April 2019

Financial Alignment Initiative Texas Dual Eligible Integrated Care Demonstration Project: First Evaluation Report

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RTI Project Number 0214448.001.007.000.000.006

FINANCIAL ALIGNMENT INITIATIVE
TEXAS DUAL ELIGIBLE INTEGRATED CARE DEMONSTRATION PROJECT: FIRST EVALUATION REPORT

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CMS Contract No. HHSM-500-2014-00037i TO#7

April 2019

This project was funded by the Centers for Medicare & Medicaid Services under contract no. HHSM-500-2014-00037i TO #7. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

Acknowledgments

We would like to thank the State officials who contributed information reflected in this Evaluation Report through interviews during site visits and quarterly telephone calls. We also thank the Medicare-Medicaid enrollees, managed care plan staff, consumer advocates, and other stakeholders who also answered our questions about their experience and perspectives on the demonstrations. We gratefully acknowledge the many contributions of CMS staff, especially our COR, Sai Ma, and our former COR, Daniel Lehman. We also thank other staff at RTI International and staff at the National Academy for State Health Policy, who helped to gather information and produce tables for this report. Christopher Klotschkow and Catherine Boykin provided excellent editing and document preparation.

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Executive Summary

The Medicare-Medicaid Coordination Office and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. CMS contracted with RTI International to monitor the implementation of the demonstrations and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation will include a final aggregate evaluation and State-specific evaluation reports.

The Texas Dual Eligible Integrated Care Demonstration Project is a capitated model demonstration that began in March 2015 and is scheduled to end December 31, 2020. The demonstration builds on the State's Medicaid managed care program, STAR+PLUS, by integrating Medicare benefits into the health plan benefits package for Medicare-Medicaid enrollees and by paying Medicare-Medicaid Plans (MMPs) a blended capitated rate to arrange for and coordinate all primary, specialty, and behavioral health care, as well as long-term services and supports (LTSS).

The demonstration operates in the six Texas counties with the largest populations of Medicare-Medicaid enrollees. Health plan participation is limited to the five plans that were competitively chosen in a prior State procurement process to manage STAR+PLUS.

This first Evaluation Report for the Texas demonstration describes implementation and early analysis of the demonstration's impact. The report includes qualitative evaluation findings through December 2017, as well as clarifying information obtained after the site visit. Data sources include key informant interviews, beneficiary focus groups, the Medicare Advantage and Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, and other demonstration data. Two primary data sources were used to support the cost savings analyses, capitation payments—obtained from CMS Medicare Advantage and Part D Inquiry System (MARx) data—and Medicare claims. Quantitative results obtained using Medicare claims data, the Minimum Data Set nursing facility assessments and MMP encounter data will be included in the next Evaluation Report if all MMP encounter data are submitted for analysis on time and are complete. Future analyses also will include Medicaid claims and encounters as those data become available.

Highlights

- In 2016–2017, the lead State agency for the demonstration—the Texas Health and Human Services Commission (HHSC)—was reorganized, and as a result, many staff members moved to different divisions or left the agency. These changes created challenges for demonstration operations and stakeholder engagement.

- Early in the demonstration, just after nursing facility services had been carved into the State's mandatory Medicaid managed care program, nursing facility payment processes were challenging for MMPs and providers. HHSC and MMP staff believe that systemic difficulties with routine payments have been resolved, but a provider

representative expressed concern about ongoing challenges with timeliness of authorization of skilled nursing facility services.

- The results of preliminary Medicare cost savings analyses using a difference-in-differences regression approach indicate savings in the first demonstration period from March 2015–December 2016. The cost savings analyses do not include experience rebate payments to CMS and the State or Medicaid data due to current data availability, but these data will be incorporated into future calculations as they become available.

- Of the more than 155,000 Medicare-Medicaid enrollees eligible for the demonstration, approximately 43,000, or 28 percent, were enrolled as of November 2017. The enrollment rate has remained between 25 and 30 percent in most months.

- HHSC has collaborated with CMS on several strategies to improve service coordination, including increasing training requirements; compiling and distributing best practices; and conducting a survey to prompt MMPs to examine their service coordination processes.

- Most focus group participants in 2016 and 2017 indicated that their health or quality of life had improved in the previous 2 years, due to factors such as access to providers or new health benefits, weight loss achieved through MMP programs, reduced out-of-pocket costs, and diminished financial stress. Most enrollees who participated in in-depth interviews indicated that MMPs had little or no impact on their lives.

- Sixty-four percent of MMP enrollees responding to the CAHPS survey in 2017 rated their health plan a 9 or 10 on a scale of 0 to 10. This result is consistent with the national MMP average and the national average for Medicare Advantage plans.

- MMPs have reported profits throughout the demonstration and therefore have been required to pay experience rebates to the State. However, HHSC reported that MMP profit levels have declined due to annual increases in the savings rate.[1]

- State and MMP representatives have reported continued challenges with the timeliness and accuracy of MMPs' encounter data submissions, particularly those for Medicare acute care services and crossover claims.

- HHSC would like to collect liquidated damages (monetary compensation for State and CMS losses) to promote MMPs' compliance with encounter data requirements. However, CMS preferred a different approach, and following the site visit, the Contract Management Team (CMT) was continuing to discuss the issue.

- MMPs' performance on the 13 HEDIS measures was mixed relative to Medicare health maintenance organizations (HMOs). For three measures, most plans that

[1] The savings rate is the specified percentage by which MMP payments are reduced from baseline levels (MOU, p. 45, three-way contract, p. 210) in each demonstration year, based on the expectation that MMPs will achieve savings.

reported data performed better than the national Medicare HMO average benchmark value. For one measure, two plans performed better than the national Medicare HMO benchmark, and for the remaining measures, the majority of plans performed below the benchmark.

- This report does not contain the results of impact analyses using utilization data. Such analyses require not only fee-for-service utilization data for non-enrollees and comparison group beneficiaries, but also enrollee encounter data from MMPs during the demonstration period. It was not possible to conduct the utilization analysis for this report because RTI was unable to deem demonstration year one encounters complete. Future evaluation reports will contain impact analyses on utilization if all MMP encounter data are submitted on time and are complete. Such analyses would include results for prior demonstration years if encounter data for those years are deemed complete.

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1. Overview

1.1 Evaluation Overview

1.1.1 Purpose

The Medicare-Medicaid Coordination Office (MMCO) and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. The goal of these demonstrations is to develop person-centered care delivery models integrating the full range of medical, behavioral health, and long-term services and supports (LTSS) for Medicare-Medicaid enrollees, with the expectation that integrated delivery models would address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives.

This report on the Texas capitated model demonstration under the Medicare-Medicaid Financial Alignment Initiative, called the Texas Dual Eligible Integrated Care Demonstration Project, is one of several reports that will be prepared to evaluate the demonstration. CMS contracted with RTI International to monitor the implementation of the demonstrations under the Financial Alignment Initiative and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes a final aggregate evaluation (Walsh et al., 2014) and State-specific evaluation reports.

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on the beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for special populations (e.g., people with mental illness and/or substance use disorders, LTSS recipients). To achieve these goals, RTI collects qualitative and quantitative data from Texas each quarter; analyzes Medicare and Medicaid enrollment, claims, and encounter data; conducts site visits, beneficiary focus groups, and key informant interviews; and incorporates relevant findings from any beneficiary surveys conducted by other entities. In addition to this report, monitoring and evaluation activities will also be reported in subsequent evaluation reports for the Texas Dual Eligible Integrated Care Demonstration Project, and a final aggregate evaluation report for the Financial Alignment Demonstration.

1.1.2 What it Covers

This report analyzes implementation of the Texas Dual Eligible Integrated Care Demonstration Project from its initiation on March 1, 2015 through December 2017. The report also incorporates additional information, obtained on an as-needed basis for clarification, following the November and December 2017 site visit interviews.[2] It describes the Texas Dual Eligible Integrated Care Demonstration Project's key design features; examines the extent to which the demonstration was implemented as planned; identifies any modifications to the design; and discusses the challenges, successes, and unintended consequences encountered during the

[2] In areas of the text where the timing of this information is relevant, we describe it as "following the 2017 site visit."

period covered by this report. It also includes data on the beneficiaries eligible and enrolled, geographic areas covered, and status of the participating Medicare-Medicaid Plans (hereafter referred to as MMPs). Finally, the report includes data on care coordination (hereafter referred to as service coordination, the term used in the demonstration and STAR+PLUS); the beneficiary experience; stakeholder engagement activities; and a summary of preliminary findings related to Medicare savings results in the first demonstration year.

