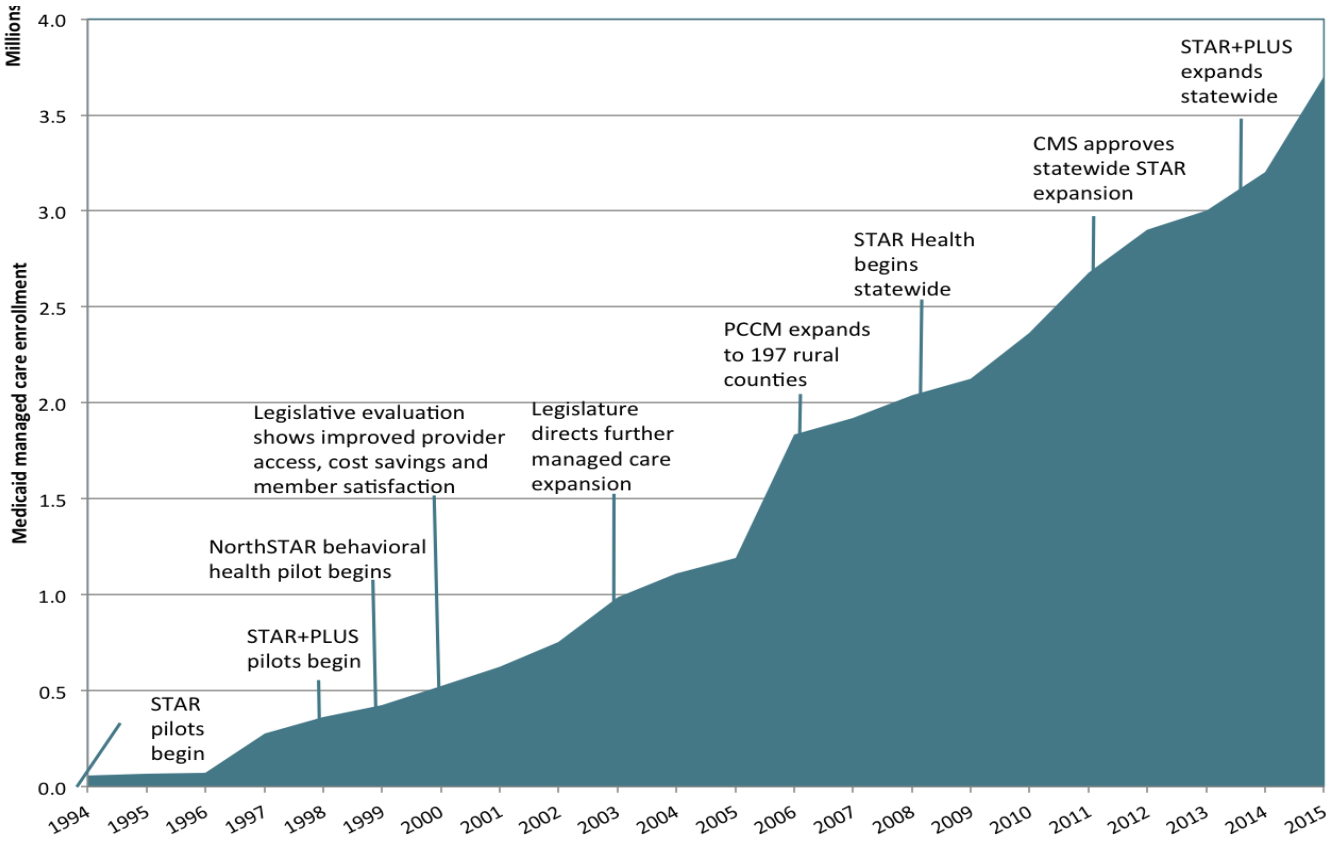


Table 4: Medicaid Clients Enrolled in Managed Care: SFYs 1994-2015

	Service Areas and Implementation Dates	Managed Care Enrollment	% in Managed Care
1993	STAR Implementation: Travis County (8/93) & Tri-County Area (12/93)	58,243	2.86%
1995	Same as above	65.388	3.16%
1996	Travis County and SE Region (Tri-County expanded to 3 additional counties 12/95	71,435	3.46%
1997	Travis (9/96), SE Region, Bexar (9/96), Lubbock (10/96), Tarrant (10/96)	274,694	13.82%
1998	Same as above, with Harris STAR (12/97) and Harris STAR+PLUS (3/98)	364,336	19.56%
1999	Same as above, with STAR expansion to Dallas (7/99)	425,069	23.45%
2000	Same as above, with STAR expansion to El Paso (12/99)	523,832	28.98%
2001	Same as above	623,883	33.35%
2002	Same as above	755,698	35.92%
2003	Same as above	988,389	39.71%
2004	Same as above	1,112,002	41.44%
2005	Same as above	1,191,139	42.86%
2006	Same as above, STAR expansion to 197 counties (PCCM Only)	1,835,390	65.74%
2007	Same as above, with STAR MCO expansion to Nueces (09/2006) and STAR+PLUS expansion to Bexar, Travis, Nueces, and Harris Contiguous (02/2007). Urban areas shift from PCCM to MCO Only (12/2006)	1,921,651	67.85%
2008	Same as above, with ICM rollout in Dallas and Tarrant (Aged & Disability-Related Clients) (02/2008) and STAR Health Foster Care Managed Care rollout statewide (04/2008)	2,039,545	70.88%
2009	Same as above, but with ICM removed in May 2009	2,127,382	71.81%
2010	Same as above	2,362,091	71.66%
2011	Same STAR+PLUS expansion to the Dallas and Tarrant Service Areas (2/2011)	2,676,149	75.57%
2012	Pharmacy benefit added into managed care (3/2012) Dental Services for enroollees under the age of 21 added into managed care STAR expansion statewide (3/2012) STAR+PLUS expansion to all areas of the state except for Medicaid rural service areas (MRSA) (3/2012)	2,893,965	79.16%

Table 4 Continued: Medicaid Clients Enrolled in Managed Care: SFYs 1994-2015

	Service Areas and Implementation Dates	Managed Care Enrollment	% in Managed Care
2013	Same as above	2,982,923	81.53%
2014	STAR+PLUS expansion statewide and IDD acute care benefits transitions into program (9/2014)	3,012,262	80.40%
2015/2016	Same as above, with nursing facility services transitioning into STAR+PLUS (3/2015) Dual demonstration implementation (3/2015) STAR Kids and IDD pilot programs implementation (9/2016)	3,627,616	86.69%

Sources: HHSC, Financial Services. Average Monthly Recipient Months including STAR, STAR+PLUS, PCCM, ICM and STAR Health.

Chapter 2
Value Based Purchasing

Value Based Purchasing is a demand side strategy to contract, measure, report, and reward excellence in health care delivery.

Texas is a national leader in VBP strategies for Medicaid managed care.

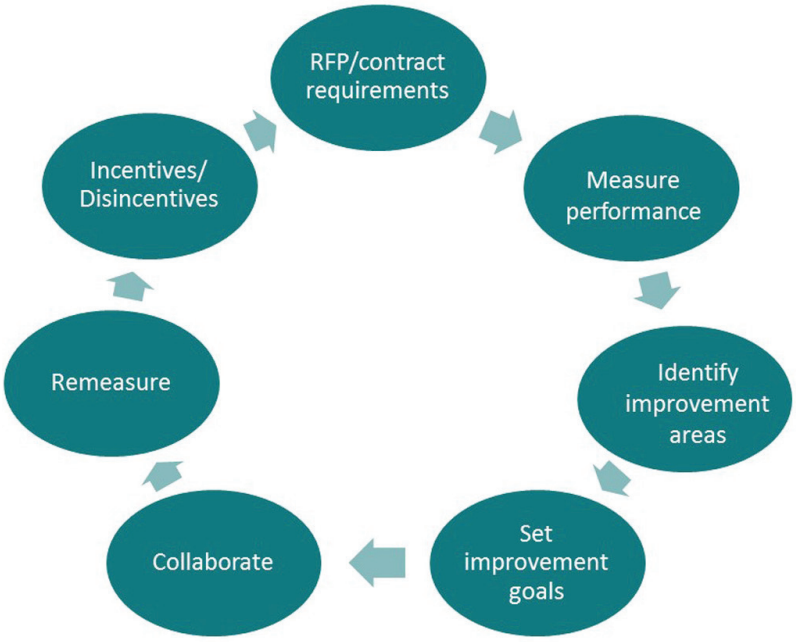
MCOs must earn a portion of their capitation rate by meeting quality performance measures.

Value based purchasing (VBP) is a demand side strategy to contract, measure, report, and reward excellence in health care delivery. As one of the largest health care payers in the state, the Texas Medicaid program is in a powerful position to help drive improvements as a purchaser. Effective value-based purchasing is an external motivator for providers to lead continuous improvement in health care delivery. Texas is recognized nationally for its VBP strategies in Medicaid managed care.

HHSC implemented the Experience Rebate program in late 1990s prior to the emergence of value based purchasing concepts. The Experience Rebate program provides a protection from excess profits being earned and ensures that the value of the state's investment in managed care is protected. Texas' implementation of 'profit-sharing' was a unique and forward thinking feature that continues in effect today, in addition to the Value Based Purchasing program.

Texas was one of the first state Medicaid managed care programs to implement VBP principles into its MCO contracts. Particularly with Texas' blend of both local and national MCOs, the VBP ensures that multi-state MCOs remain focused on key performance metrics in Texas throughout the contract period. Chart D below depicts the VBP process with its continuous cycle of quality improvement initiatives and goal attainment measurement.

Chart D: Value-Based Contract Requirements Specify Purchasing Goals and MCO Accountability



VBP starts during the Request for Proposal stage when the State clearly defines its expectations that MCOs will be held accountable for their performance through improvement collaboration and the application of incentives and disincentives.

Texas Medicaid Managed Care contracts are lauded by the Centers for Medicare and Medicaid (CMS) as a model managed care contract. CMS often refers other states to the Texas HHSC website to review the managed care contracts and the Uniform Managed Care Manual (UMCM) as "best-practices" to use when establishing their own managed care programs. The contract focus is on accountability for all aspects of the delivery of quality healthcare to members. The contracts include measureable standards that are monitored on an on-going basis including metrics for:

- network adequacy
- timely claims payment
- timely access to care
- outreach to members for preventive and follow-up care
- identification of areas for quality improvements
- cultural competency
- care management and continuity of care
- intensive service coordination for STAR+PLUS members
- provider incentives including pay-for-performance
- quality assurance and performance improvement
- integration of physical, behavioral and LTSS
- person-centered care planning

Performance Measurement

Performance Indicator Dashboards. Key MCO performance measures are summarized on the Performance Indicator Dashboard. The Dashboard is posted on the HHSC website and includes minimum threshold standards as a means to gauge performance. MCO performance data on these measures has been posted on the HHSC website.

Managed Care Organization Report Cards. HHSC has developed report cards to help guide consumers in selecting MCOs based on relevant performance on outcome and process measures.

Member Survey Reports. The Medicaid managed care external quality review organization (EQRO) conducts member surveys using validated and nationally accepted instruments, including the CAHPS® surveys, the Experience of Care and Health Outcomes survey, and the Medicare Health Outcomes Survey. The survey results are captured and compared with prior survey results and against state and national benchmarks for performance. It is important that members' perspectives about their experiences with care are reported back to the MCOs. The EQRO publishes annual comprehensive reports that are distributed to stakeholders and posted on the HHSC website. Many of the results are summarized and used as part of the MCO report card available to consumers.

Setting Improvement Goals

Performance Improvement Projects. The EQRO recommends topics for performance improvement projects based on MCO performance results, data from member surveys, administrative and encounter files, medical records, and the immunization registry. HHSC selects two of these topics which become projects that enable each MCO to target specific areas for improvement that will affect the greatest numbers of members.

Quality Assessment and Performance Improvement. Each MCO develops and operates a Quality Assessment and Performance Improvement Program that meets state and federal requirements and is based on Continuous Quality Improvement/Total Quality Management principles.

Texas Healthcare Learning Collaborative. The Texas Healthcare Learning Collaborative is a secure web portal designed and run by the EQRO. The Portal provides opportunity for MCOs, HHSC, and the EQRO to review and share healthcare metrics. Users are also able to access the portal and generate graphical reports of plan and program specific performance.

Improvement Initiatives

The top 5% of the Medicaid population account for over 50% of the expenditures.

Superutilizers. MCOs are adding new initiatives to address their most high cost and high needs members also known as "superutilizers". Superutilizers are responsible for the majority of health care expenditures. MCOs are implementing high touch programs that take the care to the member where they live to prevent unnecessary emergency room visits and inpatient stays.

Alternative Provider Payment Structures. MCOs are implementing alternative provider payment structures that focus on quality, not volume. These structures include pay-for-performance, shared savings, and bundled payment initiatives. A couple of the many examples provided by the MCOs are highlighted on the following page.

Potentially Preventable Events (PPEs). Potentially preventable events include inpatient stays, hospital readmissions, complications of care, and emergency department visits that may be avoidable if the patient receives appropriate primary and preventive care prior to or after the event in question. MCOs are working with their provider networks to reduce the occurrence of PPEs including the following types of PPEs.

Potentially Preventable Admissions: These events are considered an indicator of poor availability, accessibility, and effectiveness of primary care. MCOs can help identify persons that are "frequent flyers" to hospitals and emergency departments, help them get to their PCP and provide community based services to keep them healthy and address any chronic conditions.

Potentially Preventable Readmissions: Potentially preventable readmissions to the hospital are an indication of inadequate aftercare and can be very costly. Studies indicate that individuals eligible for Medicaid services are 70 percent more likely than people with private insurance to have had an inpatient readmission.

Innovation: Paying for Performance Makes a Difference

Community First Health Plans (CFHP) has served San Antonio Medicaid members for nearly 20 years and has developed initiatives to improve quality indicators by targeting provider engagement through incentives. CFHP has implemented a provider payment incentive program for primary care providers and prenatal care providers. The program will pay providers who are able to avoid or reduce potentially preventable expenditures relating to asthma. The program began in January 2014 and payments for improved performance will be made in 2015. To date, over 200 providers are enrolled and these providers care for 92,043 members. In addition to payments for successful results, CFHP intends to identify and share 'best practices' with all providers – particularly relating to reducing ER use – to improve for all members.

Innovation: Obstetrics Payment Reforms Motivates Providers

Blue Cross Blue Shield of Texas has introduced an enhanced payment to providers for post-partum visits. The following is excerpted from an 11/26/2014 email from Capital OB/GYN Associates of Texas which expressed their support of the new program as follows:

> "I couldn't be more pleased and excited with the news …
> The post-partum visit is an important element in the care of our families as they transition and for our women. … for the first time in my career, my practice was forced to look at the financial metrics in terms of whether we could even afford to offer care to Medicaid patients. Thank you for listening, considering and being a proactive leader."

Potentially Preventable Emergency Department Visits: Medicaid members historically have used the ED for services that should be treated by a PCP. MCOs help direct members to their PCP or offer after-hours care for members with ambulatory care sensitive conditions, such as asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and hypertension.

Potentially Preventable Complications: These complications are harmful events or negative outcomes, including an infection or surgical complication, that occurs after the person's admission to a hospital or long-term care facility, and may have resulted from the care, lack of care, or treatment provided during the hospital or long term care facility stay rather than from a natural progression of an underlying disease.[1]

One example of a MCO initiative to reduce PPEs is found on the following page.

Innovation: Using Technology to Reduce Potential Preventable Events (PPEs)

Seton Health Plan knows firsthand the importance of supporting providers to achieve better care for its members. In 2014, Seton partnered with two large primary care provider (PCP) groups to better support our members during care transitions, and to decrease unnecessary hospital admissions/readmissions and recurring emergency room [ER] visits. Using Seton's access to census information from its system hospitals, these groups receive daily lists of their members with recent hospital admissions, ER visits, and deliveries. This vital information, which is not normally included in a practice's electronic health record on a real time basis, gives the PCP information so that the PCP's staff can intervene with these members to identify any discharge problems and schedule necessary follow-up visits.

For the members being cared for in these two group practices, there have been notification of over 460 patient admissions, deliveries and ER visits provided to the PCP far in advance of when the PCP would otherwise know about the hospital event. Through this program, Seton expects to achieve an improved member and provider experience, improved member health, reduced hospitalization and ER utilization rates, and increased postpartum visit rates.

Medicaid recipients who are not in managed care don't have an advocate such as Seton to gather and disseminate actionable information to their providers on their behalf.

Incentives and Disincentives

Texas implemented financial incentives for high performing managed care organizations and financial disincentives for poorer performing managed care organizations through its VBP contracts. Certain process requirements such as timely provider payments are subject to immediate liquidated damages if standards are not met. In addition, the state developed targeted initiatives that encourage MCOs to adopt evidence-based clinical and administrative practices. Some of the state's performance remedies for MCOs include:

- Accelerated monitoring, which includes more frequent or extensive monitoring by HHSC
- Requiring the MCO to submit additional financial or programmatic reports
- Requiring additional or more detailed financial or programmatic audits or other reviews
- Terminating or declining to renew or extend a managed care organization contract
- Appointing temporary managed care organization management under the circumstances described in 42 CFR §438.706
- Initiating or suspending member disenrollment
- Withholding or recouping payment to the managed care organization
- Requiring forfeiture of all or part of the managed care organization's performance bond

Performance Based At-Risk Capitation and Quality Challenge Award. In 2010, the state implemented an initiative to focus MCOs' performance on specific measures that promote program goals and objectives and to improve managed care services. For the Performance Based At-Risk Capitation and Quality Challenge Award, up to 5 percent of MCO premiums were at-risk based on the achievement of certain quality of care measures. At-risk premiums that were not earned were reallocated to the Quality Challenge Award pool which

In 2012, the state distributed $7,230,430 in quality challenge awards to MCOs.

rewarded MCOs that demonstrated high quality, service delivery, access to care, or member satisfaction.

Pay-for-Quality Program. S.B. 7 (2013) focused on the use of outcome and process measures in quality-based payment systems that emphasize measuring potentially preventable events; rewarding use of evidence based practices; and promoting healthcare coordination, collaboration and efficiency.

In response to this legislation, HHSC implemented the Pay-for-Quality Program, which replaced the At-Risk Quality Challenge Program beginning in 2014. The Pay-for-Quality Program uses an incremental improvement approach that provides financial incentives and disincentives to managed care organizations based on year-to-year incremental improvement on pre-specified quality goals. The quality of care measures used in this initiative are a combination of process and outcome measures which include select potentially preventable events as well as other measures specific to the program's enrolled populations.

The Pay-for-Quality Program includes an at-risk pool that is 4 percent of the MCO capitation rate. Points are assigned to each plan based on incremental performance on each quality measure, with positive points assigned for year-to-year improvements over a minimum baseline. Negative points are assigned for most year-to-year declines, with the exception of modest decreases of plans whose performance is already performing within a specified range of the goal rate. The Pay-for-Quality Program model sets minimum baseline performance levels for the measures so that low performing managed care organizations would not be rewarded for substandard performance. Rewards and penalties are based on rates of improvement or decline over the baseline. All funds recouped from MCOs through the assignment of negative points are redistributed to managed care organizations through the rewarding of positive points. Each managed care organization pays in proportion to its total negative points and receives funds in proportion to its total positive points.

The at-risk portion of capitation payments is based on the following eight quality measures:

- Adolescents Well-Care Visits (STAR, CHIP)
- Antidepressant Medication Management (STAR+PLUS)
- HbA1c Control (Diabetes) (STAR+PLUS)
- Potentially Preventable Admissions (STAR, CHIP, STAR+PLUS)
- Potentially Preventable ED Visits (STAR, CHIP, STAR+PLUS)
- Potentially Preventable Readmissions (STAR, CHIP, STAR+PLUS)
- Prenatal and Postpartum Care (STAR)
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (STAR, CHIP)

Quality-Based Managed Care Organization Enrollment Incentive Algorithm. As an incentive for high performing plans, HHSC is looking at preferential auto assignment of members to these plans when the member does not select a plan.

Public Committees and Councils to Inform and Guide Managed Care Initiatives

Texas Medicaid recognizes the importance of structured public input to inform and guide their managed care initiatives. Thus, Table 5 below provides an overview of the public committees and councils that provide oversight and feedback.

Table 5: Public Committees and Councils

Managed Care Committee	General Description
STAR+PLUS Quality Council	• Created by S.B. 7 (2013), the STAR+PLUS Quality Council provides recommendations to the HHSC regarding policies ensuring that Medicaid MCO members receive person-centered acute care and LTSS in an integrated setting. • Reports to the HHSC Executive Commissioner on the assessment of quality acute care and LTSS under STAR+PLUS. • Recommends how to improve services and provide quality care to STAR+PLUS members. • Reports to the Legislature regarding these annual reports on the assessments and recommendations proposed to the Executive Commissioner.
STAR Kids Advisory Committee	• Created by S.B. 7 (2013), the STAR Kids Advisory Committee advises HHSC on the implementation of the STAR Kids program and related efforts regarding the STAR Kids model.
State Medicaid Managed Care Advisory Committee	• Created by S.B. 7 (2013), the Committee offers ongoing recommendations to the HHSC on statewide implementation of Medicaid managed care. • Assists with sharing policies and best practices with Medicaid Regional Advisory Committees and receives input from stakeholders on the operation and implementation of managed care.
IDD System Redesign Advisory Committee	• Implemented by S.B. 7 (2013), the Committee advises HHSC and DADS on system redesign efforts regarding acute care and LTSS for enrollees with intellectual and developmental disabilities. • The Committee must adhere to the goals outlined by S.B. 7 when designing the delivery system for this particular group, which include providing services using a cost-efficient approach, promoting high-quality care, and improving acute care services and LTSS, including decreasing unnecessary institutionalization and PPEs.
Quality-Based Payment Advisory Committee	• Established by S.B. 7, (2011), QBPAC advises HHSC on creating reimbursement policies and systems that reward high quality and cost-effective care. QBPAC is also responsible for advising HHSC on measures, standards, and benchmarks used to measure performance.
Texas Institute of Health Care Quality and Efficiency	• Established by S.B. 7 (2011), the Institute brings together individuals, organizations, and agencies from public, commercial, non-profit, and private sectors to collaborate and work on quality improvement initiatives. The institute seeks to develop strategies that meet the goals of the Triple Aim framework—improving experience of care, improving population health, and decreasing healthcare costs per capita. The Institute Board includes representation from state agencies and public university systems. The diverse group allows for an exchange of information on how to create quality improvement initiatives.
Perinatal Advisory Council	• Created by H.B. 15 (2013), the Perinatal Advisory Council provides recommendations for statewide hospital designation process and standards for levels of neonatal intensive and maternity levels of care that are tied to Medicaid reimbursement.

Chapter 3
Access to Care

Texas Medicaid MCOs have strong network adequacy protections for members.

MCOs surpassed performance expectations on well child visits and childhood immunizations.

MCOs have implemented a number of innovative solutions to address provider specialty shortages and after-hours urgent care needs.

No waiting list for access to Home and Community Based waiver services in STAR+PLUS has resulted in many more members having access to needed care and avoiding institutions.

Consumer-directed service options are utilized 3 times more in STAR+PLUS than traditional Medicaid.

MCOs offer a number of value added services to members at no cost to the state.

Access to care is one of the crucial factors in any health delivery system. It is defined as having easy and available access to primary care; specialty care; disability services; prescription drugs; and any other medically necessary services and supports. The overall goal is to achieve the highest quality of care for all individuals which should result in an improve quality of life and lower costs to the Medicaid program. Managed care provides an enhanced access to care compared to fee-for-service (FFS) because the state managed care contract requires the availability of a primary care physician, a medical home, and network adequacy across all practitioner/provider types. FFS only provides Medicaid eligibility and authorization of services; it does not guarantee that the individual will find a primary care physician or other specialty providers.