This report does not contain the results of impact analyses using utilization data. Such analyses require not only fee-for-service utilization data for nonenrollees and comparison group beneficiaries, but also enrollee encounter data from MMPs during the demonstration period. It was not possible to conduct the utilization analysis for this report because RTI was unable to deem demonstration year one encounters complete. Future evaluation reports will contain impact analyses on utilization if all MMP encounter data are submitted on time and are deemed complete. Such analyses would include results for prior demonstration years if encounter data for those years are also deemed complete.

1.1.3 Data Sources

A wide variety of information informed this first Evaluation Report of the Texas Dual Eligible Integrated Care Demonstration Project. Data sources used to prepare this report include the following:

Key informant interviews. The RTI evaluation team conducted three site visits. Two were conducted in person, on September 1–3, 2015 and August 1–4, 2016. One was conducted remotely via telephone from November 13–17, 2017, with additional interviews conducted through December 11, 2017. The team interviewed the following types of individuals: Texas Health and Human Services Commission (HHSC) officials; CMS staff; MMP representatives; provider stakeholders; and beneficiary advocates.

Focus groups. The RTI evaluation team conducted a total of 16 focus groups in Texas in 2016 and 2017. Each year, eight groups were held in August in Houston, and each year, two groups were conducted entirely in Spanish. In 2016, the groups had a total of 49 participants, and in 2017, a total of 42 individuals participated.

In both 2016 and 2017, participants were assigned to groups based on their LTSS and behavioral health services use, race, ethnicity, and primary language. Focus groups were not conducted with beneficiaries who opted out of the demonstration or who disenrolled.

In-depth enrollee interviews. L&M Policy Research (2017) conducted in-depth interviews with 33 demonstration enrollees in Dallas, Tarrant, and Hidalgo Counties in April 2017. Twenty-one interviews were conducted in English, and 12 were conducted in Spanish.

Surveys. CMS and HHSC conduct annual assessments of the experiences of beneficiaries using the Medicare Advantage and Prescription Drug Plan CAHPS survey instrument. The 2016 and 2017 surveys for the Texas Dual Eligible Integrated Care Demonstration Project were conducted in the first half of 2016 and 2017, respectively, and included the core Medicare CAHPS questions and 10 supplemental questions added by the RTI evaluation team and 8 supplemental questions added by HHSC. Survey results for a subset of 2016 and 2017 survey

questions are incorporated into this report. Findings are available at the MMP level only. The frequency count for some survey questions may be suppressed because too few enrollees responded to the question. Comparisons with findings from all Medicare Advantage plans are available for core CAHPS survey questions but not for the RTI or HHSC supplemental questions.

Demonstration data. The RTI evaluation team reviewed data provided quarterly by Texas through the State Data Reporting System (SDRS). These data included eligibility, enrollment, and information reported by the State on MMPs' provider outreach activities, Contract Management Team (CMT) efforts to improve service coordination, and enrollment broker outreach efforts. This report also uses data for quality measures reported by Texas MMPs and submitted to CMS's implementation contractor, NORC at the University of Chicago (hereafter referred to as NORC).[3] Data reported to NORC include core quality measures that all MMPs are required to report, as well as State-specific measures developed specifically for the Texas demonstration. Due to reporting inconsistencies, plans occasionally resubmit data for prior demonstration years; therefore, these data are considered preliminary.

Demonstration policies, contracts, and other materials. This report uses several data sources, including the Memorandum of Understanding (MOU) between the State and CMS (Centers for Medicare and Medicaid Services and State of Texas, 2014; hereafter, MOU, 2014); the three-way contract (CMS and State of Texas, 2014; hereafter, Texas three-way contract, 2017); information available on the Texas Health and Human Services website (https://hhs.texas.gov/); and follow-up information that the evaluation team requested from MMPs and the State after the site visits.

Conversations with CMS and HHSC officials. To monitor demonstration progress, the RTI evaluation team engages in periodic phone conversations with HHSC and CMS. Issues discussed during these calls might include amendments to the three-way contract, payment issues, changes to enrollment procedures, and efforts to improve service coordination.

Complaints and appeals data. Complaint (also referred to as grievance) data are from three separate sources: (1) complaints from beneficiaries reported by Texas MMPs to HHSC, and separately to CMS' implementation contractor, NORC, through Core Measure 4.2; (2) complaints received by HHSC or 1-800-Medicare and entered into the CMS electronic Complaint Tracking Module (CTM); and (3) qualitative data obtained by RTI on complaints. Appeals data are based on data reported by MMPs to HHSC and NORC, for Core Measure 4.2, and the Medicare Independent Review Entity (IRE). Although a discussion of the five MMPs is included, this report presents information primarily at the demonstration level. It is not intended to assess individual MMPs' performance, but individual MMP information is provided where MMP-level data are the only data available, or where MMP-level data provide additional context.

[3] The technical specifications for reporting requirements are in the Medicare-Medicaid Capitated Financial Alignment Model Core and State-Specific Reporting Requirements documents, which are available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

Cost savings data. Two primary data sources were used to support the savings analyses, capitation payments and Medicare claims. Medicare Capitation payments paid to MMPs during the demonstration period were obtained for all demonstration enrollees from CMS Medicare Advantage and Part D Inquiry System (MARx) data. The capitation payments were the final reconciled payments paid by the Medicare program after taking into account risk score reconciliation and any associated retroactive adjustments in the system at the time of the data pull (April 2018). Quality withholds were applied to the capitation payments (quality withholds are not reflected in the MARx data), as well as quality withhold repayments based on data provided by CMS. Fee-for-service (FFS) Medicare claims were used to calculate expenditures for all comparison group beneficiaries, demonstration beneficiaries in the baseline period, and demonstration eligible beneficiaries who were not enrolled during the demonstration period. FFS claims included all Medicare Parts A and B services.

1.2 Model Description and Demonstration Goals

The Texas Dual Eligible Integrated Care Demonstration Project began on March 1, 2015 and was originally scheduled to continue through December 31, 2018. In August 2017, the State and CMS amended the three-way contract to extend the demonstration an additional 2 years, through December 31, 2020 (Texas three-way contract, 2017).

The demonstration builds on the State's existing Medicaid managed care program for the aged and adults with disabilities, known as STAR+PLUS, by integrating Medicare benefits for the first time into the managed care benefits package for Medicare-Medicaid enrollees, and by requiring MMPs to provide a streamlined point of service to authorize, arrange, and coordinate all primary, preventive, specialty, chronic, and behavioral health care, as well as long-term services and supports, for Medicare-Medicaid enrollees. Under a three-way contract between MMPs, the State, and CMS, MMPs are paid a blended capitated rate to perform these functions. ***Appendix C*** provides a summary of predemonstration and demonstration design features for Medicare-Medicaid beneficiaries

The demonstration operates in the six Texas counties with the largest population of Medicare-Medicaid enrollees: Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant. To leverage existing health plan experience with Medicare-Medicaid enrollees, health plan participation in the demonstration was limited to the five plans that had been competitively chosen in a prior State procurement process to manage STAR+PLUS.

The demonstration's goals are to: improve beneficiary experience in accessing services; deliver person-centered care; promote independence in the community; improve the quality of services; eliminate cost-shifting between Medicare and Medicaid; and achieve cost savings for the Federal and State governments through improvements in service coordination (MOU, 2014).

MMPs. HHSC and CMS contract with MMPs to provide coverage for all Medicare- and Medicaid-related benefits and services. The MMPs are all national health plans that have experience with Medicare-Medicaid Financial Alignment Initiative demonstrations in other States.

Benefits. Covered services under the demonstration enrollees include all benefits provided in the State Medicaid program, as well as in Medicare Parts A, B, and D. Benefits also include specified pharmacy products (e.g., certain over-the-counter drugs) covered by HHSC that may not be covered under Medicare Part D. MMPs are encouraged to offer broader drug formularies than those covered under minimum requirements for Medicare Part D (Texas three-way contract, 2017, p. 321).

MMPs have discretion to use capitation payments to offer flexible benefits, which are health-related services annually approved by CMS and HHSC, at no additional cost to CMS, HHSC, or enrollees (Texas three-way contract, 2017, p. 53). Flexible benefits, which vary among MMPs, can cover items such as supplemental dental, vision, and hearing coverage; weight loss programs; smoking cessation; additional home care visits; specified coverage of over-the-counter drug products; and a variety of nominal gifts (Texas HHS, n.d.-a); Molina Healthcare, n.d.).

1.3 Changes in Demonstration Design

In addition to a 2-year extension of the demonstration (see ***Section 1.2***), the 2017 amendment to the three-way contract included changes to align with the Medicaid managed care rule,[4] technical revisions for streamlining purposes, and updates to align with Texas Medicaid program requirements. Notable provisions include: (1) an increase in the number of required service coordinator training hours from 16 to 20 (see ***Section 4.1.3, Efforts to Improve Service Coordination***); (2) a requirement for MMPs to have policies and procedures that ensure delivery of authorized services (see ***Section 8.2.1, State and CMS Quality Management Structures and Activities***); (3) authorization for the State to assess liquidated damages on MMPs that do not resolve appeals in a timely manner or that do not meet specified standards of accuracy for Medicaid encounter data submitted to the State (see ***Section 8.2.1***); and (4) a provision stating that MMPs must meet all requirements of the Quality Incentive Payment Program (QIPP) implemented in STAR+PLUS (see ***Section 2.2.2, Provider Arrangements and Services***, and ***Section 8.1.2, HHSC and MMP Experience***).

1.4 Overview of State Context

1.4.1 Agency Reorganization

In 2016–2017, Texas Health and Human Services agencies were reorganized, and new leadership was appointed to multiple divisions in an effort to streamline operations, improve accountability, and increase program integration (Texas HHS, n.d.-b). As part of the reorganization, the Texas Department of Aging and Disability Services (DADS) was abolished, and its functions were transferred to HHSC. Additionally, many responsibilities of the Texas Department of State Health Services (DSHS), such as providing services for people with special health care needs, were transferred to HHSC (Texas HHS, n.d.-c). Health Plan Management, the unit within HHSC that manages oversight and contractual compliance of the demonstration with CMS, was renamed Managed Care Compliance and Operations (MCCO).

[4] CMS-2390-F, 81 FR 27498. https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

During the 2017 site visit, State officials expressed mixed views about the effect of the reorganization, which added several program units to MCCO. Some felt that it enabled more effective coordination of services, particularly for individuals with substance use disorders. Others believed it was too early to identify any impact, and one official commented that although it did not require layoffs of State employees, "…the [agency] transformation…did generate a lot of stirring up and moving around, and leaving State employment…[and created] a sense of staff spread thin…"

Provider and beneficiary representatives believed that staff turnover associated with the reorganization has created challenges for stakeholder engagement (see ***Section 6.2.1, State Role and Approach***).

Following the 2017 site visit, HHSC staff informed the evaluation team that HHSC representation on the joint CMS-State CMT[5] has "drastically changed," and many staff changes have occurred within MCCO and in units responsible for quality assurance, enrollment, and encounter data. According to a State official, most of the demonstration team has moved to other areas of HHSC, and some have left the agency. The official indicated that the new staff were becoming oriented to the demonstration, as well as to important CMS processes and systems issues. These changes limit the State's capacity to design new initiatives to address challenges in areas such as enrollment (see ***Section 3.2.3, Passive Enrollment Experience***) and service coordination (see ***Section 4.1.3, Efforts to Improve Service Coordination***). The evaluation team will continue to monitor the effects of HHSC's reorganization during future site visits and quarterly updates.

1.4.2 Reprocurement of all STAR+PLUS Products

As discussed in ***Section 1.2***, participation in the demonstration is limited to the five health plans participating in the STAR+PLUS Medicaid managed care program (MOU, 2014, p. 4). HHSC plans to reprocure all STAR+PLUS contracts with an effective operational start date of June 1, 2020.

The new contracts will continue the current requirement for STAR+PLUS plans to offer MMPs in demonstration counties. A CMS official anticipated that STAR+PLUS plans would continue to have the option of also offering Dual Eligible Special Needs Plans (D-SNPs) in those counties. Noting that D-SNPs have been permanently reauthorized whereas the demonstration is scheduled to end in December 2020 (see ***Section 1.2***), a State official said that this approach was intended to promote continuity of services for Medicare-Medicaid enrollees after the demonstration ends. The evaluation team will monitor the impact of reprocurement on demonstration operations and enrollees.

1.4.3 Hurricane Harvey

On August 25, 2017, Harris County—which accounts for the largest share of demonstration enrollees—experienced significant flooding and damage from Hurricane Harvey (Texas HHS, n.d.-d; Texas HHS, 2017). State, CMS, MMP, and provider representatives said they worked together to coordinate and monitor disaster-related activities, including evacuation,

[5] See Section 2.1, ***Joint Management of Demonstration,*** for an overview of the CMT.

nursing facility resident transfers, and shelter-in-place arrangements for affected populations. The State obtained waivers from CMS and required managed care organizations (including MMPs) to make specified changes (e.g., requiring coverage of services from out-of-network providers through November 2017) to facilitate timely service delivery for residents of affected areas during and after the hurricane. Additionally, the State received Federal approval for a 6-month extension of medical benefits for enrollees in Medicaid, CHIP, and Healthy Texas Women (Texas HHSC, 2017). Throughout the disaster, the State held daily calls with MMPs to discuss efforts to minimize disruptions in care for affected enrollees. The State reported that MMPs submitted daily reports to the State on their efforts to provide outreach to beneficiaries, such as nursing facility residents who were evacuated and individuals needing critical services and supports, such as dialysis, durable medical equipment (DME), and lifesaving medications.

State and MMP representatives believed that the hurricane did not have any long-term effects on the demonstration. A beneficiary advocate reported that the hurricane exacerbated existing shortages in the home attendant workforce (see ***Section 5.2.5, Beneficiary Access to Care and Quality of Services***), though State and MMP representatives did not believe that it had that effect.

1.4.4 Federal Financial Support

Texas was not among the 15 States that were awarded demonstration design contracts from CMS under the State Demonstrations to Integrate Care for Dual Eligible Individuals. Thus, Texas did not receive Federal funds to support demonstration planning, and it was not eligible to receive CMS funding for implementation support. The State was eligible to receive—but, according to HHSC staff, did not apply for—funding to support the Ombudsman program and options counseling through its State Health Insurance Assistance/ADRC programs for demonstration-related activities.

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2. Integration of Medicare and Medicaid

Highlights

- Five MMPs participate in the demonstration, and at least two MMPs are available to enrollees in five of the six demonstration counties.
- State and MMP representatives reported that as primary care providers became more familiar with the demonstration, their participation increased. MMP staff noted continuing challenges in contracting with specialists due to workforce shortages and reluctance to participate in public programs.
- Early in the demonstration, nursing facility payment processes were challenging for MMPs and providers. State and MMP representatives reported that after many meetings and IT changes to address the issue, systemic challenges with the timeliness and accuracy of routine payments have been resolved. A provider representative expressed concern about ongoing delays with authorization for skilled nursing facility services.

This section provides an overview of the management structure that was created to oversee implementation of the Texas Dual Eligible Integrated Care Demonstration Project and describes the integrated delivery system, including experiences with primary and specialty care, LTSS, and behavioral health care. It also provides a general description of the other functions that HHSC, CMS, and the MMPs coordinate or integrate as part of the implementation of the demonstration. Later sections provide more in-depth discussion of the implementation successes and challenges associated with the integration of these functions.

2.1 Joint Management of Demonstration

The demonstration is jointly managed by the State and CMS. The joint CMS-State Contract Management Team (CMT) oversees MMPs and addresses issues related to Medicare-Medicaid integration. The CMT monitors plans' compliance with the three-way contract, may take compliance actions when necessary, and reviews performance and enrollment data. The CMT is also responsible for integrating Medicare and Medicaid policies and procedures, and it provides a forum to address areas of misalignment.

The CMT includes representatives from HHSC, the Dallas regional office of CMS, and CMS's MMCO. In addition to the group's core members, other State and CMS staff have participated in meetings as needed. The CMT has had regular weekly or biweekly meetings throughout the demonstration and has provided a forum to discuss major policy decisions, as well as granular management and process issues. As noted in ***Section 1.4.1, Agency Reorganization***, HHSC representation on the CMT changed significantly after the 2017 site visit.

2.2 Overview of Integrated Delivery System

2.2.1 MMPs

Distribution of the five MMPs across counties is indicated in ***Table 1***.