Managed care provides increased access to care through:

- Network adequacy requirements
- Waiting time requirements
- Medical homes
- Preventive care access (pediatric and adult)
- Service coordination
- Access to Long-Term Services and Supports
- Value-added services
- Comprehensive Information Technology (IT) structure

Network Adequacy Requirements

The current Texas provider network requirements for Medicaid MCOs include:

- Ensure sufficient provider capacity to meet all the needs of the expected client enrollment
- Meet service area needs within designated geographic catchment of preventive, primary care, specialists, and LTSS providers
- Establish and maintain networks providing access to services covered under state contract by looking at geographic location of providers and Medicaid enrollees and the physical accessibility of the location for Medicaid enrollees with disabilities
- Submit out-of-network (OON) utilization reports
- Make certain network adequacy data available to the public such as sufficiency of provider networks
- Demonstrate they have a sufficient number of LTSS and specialty pediatric care providers of home and community based services before providing services to clients (new requirement)

Although not required by CMS for Medicaid managed care, Texas Medicaid builds on the TDI travel and distance requirements from the member's residence. Travel distance is important for access to care because individuals receiving Medicaid may not have readily available and reliable methods of transportation to attend physician/specialty provider appointments. The current requirements are as follows:

Table 6: Distance Requirement by Provider Type

Primary Care Provider	30 miles
Primary Care Provider (PCP)	90% of members must have access to a PCP within 30 miles Additional Frew requirement: 90% of child members must have access to at least 2 PCPs within 30 miles
Acute Care Hospital	90% of members must have access within 30 miles
Specialists (including OB/Gyn)	90% of members must have access within 75 miles
Outpatient Behavioral Health	Urban: 90% of members must have access within 30 miles Rural: 90% of members must have access within 75 miles
Pharmacy	Urban: 80% of members must have access within 2 miles (75% for Medicaid Rural Service Area) Suburban: 75% of members must have access within 5 miles (55% for Medicaid Rural Service Area) Rural: 90% of members must have access within 15 miles (same for Medicaid Rural Service Area) Urban/Suburban/Rural: 90% of members must have access to a 24-hour pharmacy within 75 miles (same for Medicaid Rural Service Area)
Dental	Urban: 95% of members must have access to two open practice dentists within 30 miles Rural: 95% of members must have access to two open practice dentists within 75 miles Urban and Rural: 90% must have access to one specialist within 75 miles
All Other Provider Types	90% of members must have access to the provider type within 75 Miles

Network Requirements for LTSS, Nursing Services and Therapy

As the state includes new populations and services in managed care the legislature has required that they develop network adequacy standards for these providers. The 83rd Legislature S.B. 7, SECTION 2.04 (Government Code 533.005(a)(20) requires MCOs:

Provide network adequacy plans to include long term services and supports (LTSS), nursing services, and therapy services. MCOs must demonstrate they have a sufficient number of LTSS and specialty pediatric care providers of home and community based services before providing services to clients.

Consumer Protection for Network Adequacy

HHSC ensures MCO consumer protection through readiness review requirements; protections for complete network adequacy; general contract requirements; regulatory measures; and consumer satisfaction surveys.

Oversight of Network Adequacy. HHSC conducts a thorough readiness review prior to allowing a health plan to enroll members. Part of that review is a compliance check of the plan's provider network. HHSC staff have the following tools to gauge network adequacy:

- GeoAccess maps received annually from MCO
- MCO network panel status reports and provider turnover rates received quarterly
- Enrollment Broker reports
- Access to care complaints
- Review out-of-network utilization

HHSC Health Plan Managers continuously monitor network adequacy through the reports and complaint systems noted above. Corrective action plans are implemented when MCOs are found out of compliance and if appropriate sanctions are applied.

Significant Traditional Provider Requirement. The MCO contract includes the Significant Traditional Provider (STP) requirement which means that for the first three years post-implementation, providers who have traditionally provided these services under fee-for-service to persons enrolled in managed care must be offered a network contract. The STP provision applies to protections for existing providers of these services when new populations and services are included in managed care. During transitions to managed care, MCOs must honor service authorizations the member received under FFS for acute care services (for 90 days or until a new authorization is acquired, whichever is shorter) and LTSS (for up to 120 days or until a new authorization is put in place). These two protections ensure that an individual can continue traditional relationships with existing service providers and avoid a service break during the transition period.

Protection for Overutilization of Out of Network (OON) Providers. The MCOs are incentivized to have a strong provider network to enhance member enrollment and to avoid financial penalties for out of network utilization. The purpose of avoiding OON utilization is that it hampers the service coordination activity because of less oversight and required coordination with OON providers. If MCOs rely on OON special contracts, and overall utilization is higher than 15% for inpatient hospital or 20% for emergency room or other health care services, HHSC will impose financial penalties including liquidated damages and/or enrollment suspension.

MCO Performance on Access to Care

Since the inception of Medicaid managed care, HHSC has annually measured members' access to needed healthcare services. The state's contracted External Quality Review Organization (EQRO) is charged with conducting consumer satisfaction surveys, analyzing MCO encounter data, and comparing HEDIS scores (HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service) and reporting on MCO performance relative to national benchmarks. Below are some results reported by the EQRO:

Members Having a Personal Doctor and Medical Home

The majority of Texas Medicaid and CHIP members report having a personal doctor whom they see when they need a checkup, want advice about a health problem, or get sick or hurt. Among children, rates of having a personal doctor were higher ranging from 90% in CHIP up to 99% in STAR Health. For STAR+PLUS Medicaid-only the rate was 82 percent and for dual-eligible members 85 percent. For STAR Adult, the rate was lower (68%) reflecting the eligibility for pregnant women that lose Medicaid eligibility following delivery. These figures have remained fairly constant over the years.

Table 7: Children and Adolescent's Access to Primary Care Practioners - CY 2011 Results

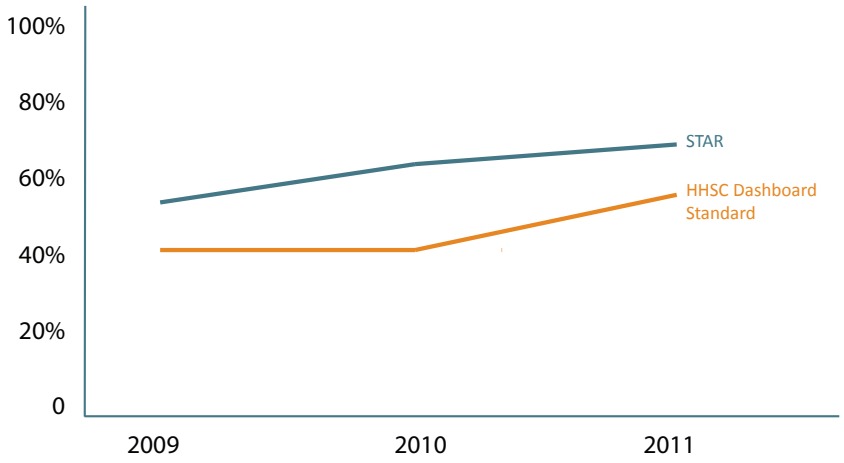
	12-24 months	25 months - 6 years	7 - 11 years	12 - 19 years
STAR	98%	93%	96%	95%
CHIP	95%	90%	93%	91%
STAR Health	99%	96%	98%	98%

Preventive Care Access

Pediatric Access to Care. Results from the External Quality Review Organization's most recent annual report to HHSC provided the following on children's access to preventative services:

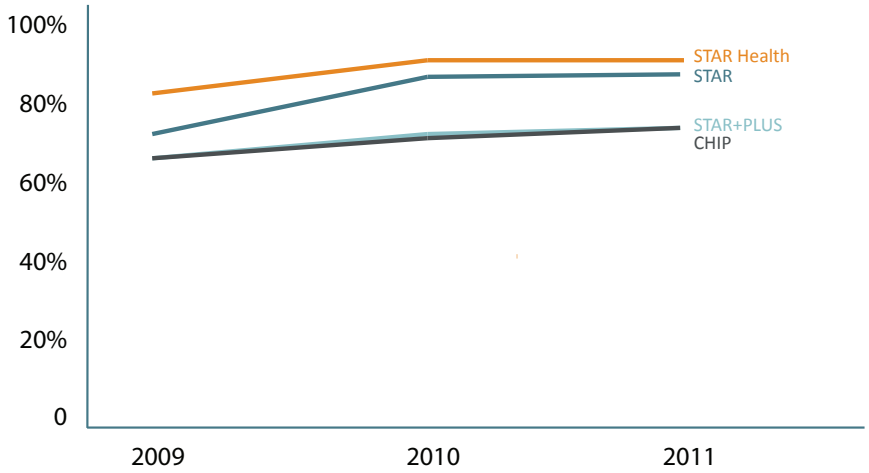
- *Access to primary care.* Across programs, child and adolescent members had good access to primary care practitioners, with over 90 percent of members visiting a PCP during the measurement period.
- *Well-care visits.* Rates of well-child and well-care visits increased slightly over the three-year period for all programs. Rates of increase were especially pronounced in STAR Health. All programs met HHSC Dashboard standards for well-child/well-care visits in all age groups across the three-year period.

Chart E: Well-Child Visits in the First 15 Months of Life in STAR, 2009-2011



Between 2009-2011, the percentage of infants in the STAR program receiving the appropriate number of well-child visits surpassed the HHSC Dashboard standard during all three years. In 2011, two-thirds of eligible STAR members had six or more well-child visits within the first 15 months of life (66% exceeding Dashboard standard of 53%)

Chart F: Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life in STAR, CHIP, STAR+PLUS, and STAR Health 2009-2011



Childhood immunization. Almost half of STAR infants received the appropriate vaccinations by their second birthday (45 percent), exceeding the 2011 HEDIS® national mean of 32 percent.

Access to dental care. Overall, the rate of annual dental visits in CHIP Dental increased from 59 percent in 2009 to 66 percent in 2011, exceeding the 2011 HEDIS® national average of 48 percent.

Adult Access to Care

Results from the External Quality Review Organization's most recent annual report to HHSC provided the following on adult access to preventative services:

Access to ambulatory health services. STAR+PLUS members over 45 years of age generally had good access to preventive care. Eighty-seven percent of members in both older age cohorts (45 to 64 years and 65 years and older) had an ambulatory or preventive care visit in CY 2011.

Prenatal care. The rate of timely prenatal care in STAR (83 percent) was comparable to the national HEDIS® mean of 84 percent. Rates of timely prenatal care increased in STAR, STAR+PLUS and STAR Health between 2009 and 2011.

MCO Innovations in Access to Care

The Texas Medicaid MCOs have implemented a host of innovative initiatives and programs to promote access to care for members in their service areas. The following examples highlight a few of these initiatives:

Innovation: Chronic Care Management Reduces Emergency Room Use

Molina Health Care members who participate in their accredited disease management programs benefit through improved quality of life and fewer emergency room visits and hospitalizations. The programs include seventeen chronic conditions such as epilepsy, cystic fibrosis, rheumatoid arthritis, Gaucher's disease, systemic lupus erythematosus and sickle cell disease. The care managers improve communications between providers and members facilitating improved compliance and supporting the physicians' plans of care. Members receive vital education, tools, resources, and skills for taking a more proactive approach to their health care. Members experience improvements in social interactions, activities and relationships as well as improved care coordination.

Innovation: Women and Children's Clinics Open in Underserved Areas

Texas Children's Health Plan identified significant access issues in its population leading to the establishment of TCHP Women and Children's Clinics in conjunction with the Baylor College of Medicine. These two staff model clinics serve TCHP members exclusively in medically underserved communities. The Centers provide Pediatric services as well as innovative OB care such as the "Centering Pregnancy" program – selected by HHSC as the sole Houston area demonstration program for the OB Medical Home. The Centers are open 10 to 14 hours daily including weekends and are NCQA certified medical homes. The Centers provide medical, behavioral health, dental, pharmacy, and ancillary therapies including Medicaid enrollment and reenrollment and social services assistance. TCHP plans to open at least two more Centers in the Houston/Jefferson service areas. TCHP has expanded the geographic coverage of its provider network in a way that traditional Medicaid could not achieve.

Innovation: Overcoming Shortage of Child Psychiatrists in South Texas

Driscoll Health Plan serves a 24 county area that covers a large portion of South Texas. 20 of those counties have no child and adolescent psychiatrists. Throughout the service area, there are only seven child and adolescent psychiatrists for 713,667 children, which is a ratio of less than 1 psychiatrist per 100,000 children. Driscoll developed a two-pronged initiative to better serve their members.

First, Driscoll knew that PCPs were concerned about their ability to deliver Behavioral Health services. With the support of their Physician Advisory Committee, Driscoll helped the PCPs to improve their competency through educational sessions and by distributing tools including "Caring for Children with ADHD: A Resource Toolkit for Clinicians", a nationally developed tool kit for primary care.

Second, Driscoll convened a joint project with UTMB and Behavioral Health Services of Nueces County (BHSNC) to implement the Tele-Psych Clinic. UTMB has well-developed telemedicine capabilities and BHSNC has behavioral specialist resources in the region to implement the program. The program was launched in October 2012 and in the first six months, 145 members were seen in the Tele-Psych Clinic, including over 200 hours of access to Child Psychiatrists. Without this program, most of these children would not have received the level of specialist intervention warranted by their condition.

Innovations like Driscoll's don't occur in fee-for-service Medicaid. It's not that providers don't care; there just isn't the accountability for knitting together our complex health care system in the best interests of the client.

Measuring Consumer Satisfaction: CAHPS® Scores on Access to Care

Consumer satisfaction surveys are currently the best measure on how well a MCO member feels their needs are being met. The EQRO administers the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to measure consumer satisfaction with their health care service delivery. The most recent survey data available from FY12 provides the following:

- *Getting Care Quickly*. Scores for Getting Care Quickly among child members ranged from 83 percent in STAR to 90 percent in STAR Health, and were similar to those reported for children in Medicaid and CHIP nationally. Scores for this measure among adult members ranged from 71 percent in STAR to 80 percent among STAR+PLUS dual-eligible members
- *Good Access to Urgent Care.* Performance on this HHSC Dashboard indicator was good for children, ranging from 86 percent in STAR to 96 percent in STAR Health. Among adults, performance ranged from 74 percent in STAR to 81 percent among STAR+PLUS dual-eligible members.
- *Good Access to Routine Care.* Performance on this HHSC Dashboard indicator among children ranged from 78 percent in CHIP to 84 percent in STAR Health. Among adults, performance ranged from 67 percent in STAR to 80 percent among STAR+PLUS dual-eligible members.
- *Good Access to Specialist Referral.* The rate for STAR Health was 84 percent, notably higher than the HHSC Dashboard standard of 75 percent.

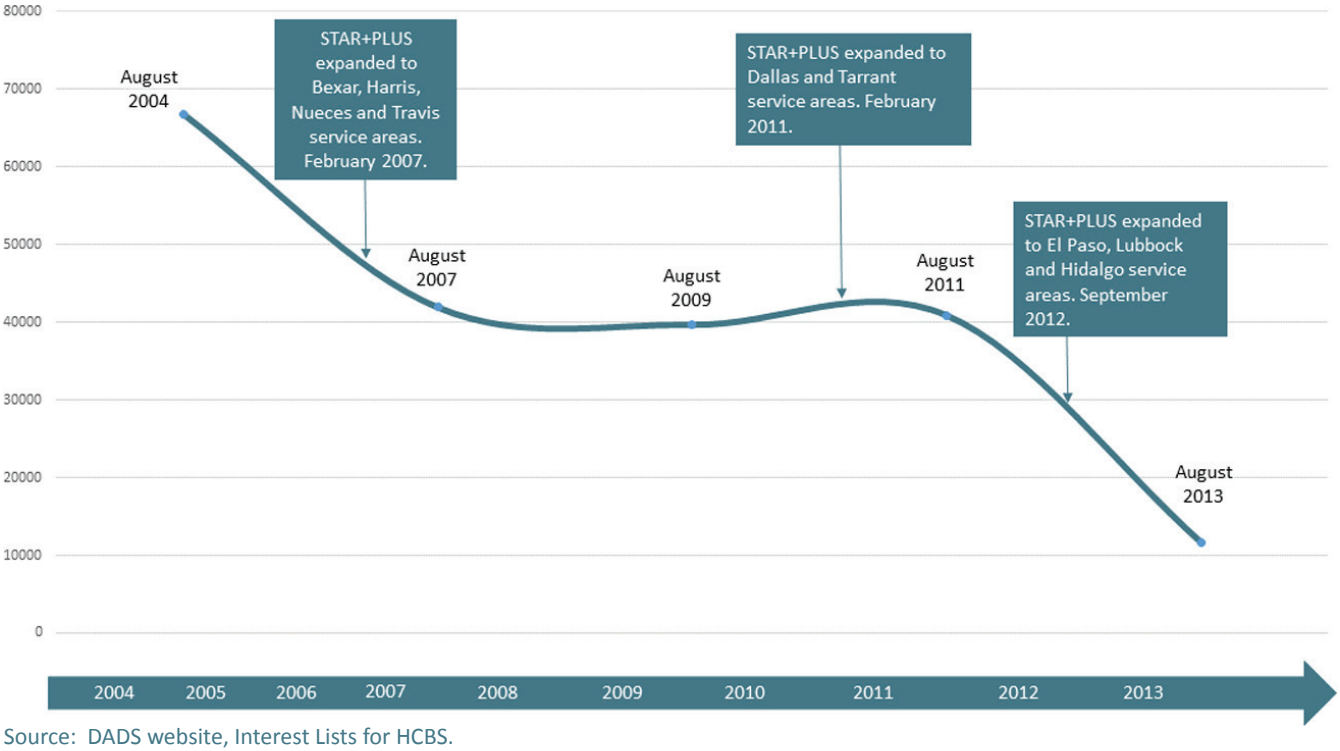
Overall, consumer satisfaction reflects that the MCOs are meeting the healthcare needs of their members and the satisfaction scores meet or exceed national and dashboard standards on a number of key measures.

Access to Long-Term Services and Supports in STAR+PLUS

No Interest List wait for Community Based Alternative waiver services. A major benefit of STAR+PLUS is the requirement that individuals at the Supplemental Security Income (SSI) level of income receive STAR+ PLUS waiver services immediately and do not have to go on an interest list. Providing immediate "waiver" services to individuals at the SSI level has many benefits for the individual and for the state: (1) individuals receive immediate community-based services which may prevent/delay further deterioration and institutionalization; (2) community-based services are 66% of nursing facility costs factoring in both acute and LTSS; (3) increased quality of life for Texans with physical disabilities. As of May 31, 2014, there were 5,110 individuals on the Community Based Alternatives (CBA) interest list.[1] With statewide expansion of STAR+PLUS on September 1, 2014 and the termination of the CBA waiver, it is estimated that 2,654 more individuals will receive CBA type waiver services because of their SSI status.

The following chart shows the dramatic decrease in Interest List for CBA waiver services.

Chart G: STAR+PLUS Impact on Interest List for Community Based Services



Source: DADS website, Interest Lists for HCBS.

Service Coordination

STAR+PLUS service coordinators integrate acute care and LTSS and function as a point of contact for the STAR+PLUS member. Individuals leaving a nursing facility are individuals with complex needs. These complex needs include: fragile medical condition; co-occurring behavioral health issue; or co-occurring intellectual and developmental disability. These individuals require a significant amount of contact especially in the first three to six months post-relocation. The STAR+PLUS service coordinator serves this function which results in a higher level of individuals remaining in the community and not returning to the institutional setting.

Behavioral Health Integration

Behavioral health is one of the leading causes of readmission to a hospital setting or an institutional placement. An Agency for Healthcare Research and Quality (AHRQ) report stated that Medicaid recipients comprised 20.6 percent of all hospital readmissions. The top two reasons are: (1) mood disorders and (2) schizophrenic and other psychotic disorders. Texas Legislature passed S.B. 58 (83rd Legislature) to ensure better coordination of behavioral health with all acute and LTSS. S.B. 58 moves Medicaid behavioral health targeted case management and psychiatric rehabilitation from the Department of State Health Services to HHSC under the STAR+PLUS program. This movement of Medicaid behavioral health services into managed care should result in a decrease of hospital readmissions and institutional placement due to better service coordination.

Case Study: Ten Year Old Bi-Polar Patient Avoids Hospital Care

Community First Health Plans serves a 10-year old member with a diagnosis of Bipolar Disorder who has had nine inpatient hospitalizations from September 2013 to March 2014 due to aggressive behaviors and suicidal ideation. The member was included in targeted case management and rehabilitative services in March 2014 and has been closely followed by an RN with Behavioral Health training. Since this intervention, this young man has not had a single inpatient hospitalization. He is currently receiving psychiatrist medication management, medication management training for his parent and anger management skills training coordinated by his case manager. His case manager has regular communication with the patient and parent and provides assistance with referrals, benefit information and service coordination. This young man is fortunate that Community First Health Plans has their arms around him.

Outreach to Members to Access Need for LTSS

STAR+PLUS adult members have better access to LTSS in STAR+PLUS due to the requirement for the MCO to outreach to every member at least annually to determine if the member has any unmet needs for LTSS. In FFS, there is no outreach by the state to Medicaid clients for LTSS. Over the years the number of persons receiving personal attendant care services has increased significantly, without adding additional cost to the state. This is because (1) MCOs are capitated so they do not receive additional payment when a member receives services, and (2) the number of authorized hours is on average less than in FFS due to MCOs ensuring more appropriate utilization.

Consumer Directed Services (CDS) Increases under Managed Care

CDS allows individuals who receive Medicaid services from the state to hire and manage the people who provide their services. In many areas of the state, it is difficult to find and retain individuals who provide direct services to the Medicaid population. There is a significant turn-over rate among direct service workers. One option is CDS which allows the Medicaid recipient to hire family members, neighbors, fellow religious congregants and others to provide the necessary services and supports. From the beginning, STAR+PLUS has always achieved a greater utilization of CDS. It is believed that Medicaid recipients received better and more thorough information through the service coordinator. Table 8 demonstrates the significant higher utilization of the CDS option in STAR+PLUS. With Community Based Alternatives (CBA) and Primary Home Care (PHC) now part of STAR+PLUS, it is believed that more individuals will access the CDS option.

Table 8: CDS Utilization: State Fiscal Year 2012

	Program	Percent using CDS
FFS Programs	CBA	1.5%
	Community Assistance Services	0.5%
	PHC	0.4%
	STAR+PLUS	4.5%

Source: HHSC and DADS enrollment data through 3rd quarter of FY 2012. Consumer Direction Workgroup: Biennial Report to the Texas Legislature, September 2012

Increasing Access for Children with Disabilities

S.B. 7 (83rd Legislature, Regular Session, 2013) created the STAR Kids program effective September 1, 2016. STAR Kids will be the first Medicaid managed care program specifically serving youth and children who get disability-related Medicaid. STAR Kids will serve children and youth age 20 or younger who either receive SSI Medicaid or are enrolled in the Medically Dependent Children Program (MDCP). They will receive all of their services through a STAR Kids health plan. Children and youth who receive services through other 1915(c) waiver programs will receive their basic health services (acute care) through STAR Kids and their STAR Kids plan will coordinate with their LTSS waiver services.