Table 1
MMP participation by county

County	Participating health plans
Bexar	Amerigroup, Molina, Superior
Dallas	Molina, Superior
El Paso	Amerigroup, Molina
Harris	Amerigroup, Molina, United
Hidalgo	Cigna-HealthSpring, Molina, Superior
Tarrant	Amerigroup

SOURCE: Texas HHSC, n.d.-e. https://hhs.texas.gov/services/health/medicaid-chip/programs/texas-dual-eligible-integrated-care-project

The CMT meets monthly with each MMP and with all MMPs together. MMP representatives reported that the CMT has been an effective forum for communication among the State, CMS, and plans.

Additional coordinated care delivery systems available to Medicare-Medicaid enrollees in the demonstration counties include a Program of All-Inclusive Care for the Elderly (PACE) in El Paso County,[6] as well as a total of six Dual Eligible Special Needs Plans (D-SNPs).[7] In four of the six demonstration counties,[8] at least two D-SNPs are available.

2.2.2 Provider Arrangements and Services

Medical Care Providers

In 2015 and 2016, MMP staff reported that some large health systems initially refused to contract with them in certain markets (e.g., Dallas and Houston), because they preferred to avoid managed care or because participation in MMP networks did not align with their overall business strategy. According to MMP and HHSC representatives, limited provider participation (including but not limited to providers in large health systems) led to increased opt-out rates, because enrollees did not want to join MMPs that did not include their providers. Additionally, HHSC staff noted that one MMP was unable to obtain a sufficient number of provider contracting agreements in Tarrant County to meet Medicare's network adequacy standards. Therefore, the

[6] https://www.npaonline.org/pace-you/find-pace-program-your-neighborhood

[7] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2017-12.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending

[8] As of December 2017, one D-SNP was operating in Harris County, and none were available in Tarrant County.

MMP withdrew from that service area, and MMP participation in the county has been limited to one plan.

In 2017, HHSC and MMP representatives indicated that as primary care providers (PCPs) became more familiar with the demonstration, their participation increased. An HHSC representative said enrollment broker outreach sometimes led PCPs to participate, particularly if the provider participated in STAR+PLUS.

MMP representatives noted continuing challenges in seeking contracts with specialists, in specialties such as behavioral health, pain management, dermatology, orthopedics, and rheumatology. Staff of one MMP attributed the challenge to workforce shortages and a general reluctance to participate in public programs, rather than to demonstration-specific issues.

Nursing Facilities

HHSC, MMP, and provider representatives noted many challenges with nursing facility payments early in the demonstration. Nursing facilities lacked experience with managed care, as they were carved in to STAR+PLUS at the same time the demonstration's launch. A provider representative commented that nursing facilities had to adjust from having the State as the only payer to having five payers (five STAR+PLUS plans/MMPs), each with different procedures and payment portals. HHSC staff noted that nursing facilities also were required to have separate STAR+PLUS and MMP contracts, each with a different contract manager. According to HHSC officials, nursing facility staff often had difficulty understanding managed care medical necessity criteria, and this difficulty contributed to delays in prior authorization and payment.

Additionally, MMPs experienced operational challenges in complying with the State requirements for nursing facility claims processing. MMP and HHSC staff reported that MMPs' information technology (IT) systems initially were unable to adjudicate nursing facility claims in the required time frames, and their payments, which were determined by the State using a risk-adjustment methodology, often did not correctly reflect the latest changes in individuals' acuity levels and utilization.

To address these challenges, HHSC facilitated regular meetings between MMPs and nursing facility representatives, and HHSC officials were in regular, sometimes daily, communication with MMP and nursing facility staff. HHSC officials noted that they hired a nursing facility specialist with experience in the industry to work with MMPs and nursing facilities on addressing the challenges. MMP staff said they rebuilt their IT systems to process changes in risk-adjusted rates received from the State. In 2017, the State modified contracts for STAR+PLUS plans (which all operate MMPs) to require that their online payment portals for nursing facilities include key payment data (e.g., data on acuity levels and copayments) and that MMPs update member eligibility verification data within 48 hours of receiving the information from HHSC. Data must be available online for the most recent 24 months.

HHSC and MMP representatives believe that because of these collaborative efforts, the systemic issues with routine payments have generally been resolved. However, a provider representative reported ongoing challenges in the timeliness of MMPs' authorizations for skilled nursing facility services, particularly for enrollees transitioning from hospitals to nursing

facilities. The representative cited frequent changes in MMPs' forms, requirements, and fax numbers needed for authorization as contributing factors.

MMP and HHSC staff indicated that MMPs have designated provider relations staff in each service area who are available to help nursing facilities with payment and other issues. According to HHSC and MMP representatives, ongoing communication to resolve nursing facility payment and authorization issues has helped build trust between MMP and nursing facility representatives. Provider representatives reported that nursing facilities' relationships with MMPs vary, and as a result, they are able to collaborate with some more than others on issues related to service coordination, claims payment, and care transitions.

Community-Based LTSS Providers

According to a provider stakeholder, a large portion of Texas community-based LTSS providers are certified for Medicare or Medicaid only, but MMPs sought to contract with only those community-based LTSS providers certified for both Medicare and Medicaid. Thus, the stakeholder said, MMP networks for community-based LTSS providers were relatively narrow, and as a result, many beneficiaries opted out (see ***Section 3.2.7, Factors Influencing Enrollment Decisions***). However, according to MMP staff, most providers are certified for both Medicare and Medicaid; provider networks have been robust; and there have not been access challenges. HHSC was not aware of access challenges related to the size of community-based LTSS provider networks or any associated impact on enrollment.

However, one State official mentioned challenges in ensuring the adequacy of MMP provider networks to deliver services to individuals with intellectual or developmental disabilities (IDD) not enrolled in IDD waivers who are eligible for the demonstration. The official said many of these providers had been reluctant to participate in managed care and indicated that the State was working with MMPs to address the issue. One MMP reported that after educating these providers about the demonstration, they were willing to participate. Another MMP noted that its service coordinators offered support to network providers to help with care management of enrollees with IDD.

Behavioral Health

State officials reported that the demonstration did not create significant changes in behavioral health care delivery, which operated under a managed care system in STAR+PLUS. State and MMP staff said they have been pursuing behavioral health integration efforts independent of the demonstration, though consistent with its goals. For example, HHSC staff noted that STAR+PLUS contracts with managed care plans require coordination among behavioral health care, substance use disorder (SUD) treatment, and PCPs. One MMP reported a recent reorganization to facilitate greater information-sharing and collaboration among medical and behavioral health teams.

HHSC staff reported that the most significant challenge they face in the behavioral health realm is the lack of access to Medicare data on utilization of behavioral health services. Due to difficulties in obtaining accurate and complete Medicare encounter data (see ***Section 7.2.1, Early Implementation Experience***), HHSC officials said they have difficulty determining when Medicare benefits for inpatient psychiatric admissions have been exhausted and when Medicaid

coverage is required to begin. Additionally, they are unable to conduct analyses of Medicare data to ensure compliance with mental health parity requirements.

Innovative Payment Arrangements

Primary care providers. In 2016, some MMPs said they were in the process of developing and refining value-based payment programs for PCPs. Initially the programs provided per-member per-month (PMPM) incentive payments, and MMPs planned to transition to shared savings payment over time. In 2017, MMPs reported varying levels of progress toward this goal. One health plan reported that it was still working toward including its MMP product in value-based contracts, whereas another indicated extensive use of value-based payment methods. More than 200 PCPs, attributed to over 25 percent of MMP enrollees, were participating in the plan's initiative, which included both shared savings and shared risk components. The MMP also has a physician payment incentive program for delivery of high-value diabetes care.

Nursing facilities. In September 2017, the State implemented the Quality Incentive Payment Program, a voluntary initiative to encourage nursing facilities in STAR+PLUS to improve quality and pursue service delivery innovations.[9] MMPs must meet all QIPP requirements (Texas three-way contract, 2017, p. 106).

As of October 2018, 514 of the approximately 1,200 eligible nursing facilities were participating, and 15 performance-based (12 monthly Quality Assurance and Performance Improvement attestation and 3 quarterly quality metrics) payments had been made. The State will evaluate the program's impact at the end of fiscal year 2018.

2.2.3 Training and Support for Plans and Providers

HHSC reported that during the demonstration's rollout, State officials met with representatives of State and county medical associations, trained providers, and made presentations available via webinar to every nursing facility in the State. To address nursing facility payment challenges (see ***Section 2.2.2***), State officials communicated regularly, often daily, with MMPs and nursing facility representatives. HHSC continues to conduct training for nursing facility representatives on managed care processes and demonstration operations.

The State reported that MMPs have conducted training for other providers on topics such as cultural competency and serving individuals with disabilities, addressing care gaps, providing services related to Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, and billing.

2.3 Major Areas of Integration

2.3.1 Integrated Benefits and Enrollment

As discussed in ***Section 1.2***, ***Model Description and Demonstration Goals***, demonstration enrollees receive all Medicaid benefits, as well as all Medicare Parts A, B, and D

[9] Eligibility for QIPP is limited to government nursing facilities that are not State-owned and private nursing facilities in which at least 78 percent of service units are provided to Medicaid beneficiaries.

benefits. Enrollees also have access to specified pharmacy products, such as over-the-counter (OTC) items, that may not be covered under Medicare Part D, and an array of flexible benefits.

Initial enrollment occurred in three phases (see ***Section 3.2.2, Phases of Enrollment***), including an opt-in phase, a passive enrollment phase for enrollees residing outside of nursing facilities, and passive enrollment for nursing facility residents. Systems challenges prevented the State from conducting monthly passive enrollment from October 2015 until August 2017. As of November 2017, approximately 43,000, or 28 percent, of eligible beneficiaries were enrolled in the demonstration.

2.3.2 Integrated Care Coordination and Planning

MMPs must provide each enrollee with a service coordinator who is responsible for coordinating across medical, behavioral health, and LTSS delivery systems and for leading multidisciplinary care teams (see ***Section 4.1, Service Coordination Model***).

2.3.3 Integrated Quality Management

As discussed in ***Section 8***, the demonstration's quality management framework includes quality measurement and reporting; joint compliance monitoring by the State and CMS; ongoing State oversight; MMPs' internal quality management activities; and independent quality management structures and activities by an external quality review organization and HHSC's Office of the Ombudsman.

2.3.4 Integrated Financing

All demonstration-covered services are financed through prospective capitated payments to STAR+PLUS MMPs (see ***Section 7.1, Rate Methodology***). Monthly capitation rates include three components: a payment from CMS for services covered under Medicare Parts A and B; a CMS payment for Medicare Part D-covered benefits; and a payment from HHSC for Medicaid-covered services (Texas three-way contract, 2017, pp. 206, 207).

3. Eligibility and Enrollment

Highlights

- Of the more than 155,000 beneficiaries eligible for the demonstration, approximately 43,000, or 28 percent, were enrolled as of November 2017. The enrollment rate has remained between 25 and 30 percent in most months of the demonstration.
- Factors contributing to the enrollment trend include the State's inability to conduct monthly passive enrollment from October 2015 until August 2017, the scope of exemptions from passive enrollment requirements, as well as enrollee opt-outs due to concern about provider access and desire to avoid change.
- According to HHSC and MMP representatives, misalignment in Medicare and Medicaid enrollment systems created significant discrepancies in State and CMS enrollment data. Although the large volume of manual work needed to reconcile discrepancies created capacity challenges for the State, HHSC reported that ongoing efforts have substantially reduced the number of discrepancies.

3.1 Introduction

In this section, we describe eligibility for the Texas Dual Eligible Integrated Care Demonstration Project; phases of enrollment; the passive enrollment experience; enrollment broker outreach; integration of Medicare and Medicaid enrollment systems; MMPs' efforts to reach enrollees; and factors affecting enrollment decisions.

3.2 Enrollment Process

3.2.1 Eligibility

Full-benefit Medicare and Medicaid enrollees age 21 or older are eligible for the demonstration if they are required to receive their Medicaid benefits through the STAR+PLUS program, which serves individuals who qualify for Supplemental Security Income (SSI) benefits, most residents of nursing facilities, and individuals who meet a nursing facility level of care and receive STAR+PLUS home and community-based waiver services. Participation in the demonstration is voluntary, and beneficiaries can opt out or disenroll at any time.

Individuals are not eligible to enroll in the demonstration if they live in intermediate care facilities for individuals with intellectual disabilities and related conditions (ICF/IIDs), or if they have an intellectual or developmental disability (IDD) and receive services through one of the following home and community-based service waivers for IDD: Community Living Assistance and Support Services (CLASS); Deaf Blind with Multiple Disabilities (DBMD); Home and Community-based Services (HCBS); or the Texas Home Living Program (MOU, 2014, p. 6).

3.2.2 Phases of Enrollment

As shown in ***Table 2***, enrollment in the demonstration occurred in three phases. In Phase 1, beginning March 1, 2015, eligible beneficiaries in all demonstration counties could opt in. Phase 2—passive enrollment for beneficiaries in all demonstration counties residing outside of nursing facilities—began on April 1, 2015. In Phase 2, 20 percent of non-facility residents were enrolled each month, from April 1–August 1, 2015, based on zip code. Enrollment was not allowed to exceed 5,000 beneficiaries per MMP per month in Harris County, or 3,000 per MMP per month in the remaining demonstration counties.

Because nursing facility residents had just been added to STAR+PLUS on March 1, 2015, industry representatives advocated for additional time to adjust to managed care before participating in the demonstration. The State responded to the industry's concerns by delaying passive enrollment for nursing facility residents until August 1, 2015 (see ***Section 6.2.1, State Role and Approach***). The State reported that it phased in passive enrollment of these residents by county, in Phase 3 of the enrollment process, from August 1 through October 1.

Table 2
Texas Dual Eligible Integrated Care Demonstration Project enrollment plan

Aspect	Phase 1	Phase 2	Phase 3
Enrollment method	Opt-in	Passive, with continued opt-in available	Passive, with continued opt-in available
Target population	All eligible beneficiaries	Beneficiaries eligible for passive enrollment and residing in the community	Nursing facility residents
Geographic area	All demonstration counties	All demonstration counties	All demonstration counties
Start date	March 1, 2015	April 1, 2015	August 1, 2015
Gradual rollout	N/A	April 1–August 1: 20% of eligible beneficiaries per month in each county by zip code	August 1: All eligible nursing facility residents in Bexar and El Paso Counties September 1: All eligible nursing facility residents in Harris County October 1: All eligible nursing facility residents in Dallas, Hidalgo, and Tarrant Counties

SOURCE: RTI International: State Data Reporting System (SDRS). 2017.

3.2.3 Passive Enrollment Experience

Following the initial phase-in of passive enrollment in 2015, the number of enrollees declined, and the enrollment rate has remained between 25 and 30 percent in most months (RTI, SDRS, 2016–2017) (see ***Section 3.3, Summary Data***, for a summary of enrollment data). Factors associated with this trend include the State's inability to conduct monthly passive enrollment

from October 2015 until August 2017, the scope of exemptions from passive enrollment requirements, as well as enrollee opt-outs due to concern about provider access and desire to avoid change. Other than working with CMS to begin ongoing monthly passive enrollment, the State did not focus extensively on efforts to boost enrollment following the initial rollout. In light of capacity challenges associated with HHSC's reorganization (see ***Section 1.4.1, Agency Reorganization***), such additional efforts may not have been feasible.

Monthly Passive Enrollment

State officials reported that systems challenges prevented them from conducting monthly passive enrollment following the phase-in period. Because they had not developed the needed IT systems and processes and lacked access to certain CMS enrollment data files, they were unable to identify Medicaid enrollees who become eligible for Medicare before they were passively enrolled into Part D prescription drug plans. They were also unable to determine whether Medicare enrollees who become Medicaid-eligible during the year had previously selected a Medicare plan or had been passively enrolled. Because CMS guidance prohibits more than one passive enrollment per beneficiary per calendar year (CMS, 2013), passive enrollment in the demonstration was limited to large waves of newly eligible Medicare-Medicaid enrollees in January 2016 and January 2017. In subsequent months of each year, as relatively small numbers of newly eligible beneficiaries were being added while disenrollments and opt-outs continued, enrollment steadily declined.

MMPs reported that these enrollment trends created operational challenges. When they gained thousands of new enrollees at the beginning of the year, it was difficult to conduct health risk assessments (HRAs) in the required time frames (see ***Section 4.1.1, Assessment***). As enrollment declined and fell below projections, they had to re-assign service coordination staff they had originally hired for the demonstration.

After State and CMS officials collaborated on key system changes and data-sharing procedures needed for passive enrollment, they were able to begin the ongoing passive enrollment process in August 2017. Since then, MMPs have been allowed to conduct outreach to newly eligible Medicare-Medicaid beneficiaries 60 days prior to their effective enrollment date to provide information about the demonstration.