The program will provide benefits such as prescription drugs, hospital care, primary and specialty care, preventive care, personal care services, private duty nursing, and durable medical equipment and supplies. Children and youth who get additional services through MDCP will receive additional LTSS through STAR Kids. Additionally, each member will be assigned a service coordinator to coordinate all activities and be a specific point of contact. This putting together of all children's programs into a singular managed care program will have major benefits to the children and youth and to their families and legal guardians. There will be, for the first time, a coordinated focus of services and supports and the development of a comprehensive service plan versus multiple plans which can often be at odds with each other. Additionally, there will be a focus of meeting the child's and the families'/legal guardians' aspirations and future goals with increased attention for planning toward transitioning to adulthood. This planning will include vocational aspirations and employment services. This unified approach did not and could happen in FFS.

Value Added Services Offered by MCOS

All of the Medicaid/CHIP MCOs offer Value Added Services. These are services that are not covered or paid for by the Medicaid program but are highly appreciated by members. Many members select their MCO based on the value added services offered by that MCO. On the following page, in Table 9, are some of the most common services/benefits offered by the MCOs that improve access to care:

Case Study: Plan Provides Infant Car Seats to Members

Blue Cross/Blue Shield of Texas provides infant care seats as a value-added benefit to members. BCBSTX shared a story of a member who was in the hospital for delivery of her baby, and the infant car seat had not been delivered to her home yet. Before she could be released from the hospital, she needed an infant car seat to transport her newborn home. BCBSTX immediately brought one to the hospital and when the member saw the car seat, she started crying because she couldn't believe BCBSTX health plan would do that for her.

Table 9: Value Added Services

Type of Service	Service Examples from MCO Contracts
24 Hour Nurse Line	Most plans provide this service
Extra Transportation	Transportation to doctors' appointments and to non-medical services
Extra Dental Services	Adult dental services that are not a Medicaid benefit
Extra Vision Services	Coverage for additional choices for eyeglass frames and contact lenses
Health and Wellness	Weight loss programs Smoking cessation programs and products Birthing classes Sports physicals for school and community sports
Gift program	Child car seats Over the counter medications discount cards or rebates Up to $50 gift cards for health prevention programs
Gym and Club Memberships	Boy and Girls Club memberships YMCA for members and their families Adult fitness classes
Meals and Nutrition	Home delivered meals Nutritionist consultations and home visits
Safety and Monitoring	Free cell phones Pest control Emergency Response Systems
Respite Services	For family caretakers so that they can take some personal time

Information Technology (IT) Systems Enhancements Improve Access

An unintended result of managed care expansion may be the impact on IT systems. Under FFS, there are multiple programs with hundreds if not thousands of providers. Each program has its own IT platforms/software and it has been extremely difficult to generate good data that is interoperable, can be shared across programs, and easily amended to accommodate change. Having a singular managed care system with one set of IT data requirements benefits all providers and the state. Equally important is the potential of creating comprehensive service plans, sharing of real-time data, and the ability to respond to ongoing change quickly. If a managed care organization can have all data under one entity and comprehensive service plan (developing a health/life record) then they should be able to respond quickly to a significant change in condition, target emergent health/LTSS issues immediately and be able to deescalate a potential crisis before a member is admitted into a hospital or institutional setting. Additionally, MCOs may be positioned to take better advantage of telemedicine and telehealth by virtue of the power of their local and national systems.

Chapter 4
Quality of Care

Managed care is the primary vehicle for improving quality of health care services for Medicaid members since it provides continuous improvement and monitoring processes as well as offers additional services that promote healthy outcomes.

Performance outcomes are tied to payment.

MCOs have demonstrated continuous performance improvement on key quality measures.

In order to achieve Texas' overarching goal of the "Triple Aim" (improving the experience of care, improving the health of populations, and reducing the cost of care) while simultaneously delivering quality care to Texans, the state established the Quality Improvement Strategy to guide current and future efforts. Specifically, the Quality Improvement Strategy seeks to accomplish the following:[1]

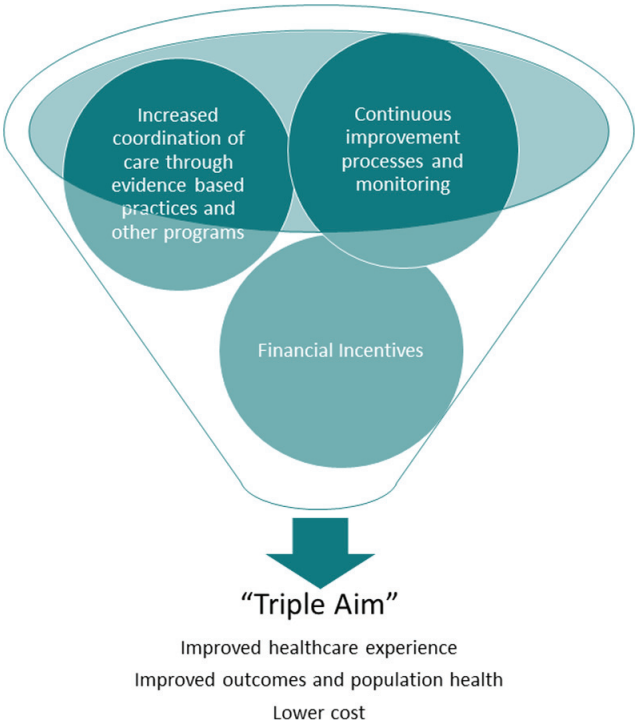
- Transition from volume-based purchasing models to pay-for-performance models
- Improve member satisfaction with their healthcare
- Reduce payments for low quality care

The expansion of Medicaid managed care has been a primary vehicle to reach the Triple Aim. Managed care can drive quality because of:[2]

- Continuous monitoring through internal MCO processes and external reviewer processes (State, external quality review organization)
- Financial incentives that are aligned with quality so that high-performing MCOs receive incentives while lower-performing MCOs experience disincentives
- Evidence-based practices that managed care organizations implement in both administrative and clinical settings

This chapter describes how managed care drives quality, both in principle and by specific examples. The latter part of this chapter demonstrates the quality improvements driven by managed care.

Chart H: Triple Aim



Managed Care Drives Quality

Managed care programs allow for an increased focus on quality of care and more personalized services. Compared to traditional FFS Medicaid, managed care provides:

1. *Medical Homes*: Members are assured that a primary care provider (PCP) or team of healthcare professionals provides comprehensive care, improves access, ensures appropriate utilization of services, and improves cost-effectiveness.

2. *Network Adequacy:* MCOs develop and maintain a network of providers that can deliver all services to enrollees.

3. *Care/Service Coordination:* Members receive support in coordinating all of their services and supports in an integrated, written plan of care.

4. *Cost, Quality and Healthcare Utilization Tracking:* MCOs track and report on the utilization, cost and quality of services and evaluate their appropriateness, efficacy, and necessity.

5. *Continuity of Care and Preventive Care services:* MCOs provide value-added services such as weight loss programs, 24 hour nurse hotlines, transportation services, and a full slate of preventive care services.

6. *Continuous Oversight:* Managed care implements regular assessments and audits, performance-based initiatives through compliance with contractual obligations.

7. *Innovations:* MCOs have strong incentives to implement cost effective innovations to improve the delivery of health care.

8. *Managed Care Accountability:* MCOs are responsible for managing and coordinating all the care of their enrollees within the given capitation payment. Relative to traditional Medicaid, this financial risk provides a profound incentive for MCOs to ensure that care is efficiently and effectively organized across the many providers of care as well as to encourage patient compliance with treatment plans.

9. *Members Experience of Care:.* In contrast to FFS, managed care aims to improve the patient experience of care through its focus on care coordination and better access and navigation of the healthcare system. Managed care organizations assist enrollees with coordinating medical appointments with both primary care providers and specialists. MCOs also arrange transportation services and issue reminders for preventive appointments, such as immunizations, required lab tests and examinations.

10. *Provider Engagement:* Physicians and other providers serve on oversight committees for each MCO's Quality Management Program. This important engagement ensures accountability of the MCO back to the practicing network of providers and provides a rich experience for the providers to guide and assess the impact of various practices and initiatives. This undoubtedly leads to a more progressive and dynamic delivery of health care for Medicaid members and the larger community.

Innovation: Success in Preventive Care for Asthma | ER Visits and Inpatient Admissions Reduced by 40%

Parkland Community Health Plan (PCHP) has a unique perspective on caring for Dallas area asthma clients since it provides acute care services through its emergency rooms and community care clinics. Following the implementation of managed care, Parkland has collaborated with local community based efforts to improve asthma care for all ages. Importantly, over 40% of asthma spending is for children under age four. PCHP sent respiratory therapists to visit our most severe asthmatics in their homes; these staff are certified asthma educators who augment traditional telephonic disease management. This program has demonstrated statistically significant decreases in ER visits and admissions for asthma. Compared to the two baseline years preceding the Parkland "Be in Control" Program in 2004, asthma related ER rates and admissions are down about 40%. To illustrate one specific patient, PCHP identified a member with 9 asthma admissions in one year. As a result of the asthma care coordination effort, this member has gone three months with no asthma admissions. To expand the effectiveness of this preventive program, PCHP has developed a process for sharing information within 24 hours on ER visits for its members with a large provider group of 200 PCPs.

Continuous Quality Improvement

Since the inception of Medicaid managed care in Texas, ensuring quality care for all members has been the primary goal. In addition to ongoing oversight by HHSC, the State's external quality review organization (EQRO) annually assesses the performance of each MCO. The State's EQRO is the Institute of Child Health Policy at the University of Florida. The EQRO:

- Validates performance improvement projects initiated by the MCOs
- Validates performance measures submitted by the MCOs
- Reviews MCO compliance with certain federal and state Medicaid managed care regulations

The metrics to assess quality include different types of measures such as:

- Process measures: composed of both clinical and non-clinical practices in the delivery of health care
- Outcome measures: reflect the results of health care services on improving a person's state of health
- Patient Perception of Care: measures an individual's experience with their care
- Composite: focus on efficiency of care through the combination of cost and quality factors

The EQRO also assesses other dimensions of care on a longitudinal basis including:

- Access
- Utilization
- Consumer satisfaction
- Plan and provider compliance[3]

Encouraging Results in Medicaid Managed Care

Rigorous analysis of the STAR, STAR+PLUS and STAR Health programs consistently show a positive impact on quality care, including access, utilization, and effectiveness of care. MCO performance is compared to national and state level benchmarks including Healthcare Effectiveness Data and Information Set (HEDIS) and Agency for Healthcare Research and Quality (AHRQ) measures. To provide a high level summary for the public, HHSC maintains a Performance Indicator Dashboard with key selected measures.[4]

Access and Utilization of Care

Pediatric Quality Indicators (PDIs) are used to assess hospital admissions for ambulatory care sensitive conditions among enrollees aged 17 years and younger, expressed as rate per 100,000 eligible members. Ambulatory care sensitive conditions are those conditions that should not result in a hospitalization.

PDI Rates in STAR

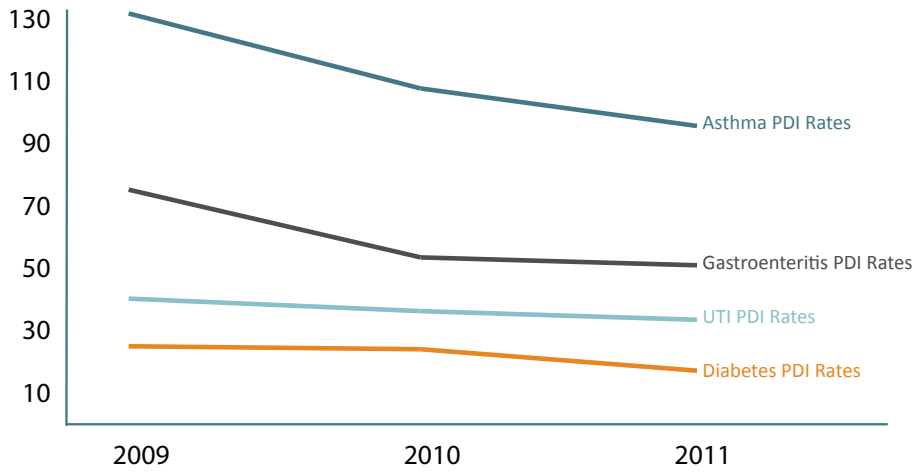
Asthma: PDI rates for asthma improved 22% from 2009 to 2011. In 2011, the asthma PDI rates of 100 per 100,000 were below the HHSC Dashboard Standard of 181 and below the AHRQ national average of 147 per 100,000.

Diabetes Short-Term Complications: Rates declined from 25.18 per 100,000 in 2009 to 18.58 per 100,000 in 2011, a 26% decrease.

Gastroenteritis: Rates decreased approximately 37% from 2009 to 2011. Moreover, PDI rates of gastroenteritis in 2011 (45 per 100,000) fell substantially below HHSC Dashboard Standards (146 per 100,000).

Urinary Tract Infection: Rates decreased by nearly 20% from 2009 to 2011. The 2011 rates (31) were significantly lower than the HHSC Dashboard Standard of 53 per 100,000.

Chart I: PDI Rates in STAR, 2009-2011



PDI Rates in STAR Health

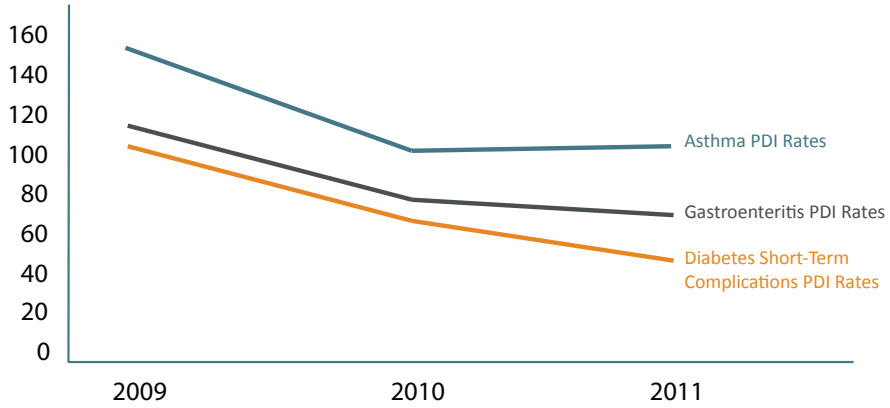
Results for STAR Health (foster care children) showed annual improvments.

Asthma: Admission rates decreased by 33% between 2009-2011.

Diabetes Complications: Admission rates declined by over half, from 97 per 100,000 to 45 per 100 from 2009 to 2011.

Gastroenteritis: Admission rates declined from 111 per 100,000 in 2009 to 68 per 100,000 in 2011, a 39% decrease.

Chart J: PDI Rates in STAR Health, 2009-2011

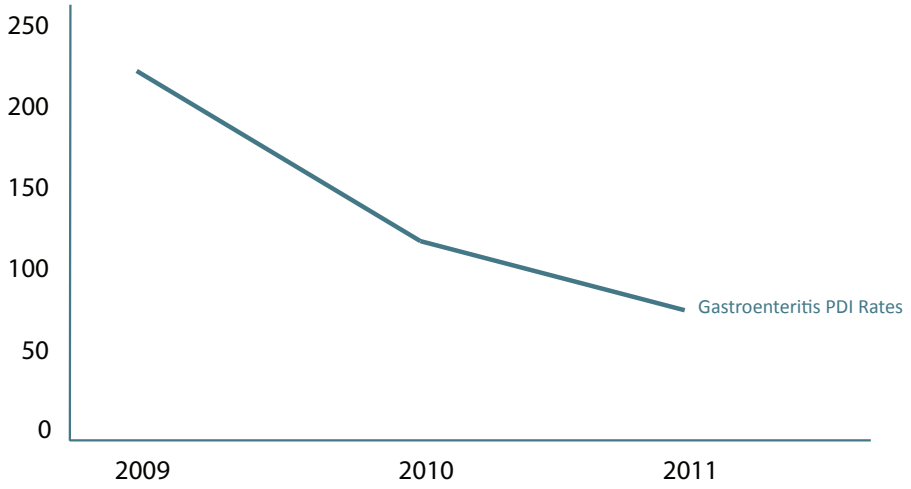


PQI Rates STAR+PLUS Program

Prevention Quality Indicators (PQI) are similar to the PDIs, but assess adult hospital admissions.

Gastroenteritis: Admission rates experienced a significant decline of 67% from 2009 to 2011. In 2009, the gastroenteritis rates were 214 per 100,000; in 2011, they decreased to 70 per 100,000.

Chart K: Gastroenteritis PDI Rates in STAR Health, 2009-2011



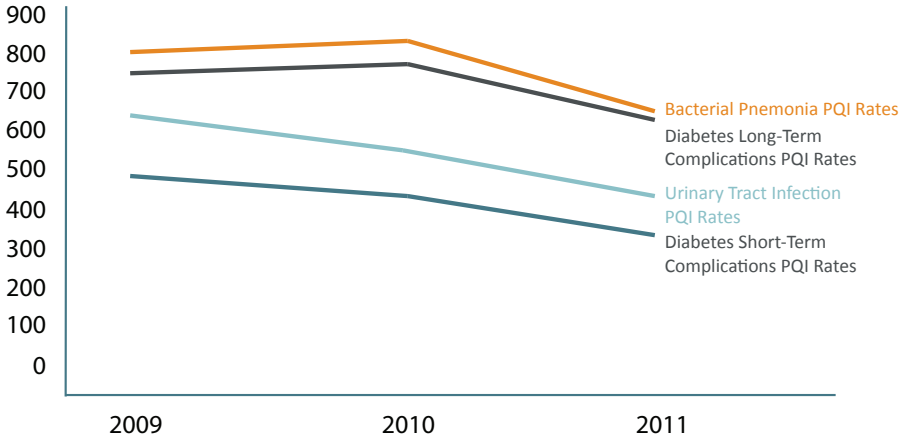
Diabetes Short-Term Complications: Rates dropped substantially from 466 per 100,000 in 2009 to 320 per 100,000 in 2011. This signifies a 31% decrease in short-term complication rates.

Diabetes Long-Term Complications: STAR+PLUS saw a slight increase in this rate from 2009 to 2010; however, between 2009 and 2011, the rate decreased by 17%. In 2009, the rate was 725 per 100,000, and in 2011, the rate declined to 602 per 100,000.

Bacterial Pneumonia: These rates also experienced an increase from 2009 to 2010 (765 to 807 per 100,000) but declined once again in 2011 (622 per 100,000). The total decrease during this period was 19%.

Urinary Tract Infection: These rates saw a steady decline from 2009 to 2011. Total decrease was 31%. In 2009, the rate was at 623 per 100,000. In 2011, the rates declined to 428 per 100,000.

Chart L: PQI Rates, 2009-2011



Effectiveness of Care

The Texas EQRO evaluates effectiveness of care by using HEDIS process measures to assess provider compliance to evidence-based practices and patient compliance with follow up regimens. The following charts show how managed care has improved the quality of care by ensuring appropriate and effective management of acute and chronic conditions.

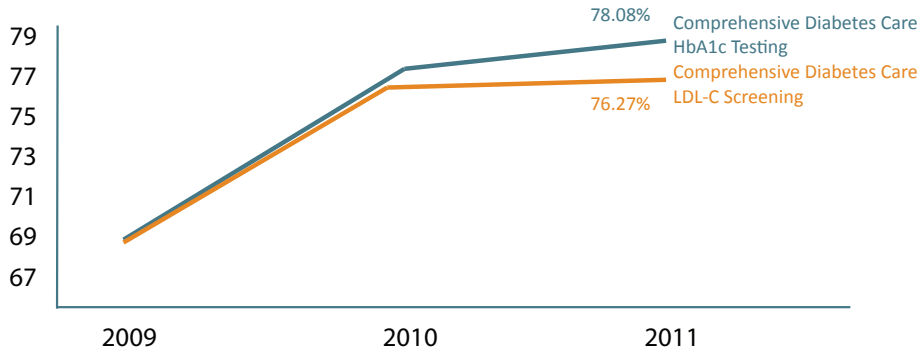
Screening and Testing. Appropriate screening and testing improves quality by ensuring appropriate diagnosis and follow up.

Diabetes can be a big cost driver for Medicaid. By increasing LDL-C screening, members can better control their diabetes, leading to better health at lower costs. Between 2009 and 2011, LDL-C screening increased by 5% in STAR.

Comprehensive Diabetes Care (CDC): For this measure, the EQRO assesses the percentage of enrollees 18 to 75 years of age with diabetes (type 1 or 2) who received HbA1 testing and LDL-C screening. Results for the STAR+PLUS program showed:

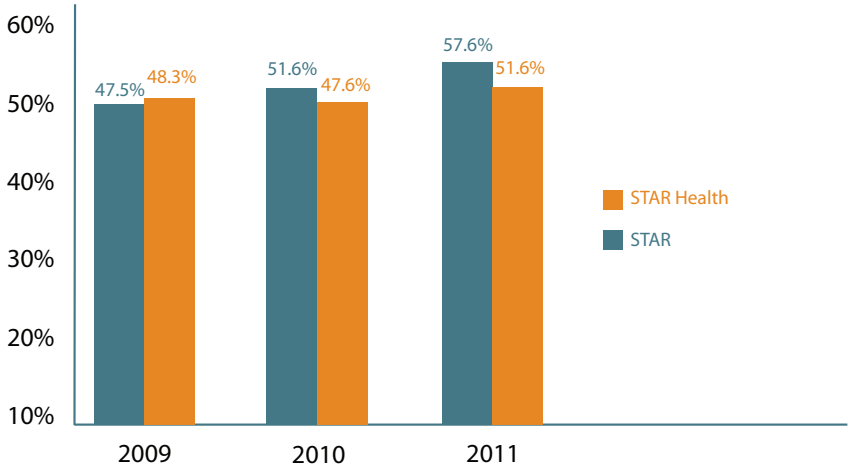
- CDC HbA1c Testing: Testing rates increased from 68% in 2009 to 78% in 2011. The 78% rate in 2011 is 1 percentage point higher than the HHSC Dashboard Standard of 77%.
- CDC LDL-C Screening: Screening rates increased from 68% in 2009 to 76% in 2011.

Chart M: Comprehensive Diabetes Care in STAR+PLUS, 2009-2011



Appropriate Testing for Children with Pharyngitis: This measure assesses the percentage of children ages 2-18 diagnosed with pharyngitis who received an antibiotic and also received a group A streptococcus test. The rates reflect an improvement in testing in Texas Medicaid. Testing rates increased by 10% from 2009 to 2011 for children in STAR. STAR Health members also showed incremental progress over the same time period.

Chart N: Appropriate Testing for Children with Pharyngitis in STAR and STAR Health, 2009-2011



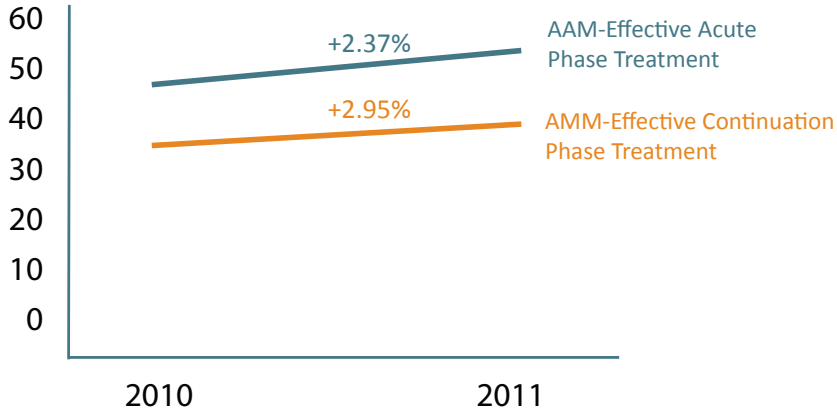
Medication Management

Adhering to pharmaceutical protocols allows members to better manage their conditions while containing costs.