HHSC representatives reported that monthly passive enrollment has proceeded smoothly, and they believed that opt-out rates have been lower since beginning the process, due to successful enrollee and provider outreach (see ***Section 2.2.2***). MMP staff reported mixed views on whether pre-enrollment outreach has reduced opt-outs, and they indicated that enrollment fluctuations from month to month create ongoing operational challenges. After ongoing monthly passive enrollment began, enrollment rates were slightly higher—ranging from approximately 25 percent in August 2017 to nearly 28 percent in November 2017—than they were at the same time in 2016, when enrollment rates ranged from approximately 23 percent to 25 percent (RTI, SDRS, 2017).

Disenrollment Due to Loss of Medicaid Eligibility

HHSC representatives indicated that 49 percent of demonstration enrollees who lost Medicaid eligibility from September 2015 to 2016 regained it within 60 days. Because of the

CMS guidance prohibiting more than one passive enrollment per calendar year, in 2015 and 2016, the State was unable to passively re-enroll beneficiaries who lost and regained enrollment before the next calendar year. A 2017 CMS policy change allowed HHSC to rapidly re-enroll within the same calendar year Medicare-Medicaid beneficiaries who lose and regain Medicaid eligibility within 60 days (CMS, 2016, p. 57). HHSC staff reported in November 2017 that due to resource considerations and the leadership transition (see ***Section 1.4.1, Agency Reorganization***), the agency had not yet decided whether to implement this change. State officials expressed mixed views about its likely impact.

Exemptions from Passive Enrollment Requirements

Several categories of Medicare-Medicaid enrollees are exempt from passive enrollment but may opt in, including: beneficiaries enrolled in Medicare Advantage plans operated by health plans not participating in the demonstration, if they disenroll from the Medicare Advantage plan; individuals in PACE if they disenroll from PACE; beneficiaries in the CMS Independence at Home Demonstration if they switch to the Texas Dual Eligible Integrated Care Demonstration Project (MOU, 2014); and beneficiaries who are attributed to Medicare Accountable Care Organizations (ACOs) with fewer than 9,000 members, following disenrollment from the ACO.[10]

3.2.4 Enrollment Broker Outreach

Beneficiaries who opt out of the demonstration are enrolled in STAR+PLUS Medicaid managed care and can choose to enroll in either fee-for-service Medicare or Medicare Advantage plans. In 2017, in an effort to boost enrollment, the State's enrollment broker began sending letters to eligible beneficiaries on the anniversary of their opt-out date to provide a reminder of continued eligibility, along with information on benefits and a contact phone number. Depending on resource availability, the enrollment broker has conducted outreach calls to beneficiaries receiving these letters to provide education on the demonstration's benefits. The long-term impact of these efforts remains to be determined.

3.2.5 Integration of Medicare and Medicaid Enrollment Systems

According to HHSC representatives, lack of alignment in Medicare and Medicaid enrollment systems created numerous discrepancies in State and CMS enrollment data. State officials reported that the volume of manual work required to reconcile discrepancies was greater than anticipated and created capacity challenges. A CMS representative said that initially, HHSC and the enrollment broker were not processing or reconciling enrollments in a timely way, but by summer and early fall of 2017, the enrollment broker had significantly reduced discrepancies. MMPs' estimates of discrepancies varied from about 100-200 per month, and MMP representatives said where there were discrepancies, they relied on Medicare enrollment data as the source of truth. Following the 2017 site visit, HHSC staff reported significant progress in reducing discrepancies and estimated that the total had been reduced to about 50 per month.

[10] https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/dual-eligible/dual-demonstration-faqs.pdf

3.2.6 Reaching Enrollees

Throughout the demonstration, MMPs have faced challenges reaching enrollees to conduct the HRAs required for service coordination (see ***Section 4.1.1, Assessment***), because addresses provided by the State are sometimes out-of-date. MMPs have developed a variety of outreach strategies to tackle the issue, such as: contacting providers identified on enrollee claims; making multiple phone calls; sending post cards; connecting with members during the hospital discharge process; driving by enrollees' most recently identified address; making unannounced, in-person visits; searching telephone directories; and using community connectors, or *promotoras*, who coordinate with community-based organizations to find enrollees. One MMP reported having the greatest success with unannounced home visits. If the enrollee is not at home, MMP staff leaves a door hanger that lists the service coordinator's phone number. MMP representatives believe these methods have been effective in improving their HRA completion rates.

3.2.7 Factors Influencing Enrollment Decisions

According to provider, MMP, and HHSC representatives, beneficiaries have opted out or disenrolled from the demonstration for reasons such as: lack of understanding and knowledge; concern about losing access to PCPs and specialists not participating in MMP networks; and a perception that certain prescription drug benefits (mail-order options and coverage for OTC products) available through FFS Medicare or Medicare Advantage are more generous and/or flexible than those provided by MMPs. Additionally, HHSC, CMS, MMP, and provider representatives noted in 2017 that many beneficiaries continue to opt out or disenroll because they want to avoid any type of change in service delivery.

3.3 Summary Data

When the phase-in of passive enrollment was completed in October 2015, 35.3 percent of the 150,291 enrollees eligible for the demonstration were enrolled (see ***Table 3***). As of October 2016, the enrollment rate had declined to 23.7 percent. In October 2017, following the start of ongoing monthly passive enrollment, approximately 42,000, or 27 percent of eligible beneficiaries, were enrolled. In November 2017, the most recent date for which enrollment data are available, more than 43,000, or approximately 28 percent of eligible beneficiaries, were enrolled.

Table 3
Demonstration enrollment

Enrollment indicator	Number of beneficiaries		
	October 2015	October 2016	October 2017
Eligibility			
Beneficiaries eligible to participate in the demonstration as of the end of the month	150,291	154,190	155,336
Enrollment			
Beneficiaries enrolled in the demonstration at the end of the month	53,106	36,547	41,997
Percentage enrolled			
Percentage of eligible beneficiaries enrolled in the demonstration at the end of the month	35.3%	23.7%	27.0%

SOURCE: RTI International: State Data Reporting System (SDRS) 2016–2017.

4. Service Coordination

Highlights

- MMPs must provide enrollees with service coordinators to coordinate medical care, behavioral health, substance use treatment, long-term services and supports (LTSS), and social services.
- In response to challenges in reaching enrollees to conduct required health risk assessments (HRAs), MMPs implemented a variety of outreach efforts. Though HRA completion rates have fluctuated, average rates have improved since the demonstration's first year.
- HHSC and CMS have collaborated on several strategies to improve MMPs' service coordination, such as increasing training requirements; compiling and distributing best practices; and conducting a survey to prompt MMPs to examine their service coordination processes.
- MMPs' reported use of health information exchanges (HIEs) to obtain hospital admission, discharge, and transfer (ADT) data has remained limited throughout the demonstration. Some MMPs have used specialized service coordination teams to collaborate with hospital staff on discharge planning and follow-up for care transitions.

4.1 Service Coordination Model

MMPs are required to provide each enrollee with a service coordinator responsible for coordination of all medical, behavioral health, social services, and LTSS (Texas three-way contract, 2017, pp. 58–61). Service coordinators lead care teams that include primary care providers (PCPs) and other professionals with specified expertise (e.g., behavioral health, knowledge of community resources).

4.1.1 Assessment

MMPs must ensure that each enrollee undergoes a comprehensive health risk assessment (HRA) within 90 days of enrollment, as well as a reassessment and/or care plan update within 12 months of the initial assessment (Texas three-way contract, 2017, p. 71). MMP service coordinators are required to collaborate with each enrollee to create an integrated care plan based on the HRA within 90 days of enrollment or upon receipt of all necessary information from the State, whichever is later (Texas three-way contract, 2017, p. 73).

Enrollees stratified as Level 1—including those receiving Home and Community-based Services (HCBS) STAR+PLUS waiver services, nursing facility residents, individuals with serious and persistent mental illness (SPMI), and other complex needs—must receive initial assessments and annual reassessments in person. Those stratified at Level 2—including enrollees receiving LTSS for personal assistance services or day activity and health services (for enrollees with non-SPMI behavioral health conditions and needs)—may complete HRAs telephonically,

unless the enrollee, caregiver or provider requests an in-person assessment (Texas three-way contract, 2017, pp. 68, 70).

MMPs reported challenges reaching enrollees to conduct HRAs and have used a variety of strategies to address the issue (see ***Section 3.2.6, Reaching Enrollees***). Although there have been fluctuations in the MMPs' average HRA completion rates within 90 days of enrollment, overall, rates have improved since 2015. One MMP reported having an extensive internal tracking system to monitor the HRA process and ensure timely completion. HHSC staff requested details about the system and said they may share the information with other MMPs as a best practice.

As shown in ***Table 4***, as of the fourth quarter of 2017, 67 percent of MMP enrollees had completed HRAs within 90 days of enrollment. In the previous two quarters, the HRA completion rate reached 86 percent. Among enrollees who were willing to participate and could be reached, the percentage with HRAs completed within 90 days has remained above 90 percent after the first year, with all but two quarters above 95 percent.

As indicated in ***Table 5***, the percent of enrollees that MMPs were unable to reach has generally declined during each year of the demonstration. In the first quarter of 2016 and 2017, following large waves of passive enrollment in January, these percentages were higher than in the previous quarters. In 2017, the percentage of enrollees unable to be reached increased in the last quarter.

Table 4
Total percentage of enrollees whose assessment was completed within 90 days of enrollment

Quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Assessment completed within 90 days of enrollment, %	
		All enrollees	All enrollees willing to participate and who could be reached
2015			
Q1	N/A	N/A	N/A
Q2	10,478	54.1	82.2
Q3	25,815	56.4	87.5
Q4	19,001	63.2	81.9
2016			
Q1	6,317	68.3	92.5
Q2	326	84.4	95.5
Q3	412	81.3	99.4
Q4	293	83.3	98.4

(continued)

Table 4 (continued)
Total percentage of enrollees whose assessment was completed within 90 days of enrollment

Quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Assessment completed within 90 days of enrollment, %	
		All enrollees	All enrollees willing to participate and who could be reached
2017			
Q1	11,819	67.9	96.3
Q2	574	86.2	98.2
Q3	630	85.7	98.9
Q4	5,525	67.1	92.6

N/A = not available; Q = quarter.

NOTES: Because the Texas Demonstration began in March 2015, data are not available for Q1 2015.

SOURCE: MMP reported data for Core Measure 2.1. The data for calendar years 2015 and 2016 are final; the 2017 data reflect submissions received as of October 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

Table 5
Percentage of members that MMPs were unable to reach following three attempts, within 90 days of enrollment, by quarter

Quarter	CY 2015	CY 2016	CY 2017
Q1	N/A	23.4%	27.0%
Q2	31.6%	11.0%	11.3%
Q3	32.8%	16.0%	11.7%
Q4	20.5%	15.0%	24.7%

CY = calendar year; N/A = not available; Q = quarter.

NOTES: Because the Texas Demonstration began in March 2015, data are not available for Q1 2015.

SOURCE: MMP reported data for Core Measure 2.1. Data for calendar years 2015–2016 are final; the 2017 data reflect submissions provided to RTI as of October 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

Based on the results of HRAs, service coordinators are required to work with enrollees, their families, health care providers, and other team members to develop comprehensive care plans. As ***Table 6*** shows, for all enrollees, the percentage of enrollees with a care plan completed within 90 days of enrollment varied throughout the demonstration, ranging from a low of 53.2 percent in quarter 4, 2015, to a high of 80.7 percent in quarter 2, 2017. For enrollees not

documented as unwilling to complete a care plan or un-reachable, this percentage also varied, from 70.6 percent in quarter 4, 2015, to 94.1 percent in quarter 2, 2017.

Table 6
Members with Care Plans within 90 Days of Enrollment

Quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Care plan completed within 90 days of enrollment	
		All enrollees	All enrollees not documented as unwilling to complete a care plan or un-reachable
2015			
Q1	N/A	N/A	N/A
Q2	10,418	54.7%	82.5%
Q3	27,709	53.5%	78.7%
Q4	20,920	53.2%	70.6%
2016			
Q1	6,370	55.1%	75.1%
Q2	342	76.9%	89.8%
Q3	436	70.2%	88.7%
Q4	306	67.6%	86.6%
2017			
Q1	11,802	58.4%	85.5%
Q2	596	80.7%	94.1%
Q3	668	79.5%	92.7%
Q4	5,974	62.3%	83.8%

N/A = data are not available; Q = quarter.

SOURCE: Analysis of MMP reported data for Texas State Measure 1.1. Data for calendar years 2015–2016 are final; the 2017 data reflect submissions provided to RTI as of October 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

4.1.2 Care Planning Process

The Integrated Care Team (ICT)

MMPs must encourage enrollees to identify individuals for their care teams (Texas three-way contract, p. 59). According to MMP staff, enrollees with specified diagnoses may be assigned additional service coordinators, such as behavioral health case managers and clinical staff to help manage certain disease processes or utilization patterns. For example, in one MMP, enrollees with a history of multiple admissions are assigned a nurse who provides services and supports to avoid preventable admissions and readmissions.

Non-MMP care coordinators who serve demonstration enrollees—such as nursing facility staff and coordinators from local mental health authorities (LMHAs) and local IDD authorities (LIDDAs)—are expected to collaborate with MMP service coordinators.

HHSC staff noted that because mandatory nursing facility participation in STAR+PLUS began at the same time as the demonstration, there was no track record of collaboration between MMPs and nursing facilities on service coordination. As noted in ***Section 3.2.2***, the State delayed passive enrollment of nursing facility residents by five months. According to a State official, nursing facilities were accustomed to having care plan meetings for residents without external involvement, and sometimes facilities have set up required care team meetings for residents without notifying MMP service coordinators or LMHA care coordinators.

HHSC staff reported that the State has convened meetings with MMP and nursing facility representatives to clarify the respective roles of LMHA, LIDDA, and health plan service coordinators, and they have informed nursing facility staff that they must welcome MMP service coordinators into the care planning process. Additionally, a State official indicated that pursuant to a legislative mandate, managed care organizations participating in State programs must implement processes—such as grand rounds—to promote collaboration among medical and behavioral health care coordinators.

In 2017, HHSC staff reported some progress in cross-entity collaboration—noting that some nursing facilities are now mailing schedules for care plan meetings to MMP service coordinators and local authorities in advance—but believe that there is room for improvement. A provider representative expressed concern that MMP service coordinators do not share their care plans with nursing facilities, even though facilities are required to share their care plans with MMPs.

Service Coordination at the Plan Level

Service coordination models and practices. Service coordination models vary among MMPs. One MMP created service coordination groups, called pods, by county subdivision. In this model, the MMP divided the area into four quadrants, each of which was served by a service coordination pod that could include two registered nurses (RNs), two licensed professional counselors, and two social workers. Service coordinators reached out to team members in their pod for support and assistance in addressing individual enrollee needs. Members of the pod coordinated with the MMP's utilization management team and conferred with the MMP's medical director and a pharmacy specialist as needed.

HHSC reported that all MMPs have voluntarily established hotlines that enrollees or their authorized representatives can call to obtain service coordinators' names and contact information.

Contact schedule. Under the three-way contract, Level 1 enrollees must receive at least two in-person service coordination visits per year, and Level 2 enrollees must receive at least one in-person and one telephone contact annually, or as specified in the HCBS STAR+PLUS waiver if applicable and if waiver requirements are more frequent. Level 1 enrollees in nursing facilities must receive, at a minimum, quarterly face-to-face visits (Texas three-way contract, 2017, p. 61).

Service coordinator credentials. Service coordinators for Level 1 enrollees must be RNs or nurse practitioners (NPs). Licensed vocational nurses (LVNs) serving as service coordinators before March 1, 2013 (e.g., in the STAR+PLUS program), are allowed to continue in that role. Service coordinators for Level 2 enrollees must have undergraduate or graduate degrees in social work or related fields or be LVNs, RNs, NPs, or physician assistants (PAs), or have at least a high school diploma or GED and direct experience with the aged, blind, or disabled/SSI population in 3 of the last 5 years prior to beginning the role of service coordinator (Texas three-way contract, 2017, p. 64).

Workforce issues. According to MMP staff, service coordinator recruitment has been challenging, because multiple managed care entities are competing for a limited number of qualified staff. State officials noted continued high turnover among service coordinators in some MMPs and said that CMT members have tried to "connect some dots for the MMPs," to highlight possible links between service coordinator caseloads, turnover, and challenges in completing assessments within the required time frame. HHSC staff believed that turnover may contribute to challenges in collaboration among coordinators (see above). The service coordinator turnover rate was relatively consistent in 2015 and 2016—approximately 15 percent—and increased only slightly in 2017, to 16.1 percent (see ***Table 7***).

A provider stakeholder linked high turnover in two MMPs to delays in prior authorization decisions and lack of enrollee awareness of service coordinators (see ***Section 5.2.4, Care Coordination Services***). Delays in prior authorization may occur as new service coordinators learn the process. Although service coordinators do not make prior authorization decisions, they may provide information to inform the prior authorization process. Additionally, when turnover is high, enrollees may not know or have a chance to form lasting relationships with their service coordinators.