Antidepressant Medication Management: Individuals 18 years and older with a new episode of major depression and treated with medication. The EQRO began using two sub-measures beginning in 2010. Results for the STAR program showed:

- Effective Acute-Phase Treatment: From 2010 to 2011, the rate increased by 2.37%, from 49.38% to 51.75%.
- Effective Continuation-Phase Treatment: From 2010 to 2011, the rate increased by 2.95%, from 32.75% to 35.7%.

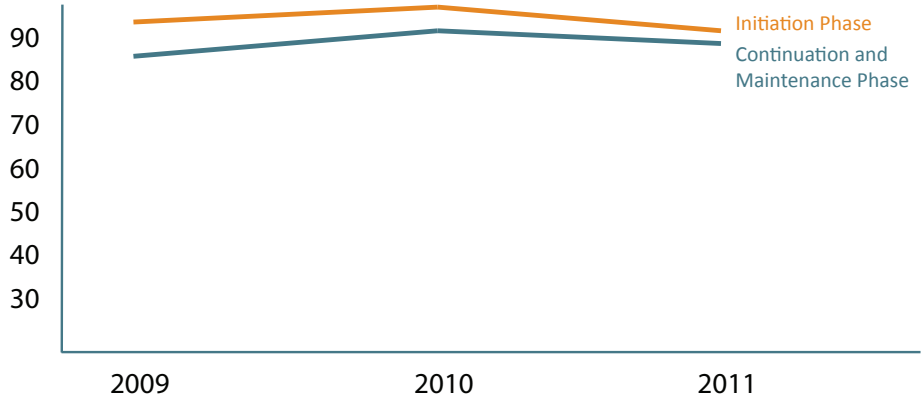
Chart O: Antidepressant Medication Management Rates, STAR, 2010-2011



Follow-up Care for Children Prescribed ADHD Medication. The percentage of children who were newly prescribed ADHD medication and received at least 3 follow-up visits within a 10-month period.

- From 2009 to 2011, the follow-up care rate increased by nearly 3%

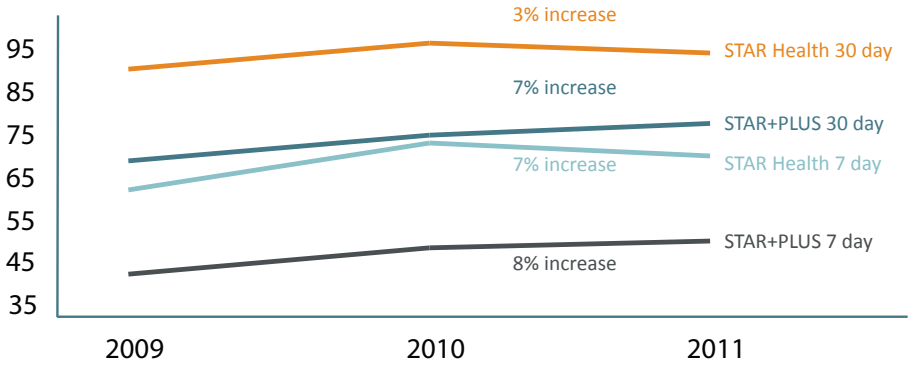
Chart P: Follow-up Care for Children Prescribed ADHD Medication STAR Health, 2009-2011



Appropriate follow-up promotes quality of care by ensuring that needed interventions are delivered and can prevent unnecessary inpatient readmission.

For members with a hospitalization for mental illness, timely follow up is key to stabilizing the situation and preventing further hospitalizations. Two sub-measures are used: follow-up within 7 days of discharge and follow-up within 30 days of discharge. STAR+PLUS and STAR Health MCOs showed increases in both metrics, generally 7% increase in follow-up rates.

Chart Q: Follow-up Care After Hospitalization for Mental Illness in STAR+PLUS and STAR Health 2009-2011



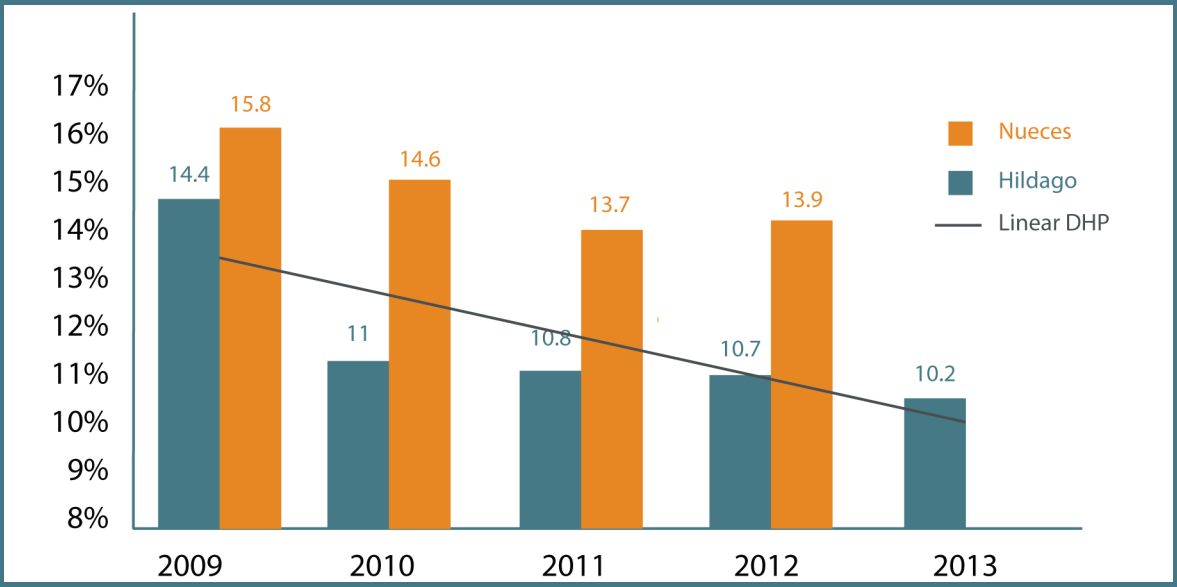
Innovation: Preterm Outreach and Education Improves Birth Outcomes

Driscoll Health Plan implemented a 3-pronged strategy to reduce prematurity in the Nueces and Hidalgo Service Areas. First, promotoras (lay health workers) host educational baby showers where pregnant women and their families receive information to assist in a healthy pregnancy and to understand the effects of nutrition and drugs and signs of premature labor. Second, Driscoll's clinical database ties the mother's prenatal care to the outcome of the infant. Quarterly, the Chief Medical Officer and other Obstetric and Maternal Fetal Medicine specialists meet with Obstetrics and Family Practice providers to review key indicators such as C-section rates, premature delivery rates, and traumatic birth rates. In addition to the sharing of outcomes, Driscoll provides continuing medical education on best practices and emerging treatment alternatives. Third, Driscoll has designed bonus incentive plans for hospitals to become "Baby Friendly" hospitals that promote breast-feeding and the use of human milk. In addition, there are incentives to work on potentially preventable events.

The results achieved are impressive:

- NICU costs reduced by $22 million over 5 years in the Nueces Service Area.
- Traumatic births were reduced by 75%.
- Elective inductions prior to 39 weeks gestation were reduced from 30% to 2%.

The following graphic shows the dramatic reduction in the Preterm Birth rate from 14.4% in 2009 to 10.2% in 2013.



Note: 2013 Nueces data was unavailable at the time of this report.

Innovation: 45% Reduction in Diabetes Readmissions for Foster Care Children

Superior Health Plan serves over 30,000 children in the foster care program (STAR Health) statewide. Because Superior is responsible for all hospital care, it drives them to identify new ways to improve care and lower costs.

Superior's Integrated Diabetes Program was implemented in 2011 and focused on care management intervention upon discharge for children with multiple diabetic admissions. This intervention reduced the Diabetes Short-Term Complications Admission rates by 45% from FY2009 to CY2012 resulting in a savings of $138,500. Further, between CY2012-CY2013, Superior reduced 30-day readmission rates after diabetes-related inpatient stays from 55.7% to 14.1% for members 5 years of age and older saving approximately $150,000.

In Medicaid fee-for-service, there are no care coordinators who can intervene or who have the motivation to pull together the complex elements of diabetic care for children in the manner achieved by Superior.

Care for Chronic Conditions

Use of Appropriate Medications for People with Asthma

In the Texas Medicaid program, asthma is one of the most common conditions impacting both adults and children. It is often the cause of preventable hospital admissions. The MCOs have put many initiatives in place to improve care for persons with asthma.

Use of Appropriate Medications for People with Asthma. This measure assesses the percentage of members with persistent asthma who were appropriately prescribed medication during the measurement period. As seen in the chart below prepared by the Texas EQRO, the MCOs have been effective in ensuring the use of medication for both adults and children with asthma.

Chart R: Use of Appropriate Medications for People with Asthma Ages 5-11 years

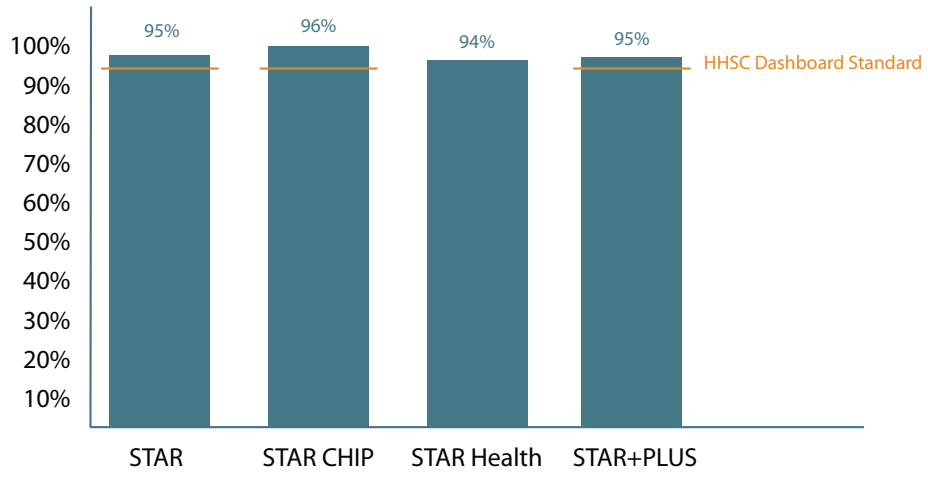
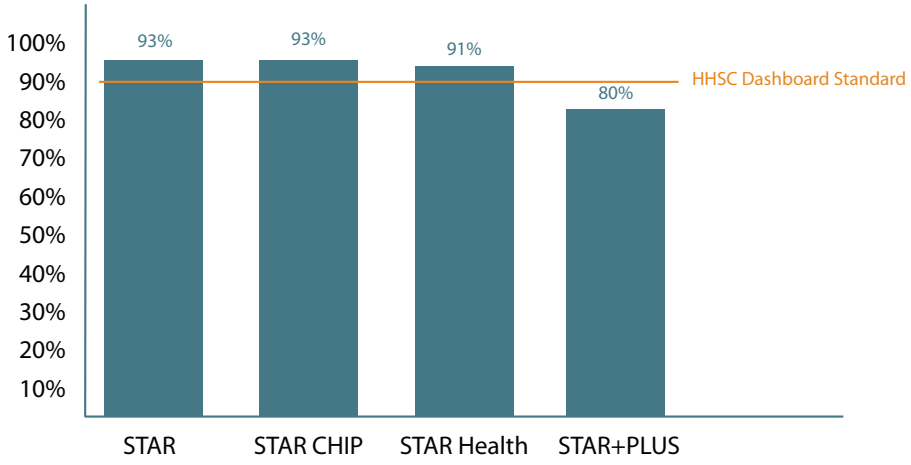


Chart S: Use of Appropriate Medications for People with Asthma Ages 12-50 years



Medication Adherence Initiatives

Patients on Persistent Medications for Chronic Conditions

Many STAR+PLUS members have chronic conditions that require ongoing, regular medication. Poor compliance with medication regimens can result in acute exacerbation of conditions leading to emergency department visits or inpatient admissions. Also, persons taking persistent medications may be at risk for adverse drug events. The HEDIS® *Annual Monitoring for Patients on Persistent Medications* measure assesses the percentage of members 18 years of age and older with at least 180 treatment days of ambulatory medication therapy who received at least one therapeutic monitoring event during the measurement year.[5]

Table 10: The HEDIS® Annual Monitoring for Patients on Persistent Medications | STAR+PLUS CY 2011 Results

ACE or ARB	92%
Anticonvulsants	67%
Digoxin	92%
Diuretics	92%
Combined Rate	88%

As indicated in the figure above, there was strong monitoring of medications for STAR+PLUS members with chronic conditions. Overall, for members with conditions such as hypertension, congestive heart failure, kidney disease, or epilepsy, the vast majority received annual medication monitoring. Also of note, this performance was seen across the state with STAR+PLUS MCOs performing equally well on this measure.

Medication Adherence Following Acute Events

The EQRO conducted a focus study using data from 2006-2011 to examine the effects of the STAR+PLUS Program on the quality of chronic care for Medicaid enrollees. They compared the results for persons in FFS/PCCM with STAR+PLUS

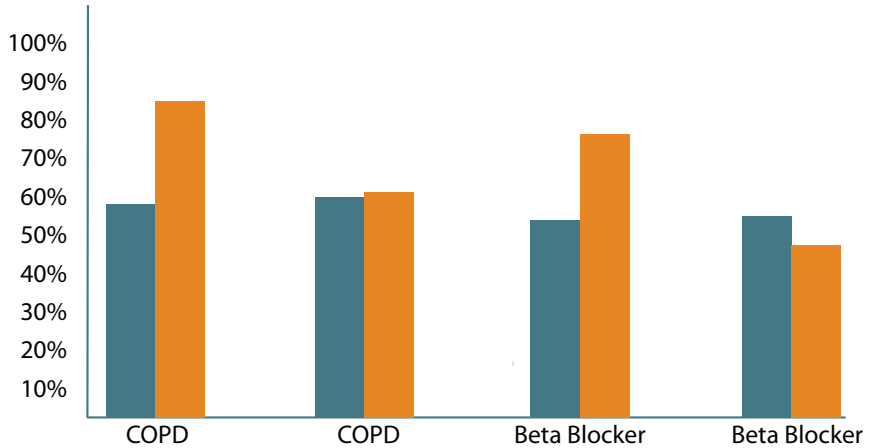
members after controlling for socio-demographic characteristics, health status, income and program year. They found "substantial and sustained improvements in Chronic Obstructive Pulmonary Disease (COPD) treatment and use of beta blockers due to STAR+PLUS."

Focus Study Results

- Pharmacotherapy for COPD Exacerbation: Pharmacotherapy is used to reduce exacerbation and mortality from COPD. Prior to 2007, 55.5% of enrollees in counties set to transition into the STAR+PLUS program adhered to COPD pharmacotherapy. For comparison, enrollees in counties using FFS and PCCM had a similar adherence rate of 56.6%. After transitioning into STAR+PLUS, enrollees increased adherence to an average rate of 82% between 2007 and 2010. This signifies a 26.5% increase in pharmacotherapy for STAR+PLUS enrollees. Among counties using FFS and PCCM, enrollees increased adherence to 57.9%.
- Persistence of Beta Blocker Treatment after a Heart Attack: Utilization of beta blockers has been associated with reductions in heart-related events and cardiovascular and all-cause mortality. Prior to 2007, only 50.7% of enrollees in transitional counties for STAR+PLUS used beta blockers after a heart attack. During the same period, enrollees in FFS and PCCM counties used beta blockers at a rate of 52.6%. From 2007 to 2010, the adherence rate of beta blocker treatment among STAR+PLUS enrollees increased to an average of 74.2%, increasing use of treatment by 23.5%. Among counties using FFS and PCCM, rates of beta blocker treatment utilization decreased to 44.8%.

Results for both chronic measures show significant improvements in STAR+PLUS compared to FFS and PCCM.

Chart T: STAR+PLUS compared to Fee for Service and PCCM



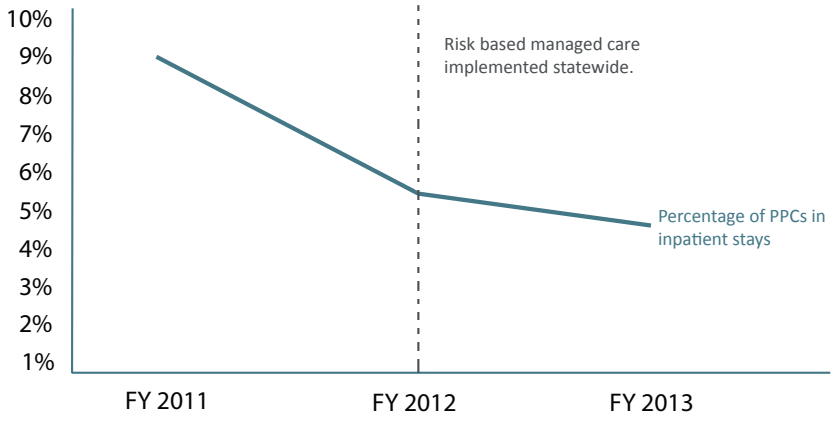
	COPD Treatment: STAR+PLUS	COPD Treatment: FFS/PCCM	Beta Blocker Treatment: STAR+PLUS	Beta Blocker Treatment: FFS/PCCM
Baseline	55.5%	56.6%	50.7%	52.6%
Average Post	82.0%	57.9%	74.2%	44.8%

Potentially Preventable Complications (PPCs) as Both a Quality and Cost Containment Measure

An important indicator of quality care in hospitals is the occurrence of potentially preventable complications (PPCs). PPCs are harmful events or negative outcomes that occur after admission into the hospital that may result from errors or anomalies in the processes of treatment and care, rather than the progression of the underlying illness. Because PPCs are not inherent to the illness, they are potentially preventable.

In addition, the occurrence of PPCs results in substantial additional costs in providing care to patients at hospitals. The EQRO reviewed a sample of at least 240,000 claims in each State Fiscal Year 2011-2013 to examine the impact of PPCs. In SFY 2012, the impact of the significant statewide shift to Medicaid managed care can be seen. The rate of PPCs dropped substantially, resulting in not only better quality of care, but significant costs savings. Of particular note is obstetrical PPCs which tend to be approximately half of all PPCs.

Chart U: Impact of Potentially Preventable Complications



Quality Assessment and Performance Improvement Program (QAPI)

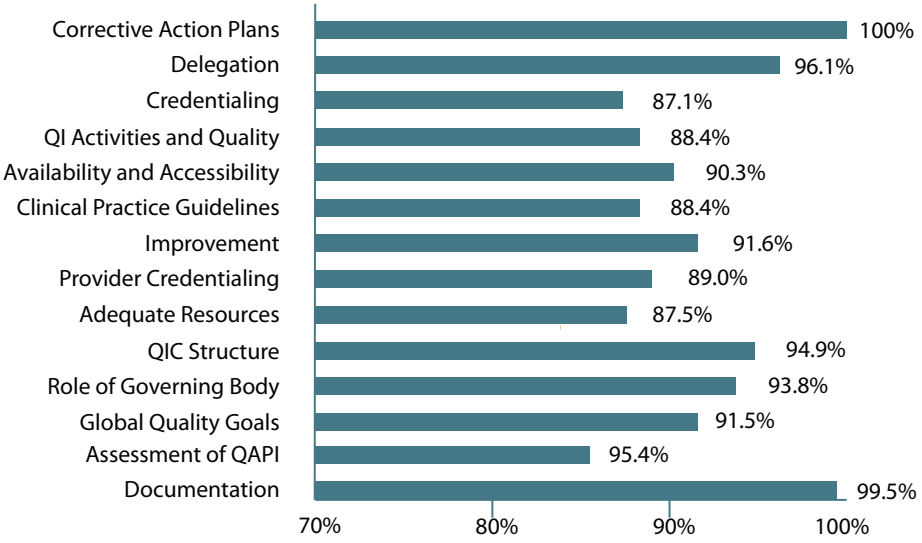
The MCO QAPI program helps ensure the provision of quality care to Medicaid enrollees through certain functions, including: [6, 7]

- Evaluating performance using objective quality indicators
- Developing mechanisms to assess quality and appropriateness of care provided to enrollees with special healthcare needs
- Developing mechanisms to identify under and over-utilization of healthcare services
- Implementing performance improvement projects that address both clinical and non-clinical aspects of care
- Engaging in discussions with providers and enrollees on performance and improvement activities
- Supporting the continuous measurement and assessment of cost-effectiveness, member satisfaction, access, and quality of care

Annually, the EQRO reviews each health plan's QAPI program to evaluate the structure and process of quality improvement activities performed by a health plan. The chart below[8] shows the average health plan score for each section of the evaluation. Scoring is based on whether a health plan completes the requirements of a comprehensive quality improvement project and followed program regulations.

The review demonstrates high levels of compliance in the MCOs quality assessment and performance improvement programs.

Chart V: Overall QAPI Score by Section, FY 2011



Chapter 5
Member Satisfaction

Medicaid managed care members are highly satisfied with the care they receive and their health plans.

Members have access to robust complaint and appeal processes.

In recognition that member satisfaction is a key piece of the health care experience, Texas included improving member satisfaction with their healthcare as one of the state's three goals within the Quality Improvement Strategy. Texas' implementation of managed care has included strong protections for members, and the data shows that members are satisfied with their care.

Tracking Member Satisfaction

Since the inception of Medicaid managed care in Texas, ensuring quality care for all members has been the primary goal. In addition to ongoing oversight by HHSC, the State's external quality review organization (EQRO) annually assesses the performance of each MCO. The State's EQRO is the Institute of Child Health Policy at the University of Florida. In addition to clinical and administrative measures, the EQRO also measures and monitors members' perception of care. The EQRO conducts telephone interviews with adult members and parents of child members of Texas Medicaid and the Children's Health Insurance Program (CHIP).

90% of STAR Health members reported being "usually" or "always" satisfied with their timeliness of care in 2012.

Timeliness of Care

One of the most important factors in determining member satisfaction is the timeliness of care. Long waits to receive care can cause emotional distress for members and also increase the risk of physical harm by delaying needed care. The EQRO evaluates member satisfaction with the timeliness of care using the CAHPS Health Plan Survey. Members have positive satisfaction with

Members Value High Touch Outpatient Behavioral Health Program

Cigna HealthSpring provides services in Hidalgo and Tarrant counties. Data analysis revealed that the 5% most expensive members have primary behavioral health and substance abuse disorders. The Intensive Outpatient Program serves the "sickest of the sick" including members with schizophrenia, bipolar disorder, substance abuse disorder and personality disorder. Its motto is reflected in the charge to the nurse care managers: "Do whatever it takes to allow the member to live as independently as possible in the community". Once identified, the nurses seek out the member in their home, a shelter or even in jail; they go wherever the member is located. Nurses administer medication, perform mental status evaluations, address and resolve social, housing, and financial issues. The program has resulted in up to a 90% reduction of inpatient admissions for the target population. And the initial cohort of 15 patients saw their monthly medical expenses decline from $24,000 to $14,000 in the first 6 months after referral to the program.

Importantly, members recognize the impact that this program has in their lives, as evidenced by the following letter from a member.

> Hi! My name is __ I live in Laredo and I was a drug addict for a little more than 9 years and I'm happy to say that I've been clean for almost 4 months. Thanks for people and doctors that saw me as a person not the drug addict. I would like to thank Mr. Sanchez cause I feel he came right into my life when I needed someone to talk to and most of all listen to what I was saying. He's really helped me through this addiction my boyfriend and I had and all it took was someone to listen and care. Mr. Sanchez is my Guardian angel. I hope you all could have more people like him out here. Cause people can change they just need the opportunity and someone to believe in them. Well I guess I'm the example that we can change if want to and thanks to your help and programs.
>
> Sincerely very thankful _____ (member name redacted)

the timeliness of care in Medicaid managed care. Over 70% of adult members in STAR and STAR+PLUS reported that they "usually" or "always" had positive experiences with timeliness of care. Member satisfaction with timeliness of care is even greater for parents of child members. Among the five surveys completed across STAR, CHIP and STAR Health, 83% or more reported that they were "usually" or "always" had positive experiences with timeliness of care.

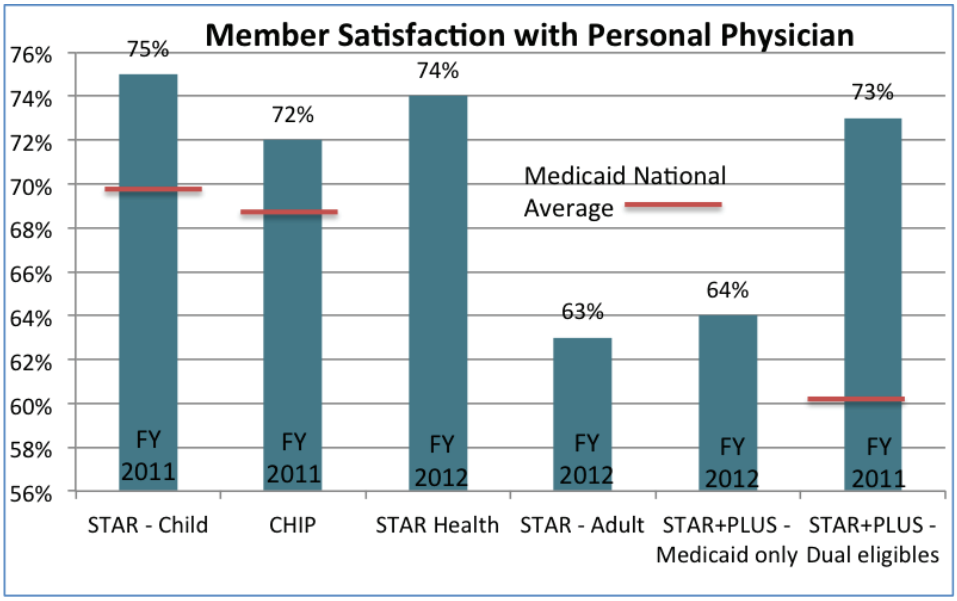
Personal Physicians

For many members, interactions with their personal doctor are their primary interaction with the health care system. Thus, satisfaction with personal doctors becomes a key measure of member satisfaction with their health plan or program. The CAHPS Health Plan Survey asks members or parents of child members to rate their personal doctor on a scale from 0 to 10.

The chart summarizes recent results from that survey, where the percentages indicate members who rated their personal doctor a 9 or 10 on the scale. A significant majority of members and families have high levels of satisfaction with their personal doctors and their rate of satisfaction is higher than the national average.

Texas managed care members are more satisfied with their personal physican than the national average.

Chart W: Member Satisfaction with Personal Physician



In 2013, 83% of child members in STAR reported that they "usually" or "always" had a positive experience with their health plan customer services.

MCO Customer Service

Customer service is an important component of member satisfaction and strongly affects the total membership of an MCO. Up to 83% of members among the STAR, CHIP, STAR Health and STAR+PLUS programs reported that they were usually or always satisfied with the services they received from their health plan.

MCO Complaint Tracking and Resolution

Medicaid MCOs provide a much higher level of accountability to members than traditional fee for service Medicaid provides. Medicaid MCOs and HHSC track every complaint received from both members and providers in managed care. Complaints are defined as any dissatisfaction expressed by the complainant.

Member Complaints

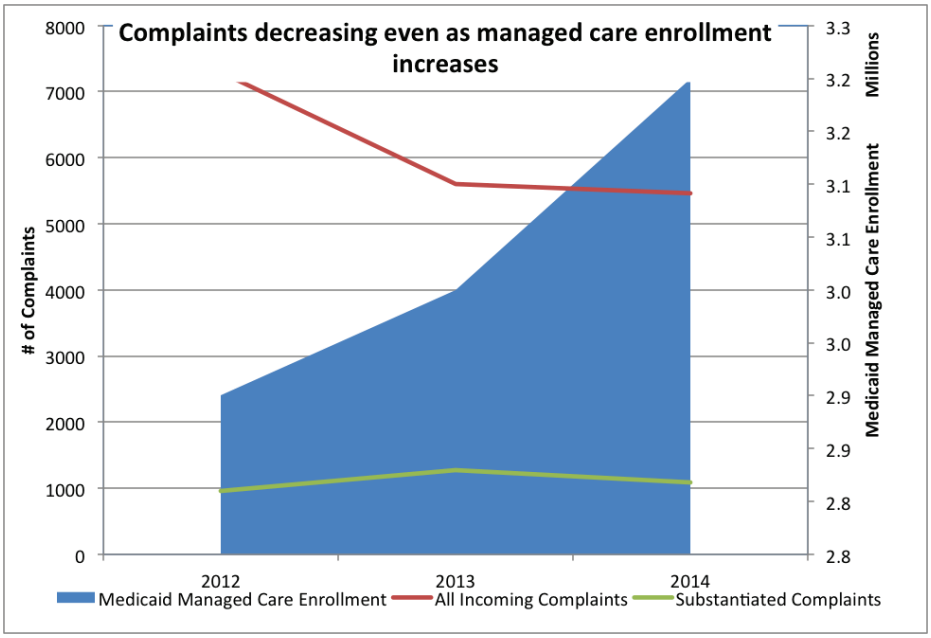
MCOs are required to continuously train member service personnel to recognize and log complaints. They are further required to resolve at least 98 percent of complaints and appeals within 30 calendar days of receipt. Each quarter, MCOs send complaint and appeal data to HHSC. HHSC also receives complaints directly through the Ombudsman office and the Managed Care Division. Results are posted on the dashboard.

Clinical Complaints and Service Denial Appeals

Importantly, clinical complaints and appeals of service denials follow a strictly prescribed and monitored process detailed in the MCO contract. These are tracked separately from member complaints. MCOs must adhere to strict guidelines for timely and impartial review of appeals by physicians of a same or similar specialty who have not been previously involved with the case. These MCO processes can be by-passed by members or their representatives at any time with an appeal to the Ombudsman or accessing the Fair Hearing Process.

While the number of complaints appears to be relatively stable year over year, overall MCO membership has steadily increased, with the result being that the rate of complaints is actually decreasing[1] (see chart below). In addition, MCOs' ongoing training of staff in the recognition of complaints assures that more complaints are appropriately recorded and resolved.

Chart X: Analysis of Complaints



Chapter 6
Dental Managed Care

Dental services for children under 21 have been provided through two Dental MCOs since 2012.

Prior to Dental Managed Care, costs for dental services had risen from $399 million in FY2007 to $1.4 billion in FY2011.

Following managed care implementation, program costs decreased by 28.4%.

Majority of program savings were due to better oversight of orthodontic services and more cost effective preventative dentistry.

Background

Medicaid dental services in Texas are provided for children under age 21 through the THSteps benefit. Prior to 2012, HHSC directly contracted with dental providers for services. Medicaid dental expenditures grew dramatically from FY 2007 through FY 2011 so much that during the 2011 Texas Legislative session an initiative was developed to move dental services into managed care to better manage costs and increase access and quality. The Dental RFP focused on procuring managed care services that would increase access to and quality of care as well as ensure appropriate utilization. Prior to implementation of dental managed care there were effectively no quality or access measures in place other than utilization data reported in an annual report to the federal government.

The table below outlines increases in total dental expenditures FY 2004 – FY 2014.

Table 11: Texas Medicaid Dental Costs

Fiscal Year	Managed Care Costs	FFS Cost	Total Costs
2004	-	$316,465,063	$316,465,063
2005	-	$357,528,020	$357,528,020
2006	-	$369,731,981	$369,731,981
2007	-	$399,152,403	$399,152,403
2008	-	$767,642,716	$767,642,716
2009	-	$963,338,280	$963,338,280
2010	-	$1,239,936,672	$1,239,936,672
2011	-	$1,430,564,979	$1,430,564,979
2012	$705,992,112	$738,308,775	$1,444,300,886
2013	$1,206,193,670	$88,755,625	$1,294,949,296
2014	$1,094,586,500	$91,446,575	$1,186,033,075

Source: HHSC SFC, 201412 FY 2014 data is not final

Orthodontia Expenditures Prior to Managed Care

Similar to the trend with dental services in general, orthodontia utilization rates increased dramatically from $102 to $185 million from 2008 to 2010. The number of prior authorization requests for orthodontia services also increased. As demonstrated in the table below, the number of requests increased and the approval rate was high. During this time period, HHSC used a fiscal agent to provide prior authorization services. There were no financial incentives associated with utilization; rather the PA process was paid as an administrative service.

Coinciding with the implementation of dental managed care HHSC implemented several policy changes to better control prior authorization, approval requirements and place limits on the number of visits associated with orthodontic maintenance and provider requirements to deliver orthodontic services. These policies were implemented by the Dental MCOs.

Table 12: Approval Rate for Orthodontia PA by State FY

State Fiscal Year	Orthodontia PA Request Received	Request Approved	Approval Rate
SFY 2007	58,850	52,027	88%
SFY 2008	74,797	61,721	83%
SFY 2009	95,975	80,428	84%
SFY 2010	125,564	109,516	87%
SFY 2011	142,043	118,410	83%

Dental Managed Care

Due to the alarming increase in dental costs and soaring rates of orthodontia utilization, the Legislature directed HHSC to look to a managed care approach for providing dental services. Following release of an RFP, three statewide contracts were awarded to dental managed care organizations (Dental MCOs). Initially, contracts were awarded to Delta Dental, DentaQuest and Managed Care of North America (MCNA). Delta Dental's contract was later terminated. The Medicaid dental managed care program was implemented effective March 1, 2012.

Utilization

According to a study published by HHSC in February 2013 the impacts of dental managed care was almost immediate. In the first six months after dental managed care implementation the number of services provided decreased by 30 percent even though the number of people eligible to receive services remained constant. A decrease in utilization of orthodontia services was the driving force behind the overall reduction in services used. Orthodontia use decreased by 72 percent, and payments to orthodontia providers decreased by 81 percent.[1]

The majority of Medicaid dental services are diagnostic or preventive. A well-performing dental program will reflect a move away from invasive and expensive treatment and toward increased use of diagnostic and preventative services. Such has been the case with dental managed care. Approximately 65 percent of services in the 2011 time period prior to dental managed care implementation were associated with diagnostic and preventative services. After dental managed care was implemented, the number increased to 73 percent—an 8 percent increase in a six-month period despite an overall utilization decrease in that same time period in the use of dental services.

Orthodontia

Orthodontic services accounted for 10 percent of services between March and August 2011. Six months following implementation of dental managed care, orthodontia utilization was only four percent of services due to dental MCOs comprehensive prior authorization processes.

Costs

Within six months of implementation, the Dental MCOs were able to demonstrate the ability to better control costs. During the period March 2012 – August 2012 the total amounts paid in premiums to the Dental MCOs was $707 million. By comparison total FFS payments to providers between March and August 2011 were $770.2 million. Adding the remaining FFS payments to providers during this same period of $58.8 million, the total comparable spending was $763.8 million, saving the state over $6 million. In addition to those savings, the premium tax revenue for the 2012 corresponding time period is $12 million. The combined impact of better managed dental costs plus premium tax resulted in a net gain to the state of $18 million—all in a six-month period.

Innovations in Improving Quality of Care

DentaQuest's industry leading Preventistry program is increasing the number of high-risk children receiving preventive fluoride treatments and sealants, and the timeliness of oral evaluations. Their initial focus was to improve results for the bottom 20% of providers comparing them to their peers. From 2012 to 2013, sealant usage increased 10% while restoration costs dropped by 30% in 2013. As DentaQuest moves forward, they plan to expand efforts to impact more children.

DentaQuest's provider incentive program promotes quality outcomes and increased efficiency. They measure the performance of each dentist against their peers and offer financial incentives for those providers for performing sealants and fluoride. In 2014, DentaQuest paid out **over $4 million** through this initiative.

Chapter 7
Cost Savings

Texas Medicaid expenses studied produced estimated savings of $3.8 billion compared to costs expected under a fee-for-service arrangement for SFY 2010 – SFY 2015 (7.9% All Funds Savings).

Medicaid Dental has experienced the highest percentage of total program savings: 28.4% since SFY2013 on an all funds basis.

STAR Medical contributes the most estimated savings by volume, at just over $2 billion from SFY2010 – SFY2015.

From SFY2010 – SFY2015 managed care has reduced the STAR expense line of the state budget by an estimated 9.3% compared to expected FFS cost, including revenue from premium taxes.

From SFY2010 – SFY2015 managed care has reduced the STAR+PLUS expense line of the state budget by an estimated 3.8% compared to expected FFS cost, including revenue from premium taxes.

Capitation cost trends for the STAR, STAR+PLUS and Dental Medicaid programs have been below expected FFS trends for SFYs 2010 - 2015.

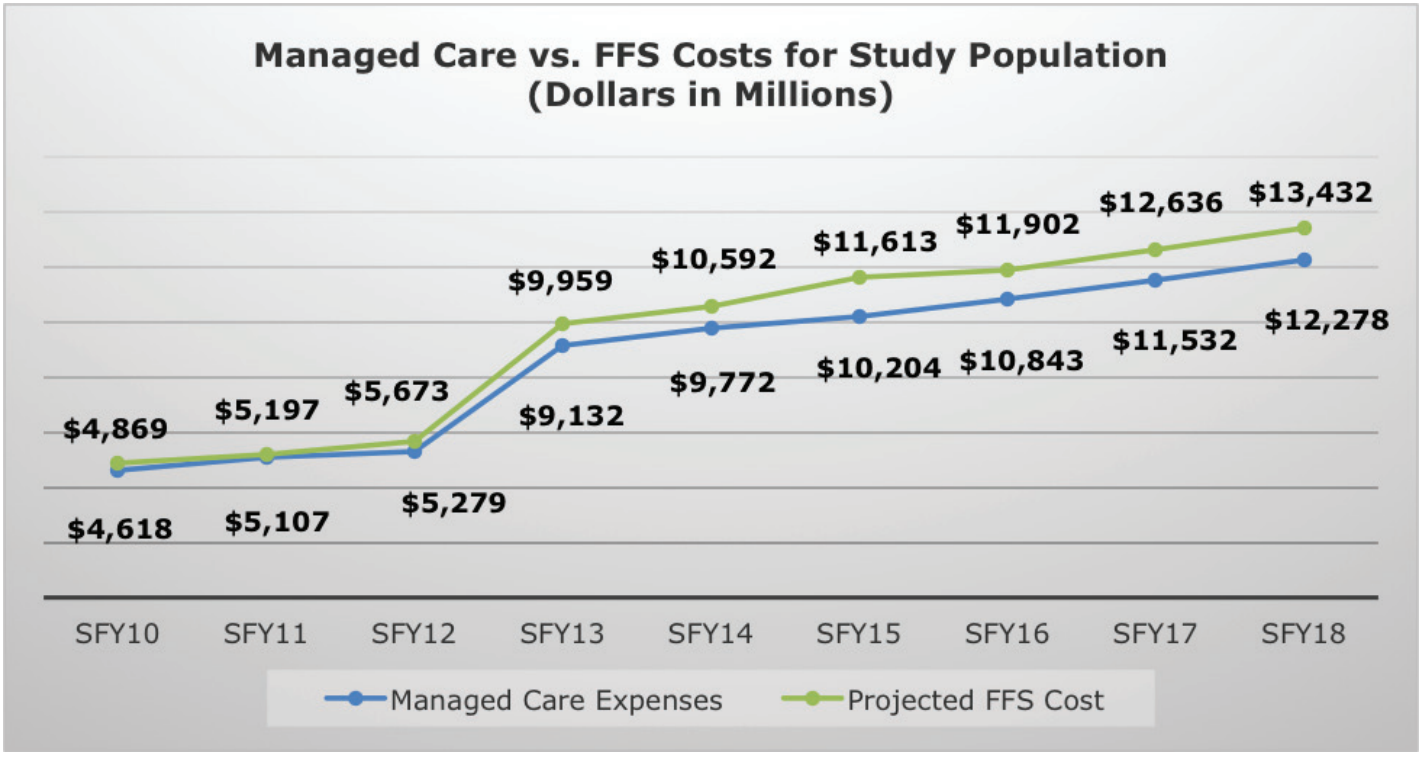
Four of the seven cohorts studied had annualized trends below 1% over the study period.

In addition to improving quality, a major goal of Medicaid managed care is to control costs associated with providing health care to the covered population. Because the vast majority of the Texas Medicaid program is now in capitated managed care, it is critical to have an understanding of how costs have trended under these programs. An analysis of costs under the STAR, STAR+PLUS, and DMO programs completed by Milliman on behalf of TAHP shows that cost trends in these programs have been below expected trends in a fee-for-service environment. Milliman has estimated that savings for the populations and services included in its study were nearly $3.8 billion over the six years from SFY 2010 through SFY 2015. Milliman's results, methodology, and assumptions are briefly described in this Chapter. The complete report can be found in the Appendix.

Results

For the six year period from SFY2010 – SFY2015, Milliman estimates that the managed care capitation payment structure of the STAR and STAR-PLUS programs has resulted in a Medicaid All Funds cost reduction in the range of 5.0% to 10.7% when compared to estimated expenditures on a fee-for-service structure. This range applies to the cost impact study population, which covered approximately $44.1 billion of Texas State Medicaid All Funds spending for this time period. Their best estimate is that this results in savings of approximately $3.8 billion, or 7.9% of projected FFS costs over six years. Taking into account Federal Medicaid matching (FMAP) and premium tax revenue to the state, the study estimates that managed care has reduced the state portion of Medicaid funding by 7.4% to 13.0% over this same period for the programs covered in the study. This results in a best estimate of $2 billion in savings to the state, or 10.2% of the state's share of projected FFS expense.

Chart Y: Managed Care vs. FFS Costs



A major driver enabling these programs to achieve savings can be seen in the average annual implied cost trend. These implied cost trends were determined by normalizing the year-over-year capitation expenses for population mix, program changes, and shifts in administrative expenses, with implied trends as the remainder. As you will see in the grid below, four out of the seven cohorts studied have annualized trends below 1%. STAR Medical, the largest of the cohorts, is still achieving significant savings with an annualized trend of 1.6%, as is STAR+PLUS LTSS, with a trend of 3.3%.

Table 13: Annualized Implied Trend by Program

Program - Service Type	Span	Annualized Implied Trend
STAR Medical	6-years	1.6%
STAR Pharmacy	3-years	0.5%
Medicaid Dental	3-years	-8.7%
STAR+PLUS LTSS	6-years	3.3%
STAR+PLUS Acute (Non-Inpatient)	6-years	0.8%
STAR+PLUS Acute (Inpatient)	3-years	7.2%
STAR+PLUS Pharmacy	3-years	-0.9%

Methodology

In general, Milliman's study was developed using a methodology typically used in retrospective valuations of disease and/or case management programs. The study estimates the impact that managed care organizations have on the state budget by comparing actual historical program costs to hypothetical costs under a fee-for-service arrangement.

The analysis separately addresses costs for STAR medical, STAR+PLUS medical, STAR pharmacy, STAR+PLUS pharmacy, and the Texas Medicaid Dental Program. For the medical cost analysis (including long-term services and supports (LTSS) in STAR+PLUS), it assessed the cost impact from SFY2009 through SFY2015, and projected the impacts through SFY2018. The study includes the Service Delivery Areas (SDAs) that had converted to risk-based capitated managed care in the STAR and STAR+PLUS programs prior to SFY2009, and the major service categories included in the capitation at that time.

For pharmacy, dental, and STAR+PLUS inpatient it assesses the cost impact from the initial date of the carve-in (March 1, 2012) through SFY2015, and projects the impacts through SFY2018. All SDAs are included in the study for these programs.

The primary data sources used for the analysis were the annual actuarial rate memoranda. These formed consistent and publicly available sources of information for all programs.

Sensitivities were run on the major assumptions in this study. The range of results provided were determined by assuming a 1% variance (positive and negative) in annual FFS trends for each cohort.

Caveats

As with any study of this type and magnitude, the estimated savings dollars are highly leveraged to the assumptions being used. The complete report (attached) includes the results under varying assumptions and describes the underlying methodology, assumptions, caveats and limitations in detail and is critical for an understanding of the results.

Chapter 8
Medicaid Managed Care Moving Forward

The future is promising for Medicaid managed care in Texas.

Since its inception, the managed care model has successfully improved quality and access and lowered costs in the Texas Medicaid program.

The continued benefits of managed care in Texas rely on maintaining a regulatory environment that fosters innovation, allowing full integration of services, ensuring a collaborative and transparent rate development process, and reducing administrative complexity whenever possible.

Summary

Managed care is an approach to delivering health care that seeks to stabilize health care costs and improve quality of care through a variety of methods, including provider network management, greater emphasis on preventive services, better management of chronic conditions through meaningful patient education and support and providing appropriate means for clients to live in their own homes. Texas is considered a leading innovator on the delivery of efficient and high-quality Medicaid programs.

Improvements in Quality of Care

Texas MCOs have improved quality of care for both children and adults in Medicaid managed care.

STAR Program Quality Improvement. Assessed against national quality standards, the Texas STAR care program provides encouraging results in reducing hospital admission rates for children:

- Asthma: Rates for asthma improved 22% from 2009 to 2011.
- Diabetes Short-Term Complications: Rates declined from 25.18 per 100,000 in 2009 to 18.58 per 100,000 in 2011, a 26% decrease.
- Gastroenteritis: Rates decreased approximately 37% from 2009 to 2011. Moreover, rates of gastroenteritis in 2011 (45 per 100,000) fell substantially below HHSC Dashboard Standards (146 per 100,000).
- Urinary Tract Infection: Rates decreased by nearly 20% from 2009 to 2011. The 2011 rates (31) were significantly lower than the HHSC Dashboard Standard of 53 per 100,000.

STAR+PLUS Quality Improvement. Hospital admission rates decreased for adults with disabilities as well:

- Diabetes Short-Term Complications: Rates decreased 31% between 2009-2011.
- Bacterial Pneumonia: Rates decreased 19% between 2009-2011.
- Urinary Tract Infection: Rates declined 31% between 2009- 2011.

Additionally, MCOs have developed new provider payment systems that focus on rewarding the quality of care delivered, not the volume. These alternative payment structures include specific goals and metrics for improving care to members. All Medicaid MCOs and dental managed care organizations have implemented pay for performance initiatives with network providers. One example is found on the following page.

Provider Incentive Program 2015

Texas Children's Health Plan is changing its Provider Incentive Program in an effort to align with state performance measures for Pay for Quality (P4Q). The new program focuses on rewarding provider groups for reducing Ambulatory Care Sensitive Conditions (ACSC) ER visits and admissions as well as improving utilization of preventive care based on the Healthcare Effectiveness Data and Information Set (HEDIS) measures. The program has 4 payouts. Each quarter, physicians have the opportunity to receive a bonus payout on 1 of the goals. Providers can earn an incentive for each separate measure.

1. Reduce Ambulatory Care Sensitive Conditions (ACSC) ER Admissions per 1,000 members.
2. Reduce Ambulatory Care Sensitive Conditions (ACSC) ER Admissions per 1,000 members
3. Improve utilization of preventive care based on HEDIS measures

Payout schedule

- Reduce ACSC ER visits: Biannually in January and July
- Reduce ACSC ER admissions: Annually in October
- Improve HEDIS preventive care measures: Annually in April

Cost Savings in Medicaid Managed Care

In addition to improving quality, a major goal of Medicaid managed care is to control costs associated with providing health care to the covered population. An analysis of costs under the STAR, STAR+PLUS, and dental managed care (DMO) programs completed by Milliman shows that cost trends in these programs have been below expected trends in a fee-for-service environment. Milliman has estimated that savings for the populations and services included in its study were nearly $3.8 billion or 7.9% of projected costs over the six years from SFY 2010 through SFY 2015.

Access to Care

Managed care provides an enhanced access to care compared to the traditional FFS Medicaid program. Highlights of MCO performance on access to care include:

- An average of **93% of child and adolescent members reporting having a PCP** and **90% visiting their PCP** during the year
- Surpassed national performance expectations on **child well visits and childhood immunizations**
- **No Interest List wait** to access community based waiver services
- **High level of customer satisfaction** with 83% of child members reporting overall positive experience with their

Accountability

MCOs provide a higher level of accountability to members than traditional FFS Medicaid. Texas Medicaid MCOs have excelled in meeting and exceeding measurable contractual standards for performance and quality improvement, which are monitored on an on-going basis and include:

- network adequacy
- timely claims payment
- timely access to care
- outreach to members for preventive and follow-up care
- identification of areas for quality improvements
- cultural competency
- care management and continuity of care
- intensive service coordination for STAR+PLUS members
- provider incentives including pay-for-performance
- quality assurance and performance improvement
- integration of physical, behavioral and LTSS
- person-centered care planning

Poor performance on any of these contract standards can result in significant financial penalties for MCOs.

MCOs also undergo stringent readiness reviews prior to any members being allowed to enroll in the MCO. Passing readiness review is getting tougher in Texas as more sophisticated measurement and readiness review tools become available.

Additionally, all Texas MCOs have Fraud and Abuse Detection units to investigate potential incidents. Other fraud prevention and detection requirements and activities include:

- MCOs are required to develop compliance plans with clear policies and procedures on how they will prevent fraud and abuse.
- MCOs employ cross-departmental committees to develop risk management strategic plans and action steps for preventing and detecting fraud, to evaluate the effectiveness of their activities, and to revise the action plan as appropriate. MCO Fraud and Abuse Recoveries for FY2014 are available here.

MCOs also employ utilization management and review activities to ensure members are receiving the right care at the right time in the right place.

The full MCO Deliverables Matrix from HHSC can be found here.

Moving Forward

MCOs are the platform for Texas to pursue payment reform and alignment of financial incentives. If Texas is to realize the investment it has made through the Health Care Transformation and Quality Improvement Program Waiver (1115 Waiver), there must be increased engagement with managed care. The MCOs and HHSC should continue to build upon the quality initiatives and innovative reforms promoted by the Texas legislature.

In the short term, Texas Medicaid will launch two new managed care models for complex populations- dual eligibles and children with disabilities to

better integrate and coordinate the community long term care needs of these complex populations with their acute care at a manageable cost. As the state moves forward with bringing together the coordination of all of the health services for these individuals under one entity, it is imperative that the regulatory environment and federal and state Medicaid policies are aligned to support key managed care principles.

Integration

Further service integration within managed care will reduce Texas Medicaid costs and increase quality. There is a large body of evidence showing that patients fare better when their physical, behavioral health and LTSS are coordinated in a single delivery system. Texas has taken important steps in this direction by carving in behavioral health, pharmacy and LTSS services into managed care. By having all benefits administered by a single managed care plan, members are able to receive all their healthcare and support needs through one individualized plan of care. That should raise questions when any services are proposed for "carve out" of managed care in the future.

Transparency

To operate effectively and provide the state budget predictability, the MCOs and HHSC must establish **a rate setting process that is collaborative and transparent.** The principles guiding such a process are timeliness of the rate setting process, reliable data, and greater transparency on rate setting assumptions and cost trends to include policy changes and the addition of new treatment modalities (e.g. Sovaldi in 2014) to provide a basis for establishing actuarially sounds rates. There are many factors that influence the cost of providing healthcare and services to the Medicaid population and these factors are constantly evolving.

Administrative Simplification

While Medicaid is a complex program, those complexities should not translate into administrative burdens for providers, consumers and health plans. Over the last several years there has been a tremendous increase in the MCO regulatory environment. Although some of the new regulations have been welcome, some may have unintended consequences. What makes the MCO model effective is its ability to deviate from the heavily controlled federal Medicaid rules to provide benefits and services that recognize the needs and personal choices of the consumer. HHSC should pursue **opportunities to reduce administrative complexity wherever possible.**

Innovation

Finally, the **ability to innovate** is critical to being able to provide the best services to Medicaid members while at the same time being responsible partners to the Texas Medicaid program. The Texas Medicaid MCOs have brought many best practices to the communities they serve. The community based plans have, through their hospital affiliations, developed programs targeted to the Medicaid/CHIP population that have increased access to care, promoted healthy behaviors, and addressed specific concerns such as asthma,

pre-mature births, and behavioral health/substance abuse. The health plans with a national presence have brought best practices developed in other markets to Texas such as super-utilizer house call models, telepyschiatry interventions, and home and community based service innovations to name a few.

Innovations can occur more easily under a managed care approach because of flexibility to pay for and provide services in different ways. MCOs can use cost savings from keeping persons out of the hospital or emergency department to fund new service delivery approaches that address particular populations like superutilizers or homeless populations.

Innovative programs also provide opportunities for new managed care populations. New approaches for serving high needs populations, like providing provider house calls to members with complex and chronic conditions, or peer support models for persons with behavioral health needs, are vital to improving healthcare. The best programs are those that are created with consumer input. Allowing consumers to help set the stage for how their services and supports are delivered result in more effective plans of care. Maintaining this crucial ability requires careful balance of necessary regulatory requirements with flexibility to experiment with new initiatives to improve care delivery and cost-effectiveness of the Medicaid program.

Here we provide some example of innovations that would not have occurred under traditional Medicaid.

Innovations for Homeless Populations

UnitedHealthcare launched an innovative concept in 2013 that focuses on the ability to identify members who are chronically homeless and to assign a housing case manager to move them to stable housing. The homeless population presents great challenges due to their increased risk for complex, chronic conditions and greater risk for mental health and substance abuse. National studies show that people who are high utilizers of services – ER, ambulances, inpatient -- show a 40-70% reduction in costs once they are provided housing through a shift in focus toward preventative care, chronic illness management, improvements in functional abilities, and behavioral health counseling. United's data shows that 25 of the 'unable to reach' members have generated $2.1 million in medical spending over the past 18 months.

Working with ECHO (Austin homeless coalition) and the Houston Homeless Coalition, United is designing a Pilot Program that will include engagement in housing needs assessment, assignment of a housing case manager, immediate enrollment with PCP and dedicated service coordinator who will remain with the member until member is securely housed. It is expected that many of these members will qualify for top priority placements through the coordinated care activities currently in place in Austin and Houston. In addition to dedicated case management for the members, United intends to educate homeless and housing service providers on Medicaid, STAR+PLUS, Service Coordination, homeless services and supportive services and continue to explore new ways to collaborate. For formerly homeless members who have moved into supportive housing, care coordinators will ensure that relationships with the providers are established and that care plans include other essential community service providers.

Innovations in Telemedicine

The Medicaid MCOs use technology to address the lack of providers in certain areas of the state. Increasingly, telemedicine is being used to fill unmet needs, especially in underserved communities. For example, **Driscoll Children's Health Plan** convened a joint project with UTMB and Behavioral Health Services of Nueces County (BHSNC) to implement the Tele-Psych Clinic. UTMB has well-developed telemedicine capabilities and BHSNC has behavioral specialist resources in the region to implement the program. The program was launched in October 2012 and in the first six months, 145 members were seen in the Tele-Psych Clinic, including over 200 hours of access to Child Psychiatrists. Without this program, most of these children would not have received the level of specialist intervention warranted by their conditions.

Innovations like Driscoll's don't occur in fee-for-service Medicaid. It's not that providers don't care; there just isn't the accountability for knitting together our complex health care system in the best interests of the client.

Innovations for Chronic and Complex Populations

Amerigroup has implemented a unique In-Home Program that offers in-home medical services including: provider visits, x-rays and laboratory tests and includes monitoring long-term treatment of chronic illnesses such as Diabetes, CHF, COPD and Hypertension. The services are in addition to an assigned care manager. The program greatly benefits members who may be homebound, or have significant barriers to getting to their PCP's office for care, while appropriately decreasing unnecessary ER and inpatient utilization. The program launched in 2009 will continue to expand.

Appendix
Report from Milliman

Milliman Client Report

Texas Medicaid Managed Care Cost Impact Study

Prepared for:
Texas Association of Health Plans

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February 17, 2015

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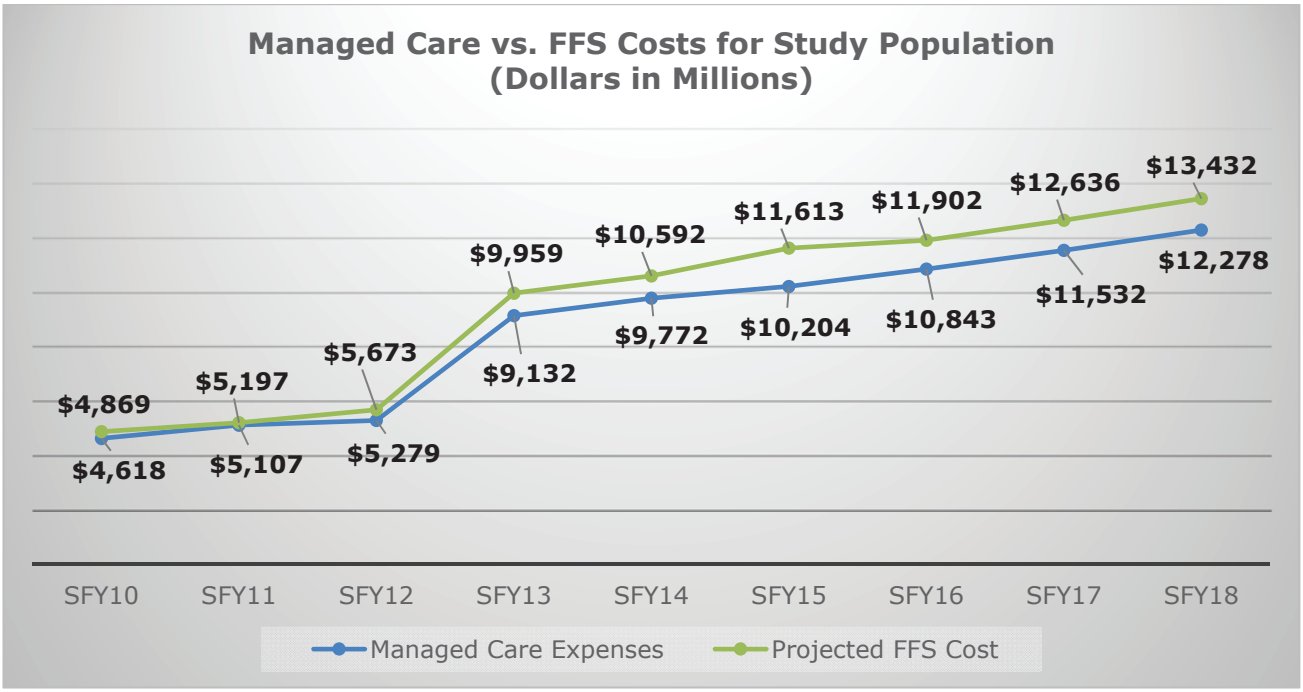
EXECUTIVE SUMMARY

Milliman was engaged by the Texas Association of Health Plans (TAHP) to evaluate the cost impact that managed care has on costs to the state for Texas Medicaid. Since the initial Travis County STAR pilot in 1993, Texas has continued to expand the scope and reach of managed care to the current time, when the vast majority of Medicaid recipients and healthcare services are covered through capitated managed care organizations (MCOs). Therefore, it is critical to have an understanding of how costs have trended under these programs. Cost changes are driven by a large number of factors, including changes to the mix of the populations enrolled, covered benefits and services, and healthcare cost trends. In our analysis, we have isolated these cost drivers in order to provide a better understanding of the sources of cost changes, and ultimately the estimated impact that the MCOs have had on costs in the STAR, STAR+PLUS and Medicaid Dental programs.

This study was developed using a methodology typically used in retrospective valuations of disease and/or case management programs. This study estimates the impact that managed care organizations have on the state budget by comparing actual historical program costs to hypothetical costs under a fee-for-service arrangement.

For the six year period from SFY2010 – SFY2015, we estimate that the managed care capitation payment structure of the STAR and STAR-PLUS programs have resulted in a Medicaid All Funds cost reduction in the range of 5.0% to 10.7% when compared to estimated expenditures on a fee-for-service structure. This range applies to our cost impact study population, which covered approximately $44.1 billion of Texas State Medicaid All Funds spending for this time period. Our best estimate is that this results in savings of nearly $3.8 billion, or 7.9% over six years. Taking into account Federal Medicaid matching (FMAP) and premium tax revenue to the state, we estimate that managed care has reduced the state portion of Medicaid funding by 7.4% to 13.0% over this same period for the programs covered in the study. This results in a best estimate of $2 billion in savings to the state, or 10.2% of the state's share of projected FFS expense.



The analysis separately addresses costs for STAR medical, STAR+PLUS medical, STAR pharmacy, STAR+PLUS pharmacy, and the Texas Medicaid Dental Program. For the medical cost analysis (including long-term services and supports (LTSS) in STAR+PLUS), we assessed the cost impact from SFY2009 through SFY2015, and projected the impacts through SFY2018. We included the Service Delivery Areas (SDAs) that

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The primary data sources used for the analysis were the annual actuarial rate memoranda. These formed consistent and publicly available sources of information for all programs.

As with any study of this type and magnitude, the estimated savings dollars are highly leveraged to the assumptions being used. The complete report describes the underlying methodology, assumptions, and limitations in detail and is critical for an understanding of the results.

INTRODUCTION

Milliman was engaged by the Texas Association of Health Plans (TAHP) to evaluate the cost impact that managed care has on costs to the state for Texas Medicaid. Since the initial Travis County STAR pilot in 1993, Texas has expanded the scope and reach of managed care to the current time, when the vast majority of Medicaid recipients and healthcare services are covered through capitated managed care organizations (MCOs). Therefore, it is critical to have an understanding of how costs have trended under these programs. Cost changes are driven by a large number of factors, including changes to the mix of the populations enrolled, covered benefits and services, and healthcare cost trends. In our analysis, we have isolated these cost drivers in order to provide a better understanding of the sources of cost changes, and ultimately the estimated impact that the MCOs have had on costs in the STAR, STAR+PLUS, and Medicaid Dental programs.

The report includes our key findings, methodology, and assumptions.

Scope of Study

We were asked to estimate the impact that MCOs in Texas have had on Medicaid costs in recent periods and to project the ongoing cost impact. We separately analyzed costs for STAR medical, STAR+PLUS medical, STAR pharmacy, STAR+PLUS pharmacy, and the Texas Medicaid Dental Program. For the medical cost analysis (including long-term services and supports (LTSS) in STAR+PLUS), we assessed the cost impact from SFY2009 through SFY2015, and projected the impacts through SFY2018. We included the Service Delivery Areas (SDAs) that had converted to risk-based capitated managed care in the STAR and STAR+PLUS programs prior to SFY 2009, and the major service categories included in the capitation at that time.

For pharmacy, dental, and STAR+PLUS inpatient we assessed the cost impact from the initial date of the carve-in (March 1, 2012) through SFY2015, and projected the impacts through SFY2018. All SDAs are included in the study for these programs.

Caveats

This report has been prepared for the use of TAHP. It may not be released to other parties without the prior written permission of Milliman, Inc. If Milliman grants permission to distribute this report to third parties, the report should be distributed in its entirety. Any user of the report must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Third parties receiving this report must rely upon their own experts in drawing conclusions about the information contained herein.

The enclosed projections reflect financial consequences that will result if the underlying assumptions are realized precisely. Actual results will differ from the projections due to a variety of influences, including random variation in the need for healthcare services. While we estimate the fee-for-service (FFS) costs that may have emerged in the absence of managed care, there is no way to precisely quantify those costs. This report discusses the specific assumptions, methodology, and limitations related to this evaluation.

In performing this analysis, we relied on data and other information provided by MCOs who are TAHP member companies, as well as public sources of data such as that available on the Texas Health and Human Services Commission (HHSC) and the Centers for Medicare and Medicaid Services (CMS) websites. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond

the scope of our assignment. This report is subject to the terms of the Consulting Services Agreement between TAHP and Milliman, Inc. dated September 19, 2012.

Qualification Statement

I, Susan K. Hart, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a member of the American Academy of Actuaries and I meet the qualification standards for performing the analyses in this report.

BACKGROUND

In the STAR and STAR+PLUS programs, MCOs are paid a capitation rate to provide specified benefits to Medicaid enrollees. These capitation rates are paid on a per member per month (PMPM) basis, and vary based on the member's risk group and SDA.

The general capitation pricing methodology applied by HHSC's consulting actuaries is as follows:

1. Starts with an experience period incurred claim amount PMPM based on MCO experience (or FFS experience prior to availability of MCO experience). Typically the experience period will be the SFY two years prior to the rating period, i.e., SFY2013 claim costs as the basis for SFY2015 rating;
2. Applies trend factors for expected cost changes from the experience period to the rating period;
3. Applies provider reimbursement and program change adjustments;
4. Adds components for capitation, net reinsurance costs, administrative expenses, risk margin, premium tax, and maintenance costs;
5. Adjusts the rates by rate cell to provide a separate payment for deliveries (for STAR Medical);
6. Applies MCO-specific risk adjustment to arrive at MCO capitation rates.

The first 5 steps are performed within each SDA for each risk group and limited service category. Service categories include Medical and Drugs for STAR, and Medical Other than IP Hospital, Drugs, and IP hospital for STAR+PLUS. The first five steps result in community rates by SDA while the last step results in rates that vary by MCO.

The MCOs take the risk of costs being in excess of those expected in the rate development. If an MCO's costs are significantly below projected, excess gains are shared with the state beginning at 3% profit through an experience rebate. Excess losses, however, are borne completely by the health plan. There is no negative risk for the state.

The rates are generally finalized in the summer and are applicable for the upcoming SFY. In this manner, the state is able to reasonably estimate its costs for the capitated Medicaid enrollees prior to the SFY, with the main deviations being due to differences between actual-to-expected population counts, the mix of the population by risk group and SDA, and experience rebates. The state pays based on the estimated impacts of cost trends and program changes, rather than being subject to significant potential variability from those estimates as they would be in a fee-for-service environment.

While that predictability is an advantage of a capitated model, the primary expected financial value of Medicaid managed care is driven by the MCOs' abilities to manage and control costs. When managed care is rolled out to a new area, the initial cost savings or cost neutral results for the state are essentially guaranteed. In the rate development steps described above, the experience period costs in step 1 are based on FFS experience. In addition to the normal adjustments, the rate development will include a managed care savings component, or an assumed cost savings that can be achieved by the MCOs. This savings must be sufficient to allow for total costs, including the administrative components and risk margin in step 4 to not exceed projected FFS costs.

The state also receives savings via additional revenue through the premium tax included in the capitation rates paid to the MCOs. The capitation rate development includes a 1.75% premium tax, which is partially funded through federal matching funds. This revenue source does not exist in a FFS arrangement.

As managed care matures in an area, the experience period costs are based only on MCO experience. Because Texas Medicaid has moved from primarily a fee-for-service program to one in which the majority of enrollees (80% in 2014) are enrolled in managed care through the MCOs, the ability to compare FFS to managed care costs and results are limited. This is what led to TAHP's desire for this study to review and evaluate the cost impact of managed care in Texas.

COST IMPACT RESULTS

For the six year period from SFY2010 – SFY2015, we estimate that managed care capitation payment structure of the STAR and STAR-PLUS programs have resulted in a Medicaid All Funds cost reduction in the range of 5.0% to 10.7% when compared to estimated expenditures on a fee-for-service structure. This range applies to our cost impact study population, which covered approximately $44.1 billion of Texas State Medicaid All Funds spending for this time period. Our best estimate is that this results in savings of nearly $3.8 billion, or 7.9% over six years. Taking into account Federal Medicaid matching (FMAP) and premium tax revenue to the state, we estimate that managed care has reduced the state portion of Medicaid funding by 7.4% to 13.0% over this same period for the programs covered in the study. This results in a best estimate of $2 billion in savings to the state, or 10.2% of the state's share of expense. Chart A, below, provides more detail on our best estimate.

Chart A
Texas Association of Health Plans
Cost Impact by Cohort - Through State Fiscal Year 2015

Program - Service Type	All Funds (Dollars in Millions)	All Funds %	State Funds (Dollars in Millions)	State Funds %
STAR+PLUS Programs				
STAR+PLUS Pharmacy	$ (327)	-10.8%	$ (163)	-13.0%
STAR+PLUS LTSS	$ (172)	-3.5%	$ (117)	-5.8%
STAR+PLUS Acute (Non-Inpatient)	$ 114	3.7%	$ 12	1.0%
STAR+PLUS Acute (Inpatient)	$ 219	16.0%	$ 74	13.0%
Subtotal STAR+PLUS	$ (166)	-1.3%	$ (194)	-3.8%
STAR Programs				
STAR Pharmacy	$ (40)	-1.1%	$ (56)	-3.5%
STAR Medical	$ (2,066)	-7.8%	$ (1,104)	-10.1%
Subtotal STAR	$ (2,106)	-7.0%	$ (1,160)	-9.3%
Subtotal - Medicaid Dental	$ (1,519)	-28.4%	$ (670)	-30.2%
Total - Study Population	**$ (3,791)**	**-7.9%**	**$ (2,025)**	**-10.2%**

A major driver enabling these programs to achieve savings can be seen in their average annual implied cost trends. These implied cost trends were determined by normalizing the year-over-year expenses for population mix, program changes, and shifts in administrative expenses. Please see the Methodology and Assumptions section of this report for more details on this process. As you will see in the grid below, four out of the seven cohorts we studied have annualized trends below 1%. STAR Medical, the largest of the cohorts, is still achieving significant savings with an annualized trend of 1.6%, as is STAR+PLUS LTSS, with a trend of 3.3%. Chart B, below summarizes these trends.

Chart B Texas Association of Health Plans Annualized Implied Trends		
Program - Service Type	Span	Annualized Implied Trend
STAR Medical	6-years	1.6%
STAR Pharmacy	3-years	0.5%
Medicaid Dental	3-years	-8.7%
STAR+PLUS LTSS	6-years	3.3%
STAR+PLUS Acute (Non-Inpatient)	6-years	0.8%
STAR+PLUS Acute (Inpatient)	3-years	7.2%
STAR+PLUS Pharmacy	3-years	-0.9%

We investigated the larger trend on STAR+PLUS Acute Inpatient. Claim costs increased significantly between the base years under FFS and the initial years of the IP carve-in, causing a large increase in capitation rates for SFY2014. It is not clear whether this increase would have also occurred in a continued FFS environment. One contributor to the increase was that the MCOs were not initially permitted to implement a "spell of illness" limitation that existed in FFS. We have applied adjustments to reflect this limitation. Because we are not able to identify other significant drivers of this increase, we have applied a consistent methodology to the inpatient cohort as to the other blocks.

Sensitivities were run on the major assumptions in this study. The range of results provided were determined by assuming a 1% variance in annual FFS trends for each cohort. Chart C provides a comparison of these ranges.

Chart C Texas Association of Health Plans Trend Sensitivity (Dollars in Millions)				
Total Population Cost Impacts	All Funds Impact	All Funds %	State Funds Impact	State Funds %
Through SFY2015				
1% Reduction in Trend	($2,323)	-5.0%	($1,417)	-7.4%
At Current Trend	($3,791)	-7.9%	($2,025)	-10.2%
1% Increase in Trend	($5,304)	-10.7%	($2,650)	-13.0%
Through SFY2018				
1% Reduction in Trend	($4,497)	-5.4%	($2,683)	-7.7%
At Current Trend	($7,108)	-8.3%	($3,771)	-10.5%
1% Increase in Trend	($9,798)	-11.1%	($4,890)	-13.2%

Negative Values and Percentages Indicate Savings

Accompanying this report are the following exhibits detailing our results:

- Exhibits 1a and 1b "Managed Care Cost Impact by Cohort": These exhibits show the All Funds Impact and the State Budget Impact for each of the specific cohorts we studied, combined at the program level, and as a combined population. Exhibit 1a compiles results as of SFY2015, and Exhibit 1b projects through SFY2018.
- Exhibit 2 "STAR, STAR+PLUS, and Dental": This exhibit shows a year-to-year comparison of the aggregate managed care program expenses compared to the estimated FFS costs that would exist in its absence. This is the first look at the savings calculation we utilized across all cohorts, providing a cost impact at the All Funds level (column D) and the state level (column I).

- Exhibit 3 "STAR - Medical and Pharmacy": This exhibit is the same format as Exhibit 2, but it only focuses on the cost impacts on the STAR program.
- Exhibit 4 "STAR+PLUS - Medical and Pharmacy": This exhibit is the same format as Exhibits 2 and 3, but it only focuses on the cost impacts on the STAR+PLUS program.
- Exhibit 5 "Medicaid Dental Program": This exhibit provide a detailed view of the method used to assess the dental program expenses against theoretical FFS costs that would have been incurred in the absence of managed care. The first section, "Managed Care Experience", provides an historical look at the enrollment, claims, capitation rates, and trends. The section to the right of that, "Projected FFS", contains the method used to project the theoretical FFS costs. Finally, the bottom section, "Savings Calculation", compiles the information from the sections above using the same methods as the prior exhibits. Please see the Methodology and Assumptions section of this report for more details.

  The analysis shows significant savings in the dental managed care program. This result is consistent with findings in a report prepared for HHSC in 2013, evaluating the initial 6 months of the rollout.[1]
- Exhibit 6a – 6f (cohort specific): These exhibits provide a detailed view of the method used to assess each of the STAR and STAR+PLUS cohorts against theoretical FFS costs that would have been incurred in the absence of managed care. Please see the Methodology and Assumptions section of this report for more details.

[1] Capitated Managed Care Model of Dental Services Report. As Required By General Appropriations Act for the 2012-13 Biennium House Bill No. 1, Article II Health and Human Services Commission, Rider 54 – 82nd Texas Legislature, Regular Session, 2011. Prepared by Public Consulting Group, Inc. (PCG) February 15, 2013

METHODOLOGY AND ASSUMPTIONS

This section describes the methodology and assumptions used in our analysis, separately for medical costs (including acute and long-term care) and pharmacy costs.

In general, this study was developed using a methodology typically used in retrospective valuations of disease and/or case management programs. This study estimates the impact that managed care organizations have on the state budget by comparing actual historical program costs to hypothetical costs under a fee-for-service arrangement.

We first collected the relevant actuarial memorandums dating back to SFY2009. Historical membership, capitation rates, claims, and retention information was extracted from these memoranda and organized into the five main programs that our cost impact study focused on: STAR Medical, STAR+PLUS Medical, STAR Prescription Drug, STAR+PLUS Prescription Drug, and Texas Medicaid Dental. STAR Health and STAR Kids were beyond the scope of the study.

As detailed in Chapter 1 of this report, Texas has expanded its Medicaid program many times since SFY2009; including carving-in new services, extending into new geographical regions, and covering new populations. The service area expansions have not been included in the cost impact analysis for the following reasons:

1. FFS Baseline: when developing the FFS cost for comparison, the SFY2009 baseline is a key assumption that is used for projecting future FFS costs. As expansions occur during the study period, the baseline would need to be recalibrated, introducing more variance to study.
2. Credibility: when coverage is expanded into a new area, a year or more may be necessary for the experience to be credible.
3. Program Maturity: when manage care organizations begin servicing members in a new region, it takes time for the program to mature and start realizing savings.

The major service carve-ins, including pharmacy in STAR and STAR+PLUS, inpatient services in STAR+PLUS, and dental are included in this study.

Methodology

In order to assess the cost impact, we first analyzed the change in managed care per member per month (PMPM) capitation costs from a base year through SFY 2015. We did this analysis separately for cohorts within STAR and STAR+PLUS. We split the year-over-year changes in capitation rates to various components, as follow:

- Mix change, including distribution of members by risk group and SDA;
- Program changes, excluding the managed care savings discounts applied in pricing;
- Administrative changes;
- Trend;

Mix change was calculated by comparing the weighted average costs based on the actual membership mix by risk group and SDA to the average costs weighted by the prior year membership mix. Program change impacts were estimated based on the program change factors integrated into the capitation rate developments. Administrative cost changes were determined by comparing the priced loss ratios from one period to the next. We assumed the remaining cost change was attributable to implied trend, as described in the Exhibit 5 section of Cost Impact Results. The implied trend is influenced by not only the trend assumptions used in the capitation rate development but also the resetting of the experience base each year. Note that program changes and administrative costs were calculated directly from the actuarial memoranda and are assumed to be accurate. The analysis includes only capitation payments and does not

adjust for experience rebates, which could increase the savings. Based on data from recent years, we would not expect these rebates to materially increase the overall savings results.

We then developed equivalent FFS estimates for each year to compare to the managed care costs. The base year was SFY2009 for the medical projections and the second half of SFY2012 for the pharmacy and acute inpatient projections. In the base year, we set FFS equivalent costs to the managed care capitation rates. As a condition for managed care implementation, capitation rates (medical costs plus administrative costs) must be equal or less than the claims would have been in a FFS environment. Given the maturity of the programs in the SDAs analyzed, we are assuming that that condition was met in SFY2009. The SDAs in the analysis have all been in managed care since at least SFY2007, and some for many years prior.

For SFY2010 to SFY2015, we projected FFS proxy costs by applying the same mix change and program change impact factors from the managed care analysis, and an annual trend rate appropriate for the type of service (acute vs. LTSS). The development of the trend assumption is described in more detail below.

The total cost impact was calculated as the difference between the managed care medical costs and the theoretical FFS medical costs. This cost difference represents federal and state funds. We then calculated the state general revenue impact by subtracting the federal match, and adding a premium tax impact component.

The final step was to extrapolate the savings through SFY2018. This was accomplished by trending the average members and holding the capitation PMPM constant. When determining the best method to project savings for this population, we analyzed the membership, capitation rates, and pricing assumptions for patterns that may persist into future periods. In doing so we noticed that membership is the only metric showing a consistent trend (increasing). The capitation rates tend to be more erratic due to the net impact of program changes, mix changes, and ongoing expansions taken into consideration during pricing. The projected FFS costs were determined by projecting the All Funds Cost Impact % as an indicator of future savings. Except for STAR+PLUS Acute non-Inpatient, a weighted average over the historical savings for each cohort was determined and carried forward through SFY2018. This method reduces subjectivity for the future year savings. For STAR+PLUS Acute non-Inpatient the SFY2015 All Funds Cost Impact % was applied to future years. This was determined to be an appropriate divergence from the other method due to the clear trend towards savings for this cohort.

Sensitivities were run on the major assumptions in this study. The range of results provided were determined by assuming a 1% variance (positive and negative) in annual FFS trends for each cohort.

Data and Key Assumptions

The primary data sources used for the analysis were the annual actuarial rate memoranda. These formed consistent and publicly available sources of information.

Trends used to project FFS costs each year were determined on a product and service category basis. In October 2013, S&P Dow Jones Indices (S&P DJI) launched the S&P Healthcare Claims Indices. This index series is designed to provide an independent, timely measure of the changes in healthcare expenditures and utilization for individuals enrolled in commercial health insurance plans in the United States. They track healthcare trends across various commercial lines of business by geographic region, state, and select metropolitan areas. These trends are indicative of FFS trends in Texas, so we used them as a basis for the trends on STAR Medical and STAR+PLUS Acute. The state sets Medicaid payment schedules that typically increase at a slower rate than commercial FFS costs, so we have reduced the S&P Healthcare trends by 1% - 2% each year.

STAR+PLUS Long Term Care trends were set at 4% annually. This was determined as an appropriate rate following research of numerous sources: Milliman's Health Cost Guidelines, and Genworth's Long Term Care Study.[2]

[2] https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/Texas-040114.pdf

The assumed annual trend rates utilized in the initial Pharmacy carve-in actuarial memorandum (effective March 1, 2012) were used to further project the comparative FFS Pharmacy costs for STAR and STAR+PLUSThe rating period trend assumptions equal one-sixth of the actual SFY2009 trend plus two-sixths of the actual SFY2010 trend plus three-sixths of the actual SFY2011 trend. This formula was used in developing the trend assumptions for all programs and risk groups, then a weighted average was developed for each program. This resulted in an annual trend of 2.4% for STAR Pharmacy, and 3.9% for STAR+PLUS Pharmacy.

The dental trends were set at 5% a year for both dental and orthodontia. This is consistent with the most recent trends included in the actuarial memos.

CONCLUSIONS

Based on the analysis outlined in this report, we estimate that the managed care organizations servicing STAR, STAR+PLUS and the Texas Medicaid Dental programs have saved the state between 9.4% and 14.3% annually when compared to a fee-for-service arrangement over the period from SFY2010 to SFY2015. We are projecting similar savings for SFY2016 through SFY2018 based on that historical experience. As outlined in this report, each program studied is either providing annual savings, or is expected to in the near future.

Exhibit 1a
Texas Association of Health Plans
STAR and STAR+PLUS - through SFY2015
Managed Care Cost Impact by Cohort (Dollars in Millions)

Cohort	Details	Savings Period	Total Program Expense	Projected FFS Cost	All Funds Impact	%	State Share of Program Expense	State Share of Projected FFS Cost	State Budget Impact	%
Total - Study Population	Exhibit 2	SFY10 - SFY15	$44,112	$47,903	($3,791)	-7.9%	$17,705	$19,730	($2,025)	-10.2%
Subtotal - STAR	Exhibit 3	SFY10 - SFY15	$28,091	$30,197	($2,106)	-7.0%	$11,268	$12,428	($1,160)	-9.3%
Subtotal - STAR+PLUS	Exhibit 4	SFY10 - SFY15	$12,198	$12,364	($166)	-1.3%	$4,898	$5,093	($195)	-3.8%
Subtotal - Dental	Exhibit 5	SFY13 - SFY15	$3,823	$5,342	($1,519)	-28.4%	$1,538	$2,208	($670)	-30.2%
STAR Medical	Exhibit 6a	SFY10 - SFY15	$24,334	$26,400	($2,066)	-7.8%	$9,753	$10,857	($1,104)	-10.1%
STAR Pharmacy	Exhibit 6b	SFY13 - SFY15	$3,757	$3,797	($40)	-1.1%	$1,515	$1,571	($56)	-3.5%
STAR+PLUS LTSS	Exhibit 6c	SFY10 - SFY15	$4,705	$4,877	($172)	-3.5%	$1,888	$2,005	($117)	-5.8%
STAR+PLUS Acute (Non-Inpatient)	Exhibit 6d	SFY10 - SFY15	$3,196	$3,082	$114	3.7%	$1,279	$1,267	$12	1.0%
STAR+PLUS Acute (Inpatient)	Exhibit 6e	SFY13 - SFY15	$1,540	$1,373	$219	16.0%	$641	$567	$74	13.0%
STAR+PLUS Pharmacy	Exhibit 6f	SFY13 - SFY15	$2,705	$3,032	($327)	-10.8%	$1,091	$1,254	($163)	-13.0%

NOTES: Projected Membership and Costs were used for SFY2014 - SFY2015. Actuals were used for prior years.
STAR Medical includes all SDA's that were in managed care as of SFY2009 (Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant, Travis).
STAR+PLUS Acute (Non-Inpatient) and LTSS Analysis includes all SDA's that were in managed care as of SFY2009 (Bexar, Harris, Nueces, Travis).
STAR+PLUS Acute (Inpatient) Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis.
Pharmacy Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis, MRSA Central, MRSA NE, MRSA West.
Pharmacy Program Carved-In on 3/1/2012
Pharmacy Data begins in SFY13; one year after carve-in for baseline purposes
Acute Inpatient Program Carved-In on 3/1/2012
Acute Inpatient Data begins in SFY13; one year after carve-in for baseline purposes
Negative cost impacts and cost impact %'s represent savings.
Dental Program Began on 3/1/2012

Exhibit 1b
Texas Association of Health Plans
STAR and STAR+PLUS - through SFY2018
Managed Care Cost Impact by Cohort (Dollars in Millions)

Cohort	Details	Savings Period	Total Program Expense	Projected FFS Cost	All Funds Impact	%	State Share of Program Expense	State Share of Projected FFS Cost	State Budget Impact	%
Total - Study Population	Exhibit 2	SFY10 - SFY18	$78,765	$85,873	($7,108)	-8.3%	$31,906	$35,677	($3,771)	-10.5%
Subtotal - STAR	Exhibit 3	SFY10 - SFY18	$49,571	$53,134	($3,563)	-6.7%	$20,074	$22,062	($1,988)	-9.0%
Subtotal - STAR+PLUS	Exhibit 4	SFY10 - SFY18	$21,648	$22,195	($547)	-2.5%	$8,771	$9,222	($451)	-4.9%
Subtotal - Dental	Exhibit 5	SFY13 - SFY18	$7,546	$10,544	($2,998)	-28.4%	$3,063	$4,393	($1,330)	-30.2%
STAR Medical	Exhibit 6a	SFY10 - SFY18	$40,888	$44,359	($3,471)	-7.8%	$16,538	$18,400	($1,862)	-10.1%
STAR Pharmacy	Exhibit 6b	SFY13 - SFY18	$8,683	$8,775	($92)	-1.0%	$3,534	$3,662	($128)	-3.4%
STAR+PLUS LTSS	Exhibit 6c	SFY10 - SFY18	$7,628	$7,908	($280)	-3.5%	$3,085	$3,278	($193)	-5.9%
STAR+PLUS Acute (Non-Inpatient)	Exhibit 6d	SFY10 - SFY18	$4,925	$4,962	($37)	-0.7%	$1,986	$2,056	($70)	-2.7%
STAR+PLUS Acute (Inpatient)	Exhibit 6e	SFY13 - SFY18	$3,310	$2,899	$463	16.0%	$1,366	$1,208	$158	13.1%
STAR+PLUS Pharmacy	Exhibit 6f	SFY13 - SFY18	$5,733	$6,426	($693)	-10.8%	$2,332	$2,680	($348)	-13.0%

NOTES: Projected Membership and Costs were used for SFY2014 - SFY2018. Actuals were used for prior years.
STAR Medical includes all SDA's that were in managed care as of SFY2009 (Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant, Travis).
STAR+PLUS Acute (Non-Inpatient) and LTSS Analysis includes all SDA's that were in managed care as of SFY2009 (Bexar, Harris, Nueces, Travis).
STAR+PLUS Acute (Inpatient) Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis.
Pharmacy Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis, MRSA Central, MRSA NE, MRSA West.
Pharmacy Program Carved-In on 3/1/2012
Pharmacy Data begins in SFY13; one year after carve-in for baseline purposes
Acute Inpatient Program Carved-In on 3/1/2012
Acute Inpatient Data begins in SFY13; one year after carve-in for baseline purposes
Negative cost impacts and cost impact %'s represent savings.
Dental Program Began on 3/1/2012

Exhibit 2
Texas Association of Health Plans
STAR, STAR+PLUS, and Dental
Managed Care Cost Impact

Savings Calculation (Dollars in Millions)

Plan Year	Managed Care Expenses	Projected FFS Cost	All Funds Cost Impact	All Funds Cost Impact %	FMAP	State Share of All Funds Cost Impact	Federal Share of Premium Tax	Total Impact to State Budget	State Impact %
(formula)	(A)	(B)	(C) = A - B	(D) = C / B	(E)	(F) = D x (1-E)	(G) = A x E x 1.75%	(H) = F - G	(I) = H / [B x (1-E)]
SFY10	$4,618	$4,869	($251)	-5.2%	58.73%	($104)	$47	($151)	-7.5%
SFY11	$5,107	$5,197	($90)	-1.7%	60.56%	($35)	$54	($89)	-4.3%
SFY12	$5,279	$5,673	($394)	-6.9%	58.22%	($165)	$54	($219)	-9.2%
SFY13	$9,132	$9,959	($827)	-8.3%	59.30%	($337)	$95	($432)	-10.7%
SFY14	$9,772	$10,592	($820)	-7.7%	58.69%	($339)	$100	($439)	-10.0%
SFY15	$10,204	$11,613	($1,409)	-12.1%	58.05%	($591)	$104	($695)	-14.3%
SFY16	$10,843	$11,902	($1,059)	-8.9%	58.00%	($445)	$110	($555)	-11.1%
SFY17	$11,532	$12,636	($1,104)	-8.7%	58.00%	($464)	$117	($581)	-10.9%
SFY18	$12,278	$13,432	($1,154)	-8.6%	58.00%	($485)	$125	($610)	-10.8%
Total	$78,765	$85,873	($7,108)	-8.3%	58.29%	($2,965)	$806	($3,771)	-10.5%
Through SFY15	$44,112	$47,903	($3,791)	-7.9%	58.56%	($1,571)	$454	($2,025)	-10.2%

NOTES: Projected Membership and Costs were used for SFY2014 - SFY2018. Actuals were used for prior years.
STAR Medical includes all SDA's that were in managed care as of SFY2009 (Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant, Travis).
STAR+PLUS Acute (Non-Inpatient) and LTSS Analysis includes all SDA's that were in managed care as of SFY2009 (Bexar, Harris, Nueces, Travis).
STAR+PLUS Acute (Inpatient) Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis.
Pharmacy Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis, MRSA Central, MRSA NE, MRSA West.
Pharmacy Program Carved-In on 3/1/2012
Pharmacy Data begins in SFY13; one year after carve-in for baseline purposes
Acute Inpatient Program Carved-In on 3/1/2012
Acute Inpatient Data begins in SFY13; one year after carve-in for baseline purposes
Negative cost impacts and cost impact %'s represent savings.
Dental Program Began on 3/1/2012

Exhibit 3
Texas Association of Health Plans
STAR - Medical and Pharmacy
Managed Care Cost Impact

Savings Calculation (Dollars in Millions)										
Plan Year	Average Members	STAR Expenses	Projected FFS Cost	All Funds Cost Impact	All Funds Cost Impact %	FMAP	State Share of All Funds Cost Impact	Federal Share of Premium Tax	Total Impact to State Budget	State Impact %
(formula)	(A)	(B)	(C)	(D) = B - C	(E) = D / C	(F)	(G) = E x (1-F)	(H) = B x F x 1.75%	(I) = G - H	(J) = I / [C x (1-F)]
SFY10	1,372,474	$3,481	$3,756	($275)	-7.3%	58.73%	($113)	$36	($149)	-9.6%
SFY11	1,560,068	$3,880	$3,974	($94)	-2.4%	60.56%	($37)	$41	($78)	-5.0%
SFY12	1,693,089	$4,019	$4,414	($395)	-8.9%	58.22%	($165)	$41	($206)	-11.2%
SFY13	1,722,188	$5,035	$5,437	($402)	-7.4%	59.30%	($164)	$52	($216)	-9.8%
SFY14	1,919,422	$5,675	$6,002	($327)	-5.4%	58.69%	($135)	$58	($193)	-7.8%
SFY15	2,170,424	$6,001	$6,614	($613)	-9.3%	58.05%	($257)	$61	($318)	-11.5%
SFY16	2,369,516	$6,547	$6,991	($444)	-6.4%	58.00%	($186)	$66	($252)	-8.6%
SFY17	2,587,149	$7,142	$7,626	($484)	-6.3%	58.00%	($203)	$72	($275)	-8.6%
SFY18	2,824,523	$7,791	$8,320	($529)	-6.4%	58.00%	($222)	$79	($301)	-8.6%
Total	18,218,854	$49,571	$53,134	($3,563)	-6.7%	58.41%	($1,482)	$506	($1,988)	-9.0%
Through SFY15	10,437,666	$28,091	$30,197	($2,106)	-7.0%	58.64%	($871)	$289	($1,160)	-9.3%

NOTES: Projected Membership and Costs were used for SFY2014 - SFY2018. Actuals were used for prior years.
Medical Analysis includes all SDA's that were in managed care as of SFY2009 (Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant, Travis).
Pharmacy Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis, MRSA Central, MRSA NE, MRSA West.
Pharmacy Program Carved-In on 3/1/2012
Pharmacy Data begins in SFY13; one year after carve-in for baseline purposes
Negative cost impacts and cost impact %'s represent savings.

Exhibit 4
Texas Association of Health Plans
STAR+PLUS - Medical and Pharmacy
Managed Care Cost Impact

Savings Calculation (Dollars in Millions)										
Plan Year	Average Members	STAR+PLUS Expenses	Projected FFS Cost	All Funds Cost Impact	All Funds Cost Impact %	FMAP	State Share of All Funds Cost Impact	Federal Share of Premium Tax	Total Impact to State Budget	State Impact %
(formula)	(A)	(B)	(C)	(D) = B - C	(E) = D / C	(F)	(G) = E x (1-F)	(H) = B x F x 1.75%	(I) = G - H	(J) = I / [C x (1-F)]
SFY10	171,077	$1,137	$1,113	$24	2.2%	58.73%	$10	$12	($2)	-0.4%
SFY11	176,474	$1,227	$1,223	$4	0.3%	60.56%	$2	$13	($11)	-2.3%
SFY12	182,764	$1,260	$1,259	$1	0.1%	58.22%		$13	($13)	-2.5%
SFY13	189,292	$2,685	$2,751	($66)	-2.4%	59.30%	($27)	$28	($55)	-4.9%
SFY14	196,629	$2,919	$2,904	$15	0.5%	58.69%	$6	$30	($24)	-2.0%
SFY15	199,040	$2,970	$3,114	($144)	-4.6%	58.05%	($60)	$30	($90)	-6.9%
SFY16	204,798	$3,059	$3,183	($124)	-3.9%	58.00%	($52)	$31	($83)	-6.2%
SFY17	210,637	$3,149	$3,276	($127)	-3.9%	58.00%	($53)	$32	($85)	-6.2%
SFY18	216,692	$3,242	$3,372	($130)	-3.9%	58.00%	($55)	$33	($88)	-6.2%
Total	1,747,403	$21,648	$22,195	($547)	-2.5%	58.14%	($229)	$222	($451)	-4.9%
Through SFY15	1,115,276	$12,198	$12,364	($166)	-1.3%	58.43%	($69)	$126	($195)	-3.8%

NOTES: Projected Membership and Costs were used for SFY2014 - SFY2018. Actuals were used for prior years.
LTSS and Acute (Non-IP) Analysis includes all SDA's that were in managed care as of SFY2009 (Bexar, Harris, Nueces, Travis).
Acute Inpatient Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis.
Pharmacy Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis, MRSA Central, MRSA NE, MRSA West.
Pharmacy Program Carved-In on 3/1/2012
Pharmacy Data begins in SFY13; one year after carve-in for baseline purposes
Acute Inpatient Program Carved-In on 3/1/2012
Acute Inpatient Data begins in SFY13; one year after carve-in for baseline purposes
Negative cost impacts and cost impact %'s represent savings.

Exhibit 5
Texas Association of Health Plans
Medicaid Dental Program
Managed Care Cost Impact

Managed Care Experience				
Plan Year	Average Members	Claims PMPM	Capitation PMPM	Implied Trend
(formula)	(A)	(B)	(C)	(D)
SFY12	2,889,221	$ 37.67	$ 46.71	
SFY13	2,961,974	$ 30.49	$ 39.73	-15.8%
SFY14	2,716,221	$ 33.00	$ 36.13	-8.2%
SFY15	2,884,287	$ 32.51	$ 35.62	-1.6%

Projected FFS			
Projected Cost PMPM	Projection Factors		
	Mix	Program	Trend
(E)	(F)	(G)	(H)
$ 46.71	1.022	0.994	1.050
$ 49.82	1.002	0.987	1.050
$ 51.74	0.998	1.004	1.050
$ 54.46			

Savings Calculation (Dollars in Millions)									
Plan Year	Dental Expenses	Projected FFS Cost	All Funds Cost Impact	All Funds Cost Impact %	FMAP	State Share of All Funds Cost Impact	Federal Share of Premium Tax	Total Impact to State Budget	State Impact %
(formula)	(I) = A x C x 12	(J) = A x E x 12	(K) = I - J	(L) = K / J	(M)	(N) = K x (1-M)	(O) = I x M x 1.75%	(P) = N - O	(Q) = P / [J x (1-M)]
SFY13	$1,412	$1,771	($359)	-25.4%	59.30%	($146)	$15	($161)	-22.3%
SFY14	$1,178	$1,686	($508)	-43.1%	58.69%	($210)	$12	($222)	-31.9%
SFY15	$1,233	$1,885	($652)	-52.9%	58.05%	($274)	$13	($287)	-36.3%
SFY16	$1,237	$1,728	($491)	-28.4%	58.00%	($206)	$13	($219)	-30.2%
SFY17	$1,241	$1,734	($493)	-28.4%	58.00%	($207)	$13	($220)	-30.2%
SFY18	$1,245	$1,740	($495)	-28.4%	58.00%	($208)	$13	($221)	-30.2%
Total	$7,546	$10,544	($2,998)	-28.4%	58.27%	($1,251)	$79	($1,330)	-30.2%
Through SFY15	$3,823	$5,342	($1,519)	-28.4%	58.53%	($630)	$40	($670)	-30.2%

NOTES: Projected Membership used for all years.
Negative cost impacts and cost impact %'s represent savings.
Program Began on 3/1/2012
SFY12 Claims PMPM 3/1/2012 - 8/31/2012
SFY13 Claims PMPM 9/1/2012 - 8/31/2013
SFY14 Claims PMPM 9/1/2013 - 8/31/2014
SFY15 Claims PMPM 9/1/2014 - 8/31/2015

Exhibit 6a
Texas Association of Health Plans
STAR - Medical
Managed Care Cost Impact

Managed Care Experience				
Plan Year	Average Members	Claims PMPM	Capitation PMPM	Implied Trend
(formula)	(A)	(B)	(C)	(D)
SFY09	1,166,624	$ 176.87	$ 226.03	
SFY10	1,372,474	$ 172.14	$ 211.35	-1.8%
SFY11	1,560,068	$ 158.91	$ 207.26	9.6%
SFY12	1,693,089	$ 156.27	$ 197.80	-1.3%
SFY13	1,722,188	$ 159.56	$ 189.62	-0.6%
SFY14	1,919,422	$ 161.56	$ 191.80	6.4%
SFY15	2,170,424	$ 145.39	$ 177.29	-2.1%

Projected FFS			
Projected Cost PMPM	Projection Factors Mix	Program	Trend
(E)	(F)	(G)	(H)
$ 226.03	0.949	1.009	1.053
$ 228.04	0.946	0.961	1.024
$ 212.28	1.028	0.953	1.045
$ 217.24	0.969	0.992	1.010
$ 210.80	0.975	0.982	1.021
$ 206.13	0.940	0.995	1.025
$ 197.77			

Savings Calculation (Dollars in Millions)

Plan Year	STAR Medical Expenses	Projected FFS Cost	All Funds Cost Impact	All Funds Cost Impact %	FMAP	State Share of All Funds Cost Impact	Federal Share of Premium Tax	Total Impact to State Budget	State Impact %
(formula)	(I) = A x C x 12	(J) = A x E x 12	(K) = I - J	(L) = K / J	(M)	(N) = K x (1-M)	(O) = I x M x 1.75%	(P) = N - O	(Q) = P / [J x (1-M)]
SFY10	$3,481	$3,756	($275)	-7.3%	58.73%	($113)	$36	($149)	-9.6%
SFY11	$3,880	$3,974	($94)	-2.4%	60.56%	($37)	$41	($78)	-5.0%
SFY12	$4,019	$4,414	($395)	-8.9%	58.22%	($165)	$41	($206)	-11.2%
SFY13	$3,919	$4,357	($438)	-10.1%	59.30%	($178)	$41	($219)	-12.3%
SFY14	$4,418	$4,748	($330)	-7.0%	58.69%	($136)	$45	($181)	-9.2%
SFY15	$4,617	$5,151	($534)	-10.4%	58.05%	($224)	$47	($271)	-12.5%
SFY16	$5,041	$5,469	($428)	-7.8%	58.00%	($180)	$51	($231)	-10.1%
SFY17	$5,504	$5,971	($467)	-7.8%	58.00%	($196)	$56	($252)	-10.0%
SFY18	$6,009	$6,519	($510)	-7.8%	58.00%	($214)	$61	($275)	-10.0%
Total	$40,888	$44,359	($3,471)	-7.8%	58.43%	($1,443)	$419	($1,862)	-10.1%
Through SFY15	$24,334	$26,400	($2,066)	-7.8%	58.71%	($853)	$251	($1,104)	-10.1%

NOTES: Projected Membership and Costs were used for SFY2014 - SFY2018. Actuals were used for prior years.
Medical Analysis includes all SDA's that were in managed care as of SFY2009 (Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant, Travis).
Negative cost impacts and cost impact %'s represent savings.
Pharmacy costs excluded.

Exhibit 6b
Texas Association of Health Plans
STAR - Pharmacy
Managed Care Cost Impact

Managed Care Experience				
Plan Year	Average Members	Claims PMPM	Capitation PMPM	Implied Trend
(formula)	(A)	(B)	(C)	(D)
SFY12	2,480,190	$ 33.32	$ 34.98	
SFY13	2,484,118	$ 31.99	$ 37.44	5.6%
SFY14	2,780,141	$ 34.47	$ 37.68	-0.7%
SFY15	3,136,415	$ 33.60	$ 36.78	-3.3%

Projected FFS			
Projected Cost PMPM	Projection Factors Mix	Program	Trend
(E)	(F)	(G)	(H)
$ 34.98	1.005	1.006	1.024
$ 36.22	1.004	1.009	1.024
$ 37.58	1.000	1.010	1.024
$ 38.88			

Savings Calculation (Dollars in Millions)									
Plan Year	STAR Pharmacy Expenses	Projected FFS Cost	All Funds Cost Impact	All Funds Cost Impact %	FMAP	State Share of All Funds Cost Impact	Federal Share of Premium Tax	Total Impact to State Budget	State Impact %
(formula)	(I) = A x C x 12	(J) = A x E x 12	(K) = I - J	(L) = K / J	(M)	(N) = K x (1-M)	(O) = I x M x 1.75%	(P) = N - O	(Q) = P / [J x (1-M)]
SFY13	$1,116	$1,080	$36	3.3%	59.30%	$15	$12	$3	0.7%
SFY14	$1,257	$1,254	$3	0.2%	58.69%	$1	$13	($12)	-2.3%
SFY15	$1,384	$1,463	($79)	-5.4%	58.05%	($33)	$14	($47)	-7.7%
SFY16	$1,506	$1,522	($16)	-1.1%	58.00%	($7)	$15	($22)	-3.4%
SFY17	$1,638	$1,655	($17)	-1.1%	58.00%	($7)	$17	($24)	-3.5%
SFY18	$1,782	$1,801	($19)	-1.1%	58.00%	($8)	$18	($26)	-3.4%
Total	$8,683	$8,775	($92)	-1.0%	57.61%	($39)	$89	($128)	-3.4%
Through SFY15	$3,757	$3,797	($40)	-1.1%	57.50%	($17)	$39	($56)	-3.5%

NOTES: Projected Membership and Costs were used for SFY2014 - SFY2018. Actuals were used for prior years.
Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis, MRSA Central, MRSA NE, MRSA West.
Negative cost impacts and cost impact %'s represent savings.
Program Carved-In on 3/1/2012
Medical Cost Excluded

Exhibit 6c
Texas Association of Health Plans
STAR+PLUS - Long Term Services and Supports
Managed Care Cost Impact

Managed Care Experience				
Plan Year	Average Members	Claims PMPM	Capitation PMPM	Implied Trend
(formula)	(A)	(B)	(C)	(D)
SFY09	159,969	$ 224.04	$ 285.71	
SFY10	171,077	$ 258.24	$ 319.29	10.2%
SFY11	176,474	$ 280.42	$ 323.82	-4.6%
SFY12	182,764	$ 296.11	$ 329.11	3.8%
SFY13	189,292	$ 291.67	$ 354.89	5.3%
SFY14	196,629	$ 327.93	$ 388.09	9.1%
SFY15	199,040	$ 323.09	$ 385.34	-3.2%

Projected FFS			
Projected Cost PMPM	Projection Factors Mix	Program	Trend
(E)	(F)	(G)	(H)
$ 285.71	1.070	1.001	1.040
$ 318.19	1.030	1.028	1.040
$ 350.46	0.990	0.973	1.040
$ 351.21	0.994	1.024	1.040
$ 371.49	0.992	0.996	1.040
$ 381.74	1.009	1.011	1.040
$ 405.03			

Savings Calculation (Dollars in Millions)									
Plan Year	STAR+PLUS LTSS Expenses	Projected FFS Cost	All Funds Cost Impact	All Funds Cost Impact %	FMAP	State Share of All Funds Cost Impact	Federal Share of Premium Tax	Total Impact to State Budget	State Impact %
(formula)	(I) = A x C x 12	(J) = A x E x 12	(K) = I - J	(L) = K / J	(M)	(N) = K x (1-M)	(O) = I x M x 1.75%	(P) = N - O	(Q) = P / [J x (1-M)]
SFY10	$655	$653	$2	0.3%	58.73%	$1	$7	($6)	-2.2%
SFY11	$686	$742	($56)	-7.5%	60.56%	($22)	$7	($29)	-9.9%
SFY12	$722	$770	($48)	-6.2%	58.22%	($20)	$7	($27)	-8.4%
SFY13	$806	$844	($38)	-4.5%	59.30%	($15)	$8	($23)	-6.7%
SFY14	$916	$901	$15	1.7%	58.69%	$6	$9	($3)	-0.8%
SFY15	$920	$967	($47)	-4.9%	58.05%	($20)	$9	($29)	-7.1%
SFY16	$947	$982	($35)	-3.5%	58.00%	($15)	$10	($25)	-6.1%
SFY17	$974	$1,010	($36)	-3.5%	58.00%	($15)	$10	($25)	-5.9%
SFY18	$1,002	$1,039	($37)	-3.5%	58.00%	($16)	$10	($26)	-6.0%
Total	$7,628	$7,908	($280)	-3.5%	58.57%	($116)	$77	($193)	-5.9%
Through SFY15	$4,705	$4,877	($172)	-3.5%	59.30%	($70)	$47	($117)	-5.8%

NOTES: Projected Membership and Costs were used for SFY2014 - SFY2018. Actuals were used for prior years.
Analysis includes all SDA's that were in managed care as of SFY2009 (Bexar, Harris, Nueces, Travis).
Negative cost impacts and cost impact %'s represent savings.

Exhibit 6d
Texas Association of Health Plans
STAR+PLUS - Acute (Non-Inpatient)
Managed Care Cost Impact

Managed Care Experience				
Plan Year	Average Members	Claims PMPM	Capitation PMPM	Implied Trend
(formula)	(A)	(B)	(C)	(D)
SFY09	74,810	$ 401.88	$ 440.87	
SFY10	80,553	$ 429.65	$ 498.74	1.7%
SFY11	83,146	$ 433.26	$ 542.59	11.7%
SFY12	87,233	$ 403.38	$ 514.05	2.9%
SFY13	91,096	$ 381.73	$ 511.71	-1.3%
SFY14	96,590	$ 406.50	$ 464.59	-5.0%
SFY15	96,711	$ 405.77	$ 463.40	-4.3%

Projected FFS			
Projected Cost PMPM	Projection Factors Mix	Program	Trend
(E)	(F)	(G)	(H)
$ 440.87	1.025	1.001	1.053
$ 476.20	1.013	0.976	1.024
$ 482.13	0.997	0.930	1.045
$ 467.29	0.999	1.011	1.010
$ 476.34	0.998	0.970	1.021
$ 470.69	1.004	1.039	1.026
$ 503.76			

Savings Calculation (Dollars in Millions)									
Plan Year	STAR+PLUS Acute (Non-Inpatient) Expenses	Projected FFS Cost	All Funds Cost Impact	All Funds Cost Impact %	FMAP	State Share of All Funds Cost Impact	Federal Share of Premium Tax	Total Impact to State Budget	State Impact %
(formula)	(I) = A x C x 12	(J) = A x E x 12	(K) = I - J	(L) = K / J	(M)	(N) = K x (1-M)	(O) = I x M x 1.75%	(P) = N - O	(Q) = P / [J x (1-M)]
SFY10	$482	$460	$22	4.8%	58.73%	$9	$5	$4	2.1%
SFY11	$541	$481	$60	12.5%	60.56%	$24	$6	$18	9.5%
SFY12	$538	$489	$49	10.0%	58.22%	$20	$5	$15	7.3%
SFY13	$559	$521	$38	7.3%	59.30%	$15	$6	$9	4.2%
SFY14	$538	$546	($8)	-1.5%	58.69%	($3)	$6	($9)	-4.0%
SFY15	$538	$585	($47)	-8.0%	58.05%	($20)	$5	($25)	-10.2%
SFY16	$557	$606	($49)	-8.0%	58.00%	($21)	$6	($27)	-10.6%
SFY17	$576	$626	($50)	-8.0%	58.00%	($21)	$6	($27)	-10.3%
SFY18	$596	$648	($52)	-8.0%	58.00%	($22)	$6	($28)	-10.3%
Total	$4,925	$4,962	($37)	-0.7%	48.65%	($19)	$51	($70)	-2.7%
Through SFY15	$3,196	$3,082	$114	3.7%	60.53%	$45	$33	$12	1.0%

NOTES: Acute (Non-Inpatient) Membership Base is Medicaid Only; Does not include Dual Eligible.
Projected Membership and Costs were used for SFY2014 - SFY2018. Actuals were used for prior years.
Analysis includes all SDA's that were in managed care as of SFY2009 (Bexar, Harris, Nueces, Travis).
Negative cost impacts and cost impact %'s represent savings.

Exhibit 6e
Texas Association of Health Plans
STAR+PLUS - Acute (Inpatient)
Managed Care Cost Impact

Managed Care Experience					
Plan Year	Average Members	Claims PMPM	Capitation PMPM	Adj. Capitation PMPM	Implied Trend
(formula)	(A)	(B)	(C)	(C')	(D)
SFY12	176,558	$ 246.47	$ 192.86	$ 216.64	
SFY13	181,316	$ 232.36	$ 193.59	$ 217.54	-2.2%
SFY14	192,233	$ 222.16	$ 244.47	$ 244.47	34.2%
SFY15	193,214	$ 216.55	$ 239.49	$ 239.49	-6.0%

Projected FFS			
Projected Cost PMPM	Projection Factors Mix	Program	Trend
(E)	(F)	(G)	(H)
$ 216.64	1.003	1.001	1.010
$ 219.67	0.997	0.841	1.021
$ 188.18	1.008	1.032	1.016
$ 198.74			

Savings Calculation (Dollars in Millions)										
Plan Year	STAR+PLUS Acute (Inpatient) Expenses	STAR+PLUS Acute (Inpatient) ADJUSTED Expenses	Projected FFS Cost	All Funds Cost Impact	All Funds Cost Impact %	FMAP	State Share of All Funds Cost Impact	Federal Share of Premium Tax	Total Impact to State Budget	State Impact %
(formula)	(I) = A x C x 12	(I') = A x C' x 12	(J) = A x E x 12	(K) = I' - J	(L) = K / J	(M)	(N) = K x (1-M)	(O) = I x M x 1.75%	(P) = N - O	(Q) = P / [J x (1-M)]
SFY13	$421	$473	$478	($5)	-1.0%	59.30%	($2)	$5	($7)	-3.6%
SFY14	$564	$564	$434	$130	30.0%	58.69%	$54	$6	$48	26.8%
SFY15	$555	$555	$461	$94	20.4%	58.05%	$39	$6	$33	17.1%
SFY16	$572	$572	$493	$79	16.0%	58.00%	$33	$6	$27	13.0%
SFY17	$590	$590	$509	$81	16.0%	58.00%	$34	$6	$28	13.1%
SFY18	$608	$608	$524	$84	16.0%	58.00%	$35	$6	$29	13.2%
Total	$3,310	$3,362	$2,899	$463	16.0%	58.32%	$193	$35	$158	13.1%
Through SFY15	$1,540	$1,592	$1,373	$219	16.0%	58.45%	$91	$17	$74	13.0%

NOTES: Column C' has adjusted the premiums for the Spell of Illness impact that wasn't actually imposed until SFY2014
Acute (Inpatient) Membership Base is Medicaid Only; Does not include Dual Eligible.
Projected Membership and Costs were used for SFY2014 - SFY2018. Actuals were used for prior years.
Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis.
Negative cost impacts and cost impact %'s represent savings.
Program Carved-In on 3/1/2012

Exhibit 6f
Texas Association of Health Plans
STAR+PLUS - Pharmacy
Managed Care Cost Impact

Managed Care Experience				
Plan Year	Average Members	Claims PMPM	Capitation PMPM	Implied Trend
(formula)	(A)	(B)	(C)	(D)
SFY12	178,716	$ 349.23	$ 377.28	
SFY13	181,316	$ 365.21	$ 389.16	-3.2%
SFY14	192,233	$ 374.28	$ 390.73	-1.9%
SFY15	193,214	$ 395.61	$ 412.90	2.4%

Projected FFS			
Projected Cost PMPM	Projection Factors Mix	Program	Trend
(E)	(F)	(G)	(H)
$ 377.28	1.002	1.063	1.039
$ 417.35	0.998	1.025	1.039
$ 443.54	1.004	1.026	1.039
$ 474.66			

Savings Calculation (Dollars in Millions)									
Plan Year	STAR+PLUS Pharmacy Expenses	Projected FFS Cost	All Funds Cost Impact	All Funds Cost Impact %	FMAP	State Share of All Funds Cost Impact	Federal Share of Premium Tax	Total Impact to State Budget	State Impact %
(formula)	(I) = A x C x 12	(J) = A x E x 12	(K) = I - J	(L) = K / J	(M)	(N) = K x (1-M)	(O) = I x M x 1.75%	(P) = N - O	(Q) = P / [J x (1-M)]
SFY13	$847	$908	($61)	-6.7%	59.30%	($25)	$9	($34)	-9.2%
SFY14	$901	$1,023	($122)	-11.9%	58.69%	($50)	$9	($59)	-14.0%
SFY15	$957	$1,101	($144)	-13.1%	58.05%	($60)	$10	($70)	-15.2%
SFY16	$983	$1,102	($119)	-10.8%	58.00%	($50)	$10	($60)	-13.0%
SFY17	$1,009	$1,131	($122)	-10.8%	58.00%	($51)	$10	($61)	-12.8%
SFY18	$1,036	$1,161	($125)	-10.8%	58.00%	($53)	$11	($64)	-13.1%
Total	$5,733	$6,426	($693)	-10.8%	58.30%	($289)	$59	($348)	-13.0%
Through SFY15	$2,705	$3,032	($327)	-10.8%	58.72%	($135)	$28	($163)	-13.0%

NOTES: Projected Membership and Costs were used for SFY2014 - SFY2018. Actuals were used for prior years.
Analysis includes the following SDA's: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis.
Negative cost impacts and cost impact %'s represent savings.
Medical Cost Excluded
Program Carved-In on 3/1/2012

End Notes

Chapter 1 | Overview of Managed Care in Texas

[1] http://www.hhsc.state.tx.us/medicaid/managed-care/plans.shtml

[2] http://www.hhsc.state.tx.us/medicaid/about/reports/confirmed_eligible/2014/06.pdf

[3] http://www.nashpconference.org/wp-content/uploads/2013/presentations/m.gold.20.managed.ltss.pdf

[4] http://www.hhsc.state.tx.us/contract/529150001/docs/1.pdf

[5] http://www.hhsc.state.tx.us/medicaid/about/reports/confirmed_eligible/2014/06.pdf

[6] *Capitated Managed Care Model of Dental Services Report*. As Required By General Appropriations Act for the 2012-13 Biennium House Bill No. 1, Article II Health and Human Services Commission, Rider 54 – 82nd Texas Legislature, Regular Session, 2011. Prepared by Public Consulting Group, Inc. (PCG), February 15, 2013

[7] http://www.hhsc.state.tx.us/news/presentations/2013/021313-House-Human-Services-Committee-Overview.pdf

[8] http://www.window.state.tx.us/specialrpt/hcc2005/section3.htm

[9] http://www.window.state.tx.us/specialrpt/hcc2005/section3.htm

[10] 2006 Report Cost Effectiveness of the Texas Medicaid Managed Care Program. The Lewin Group

Chapter 2 | Value Based Purchasing

[1] Texas Administrative Code, §354.1446

Chapter 3 | Access to care

[1] http://www.dads.state.tx.us/providers/pi/piac_reports/piac-2014-stakeholder.pdf

Chapter 4 | Quality of care

[1] http://www.hhsc.state.tx.us/medicaid/about/QIS-1115.pdf

[2] http://www.hhsc.state.tx.us/medicaid/about/QIS-1115.pdf

[3] http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf, page 18.

[4] http://www.hhsc.state.tx.us/contract/529130042/draft/docs/Section-2_Procurement-Strategy-Approach.pdf

[5] EQRO Summary of Activity and Trends in Healthcare Quality 2009-2011

[6] http://nasuad.org/sites/nasuad/files/Quality%20101%20NASUAD%20May%202014.pdf

[7] http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=353&rl=417

[8] http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf, Page 57

Chapter 5 | Member Satisfaction

[1] HHSC Health Plan Management and Ombudsman Office compiled report, analyzed by Sellers Dorsey

Chapter 6 | Dental Managed Care

[1] *Capitated Managed Care Model of Dental Services Report*. As Required By General Appropriations Act for the 2012-13 Biennium House Bill No. 1, Article II Health and Human Services Commission, Rider 54 – 82nd Texas Legislature, Regular Session, 2011. Prepared by Public Consulting Group, Inc. (PCG), February 15, 2013

Chapter 7 | Cost Savings

None

Chapter 8 | Medicaid Managed Care Moving Forward

[1] 1115 Waiver Quality of Care

[2] http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf

[3] *The Top Ten Concerns Redux: Implementing Person Centered Care*. August 2014. Janis Tondora, Psy.D; Rebecca Miller, Ph.d and Larry Davidson, Ph.D. Program for Recovery and Community Health. Yale University School of Medicine. New Haven, CT

[4] ACAP Letter

Sellers Dorsey is a national healthcare consulting firm composed of an industry-leading team of consultants and thought leaders from the worlds of policy, government, business, and industry, allowing the firm to provide a fully integrated suite of services to clients. Sellers Dorsey has a deep understanding of Medicaid, having consulted in over 30 states on a range of financing, policy and operational projects, and Medicare financing and policy. Its reputation is one of creativity, collaboration, and accomplishment.

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