Quality of service coordination. HHSC staff reported continued challenges with the quality of service coordination, noting that care plans too often have taken a boilerplate approach and have not sufficiently addressed needs identified in HRAs. A provider stakeholder believed that the quality of service coordination has varied. According to the stakeholder, some service coordinators spend ample time with enrollees and help improve their quality of life, but more often, service coordinators spend only the time needed to collect the required data and do not add as much value to enrollees' quality of life as they could. A beneficiary advocate reported that service coordination has not improved during the demonstration. However, the advocate said in light of the caring nature he had observed among service coordinators, he believed there was "a strong possibility [that service coordination] can get better and fulfill the promise of what service coordination can be."

Table 7
Care coordination

Calendar year	Total number of care coordinators (FTE)	Percentage of care coordinators assigned to care management and conducting assessments	Member load per care coordinator assigned to care management and conducting assessments	Turnover rate (%)
2015	650	71.7	100.72	15.0
2016	592	80.6	73.41	15.2
2017	392	86.7	122.75	16.1

FTE = full time equivalent.

SOURCE: Analysis of MMP reported data for Core Measure 5.1 These data reflect submissions provided to RTI as of October 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

PCP engagement. MMPs reported that they provide PCPs with ongoing education about the demonstration and emphasize the importance of PCP involvement in activities such as care plan review and follow-up. One plan has used provider advocacy groups, a clinical nurse liaison, and account management teams to encourage and educate providers about the importance of their involvement. The MMPs' experiences with PCP engagement have been mixed. One MMP reported that PCP involvement in the demonstration has been "highly variable," depending on "unique provider dynamics." Another indicated that PCPs have been receptive to contacts from service coordinators and have provided information in a timely way for HRAs and care planning.

4.1.3 Efforts to Improve Service Coordination

Notifying Enrollees of Changes

In 2016, the three-way contract was modified to reduce the amount of time that MMPs have to notify enrollees of changes in service coordinators from 15 days to 5 days (Texas three-way contract, 2017, p. 59). Notification must be in writing and include the new service coordinator's name and contact information. This change was intended to increase enrollees' knowledge of their service coordinators and how to contact them (see ***Section 4.1.2***).

The Service Coordination Improvement Project

In 2017, a provider representative expressed concern about service coordinators' preparedness, commenting that new service coordinators sometimes seem to lack understanding of their responsibilities:

> They [service coordinators] seem to get thrown in [to their positions] with a book to read, and I'm not sure if that's the case but maybe it just feels that way. Because then you get a hold of a service coordinator [by phone] and they're not understanding why you're calling them. It's like, did you get any training on what you're supposed to do?

In 2017, to address identified challenges in service coordination, as well as reported lack of beneficiary awareness (see ***Section 5.2.4, Care Coordination Services***), HHSC and CMS collaborated on the Service Coordination Improvement Project, which includes increased training requirements, care plan review, distribution of best practices, and an MMP survey on service coordination. We discuss each of these activities below.

Training. HHSC has increased the number of topics that must be covered in service coordinator training, and the three-way contract was amended in 2017 (p. 64) to increase the number of required training hours from 16 to 20 hours every 2 years. This change aligns with required service coordinator training under STAR+PLUS. HHSC has provided training for service coordinators on topics such as assessments, documentation, nursing facility services, and nursing-home-to-community transitions.

Care plan review and dissemination of best practices. The CMT reviewed a sample of care plans from each MMP and provided detailed feedback to MMPs on potential areas for improvement. Based on these reviews, in 2017 the CMT compiled and distributed to MMPs a list of care plan best practices, including: documenting care team members' names and licensure information; obtaining enrollees' signatures on care plans; providing care plans to enrollees as a matter of standard procedure rather than by request; encouraging enrollee and caregiver participation in goal-setting; incorporating enrollees' own words in care plan goals; using a simple, easy-to-read layout, avoiding jargon and acronyms, and using appropriate reading levels; and encouraging enrollees to bring copies of care plans to provider appointments. At the time of the 2017 site visit, the impact of the best practices document had not yet been determined.

After the 2017 site visit, HHSC staff indicated that the CMT was conducting a second round of reviews (to continue in 2018), focused on care plans for MMP enrollees residing in nursing facilities for long stays, MMP enrollees residing in skilled nursing facilities for short stays, and MMP enrollees with dementia. Project leads from the Texas Takes on Dementia Project (see ***Section 5.2.8, Experience of Special Populations***) will participate in the reviews, with the goal of promoting integrated systems for dementia care. The State plans to provide MMPs with a list of best practices based on these reviews.

Service coordination survey. In 2017, the CMT also sent MMPs a 10-question survey covering topics such as: service coordinator turnover; methods of communicating service coordinator changes to enrollees; enrollee information on service coordinators' roles and responsibilities; customer service staff education on service coordination; provider education and engagement in service coordination; and service coordinators' methods of tracking members' receipt of needed services. According to a State official, these questions are intended to prompt MMPs to take a closer look at service coordination processes and ultimately make improvements.

Survey highlights include the following: All MMPs indicated that they provide written materials to enrollees (e.g., member handbooks, brochures) explaining service coordinators' roles and responsibilities, and that service coordinators reinforce this information when engaging with enrollees. MMPs reported that service coordinators interact with PCPs in a variety of ways, such as by discussing and/or collaborating on care plans and by working together to address enrollees' health care needs.

All MMPs said that service coordinators track enrollees' attendance at medical appointments and receipt of scheduled treatments. One MMP reported having a specialized transition team to follow up with enrollees after hospital discharge to ensure that post-discharge appointments are kept. The evaluation team will continue to monitor and report results of the CMT's service coordination improvement efforts.

4.2 Information Exchange

HHSC staff reported that it encourages but does not require MMPs to use electronic care management systems. In 2016, MMP representatives said they had online care management systems that enable electronic communication across care teams (e.g., by service coordinators and utilization management staff) and that PCPs could access enrollees' service coordination plans through their provider portals. In 2017, MMP staff reported that PCPs receive copies of enrollees' service coordination plans via fax, mail, or hand-delivery; one MMP said it was using these methods because PCPs had opted not to use online portals.

The State does not require managed care plans to use health information exchanges (HIEs), and MMPs' reported use of HIEs has remained limited throughout the demonstration. MMP staff reported that multiple HIEs operate in Texas, and that the extent and usefulness of HIE data vary. One MMP reported obtaining admission, discharge, and transfer (ADT) and emergency department (ED) data from a HIE in one county and sharing the data in real time with PCPs to promote timely follow-up. The MMP is pursuing additional data-sharing agreements with other HIEs across the State. Staff of another MMP reported using two regional HIEs for their Medicaid product but not for the demonstration, though they are exploring the potential to expand use of these and other HIEs in their Medicare products.

In the absence of ADT data to inform discharge planning, some MMP representatives said they designate specified service coordination teams to collaborate with hospital staff on needs assessment, discharge planning, care management, and post-discharge follow-up. One MMP described a process in which a transition coach takes the lead in arranging for post-discharge services, and, once enrollees have everything they need, the service coordinator again takes charge of managing the enrollees' care.

In summer 2017, HHSC implemented a pilot program to integrate provider health information portals with those of managed care plans through a single sign-on. The system allows providers to view information for beneficiaries' in all Medicaid managed care plans and FFS Medicaid, and it provides a centralized tool to share patient consent. The initiative is intended to reduce duplication and improve access to information across the Medicaid program (Texas HHS, n.d.-f) and thus has the potential to enhance service coordination. According to a State official, plans participating in the pilot operate both STAR+PLUS and MMP products. The evaluation team will monitor the initiative's impact.

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5. Beneficiary Experience

Highlights

- In 2017, 64 percent of MMP enrollees rated their health plan a 9 or 10 on a scale of 0 to 10. This result is consistent with the national MMP average and the national average for Medicare Advantage plans.
- Most RTI focus group participants in 2016 and 2017 indicated that their health or quality of life had improved in the previous 2 years, due to factors such as access to providers or new health benefits, weight loss achieved through MMP programs, as well as reduced out-of-pocket costs and diminished financial stress. Most participants in the 2017 L&M interviews believed that MMPs had little or no impact on their lives.
- The vast majority of RTI focus group participants believed they did not have service coordinators in 2016. In the following year, most said they had been contacted by service coordinators, but the extent of reported engagement with service coordinators varied widely in the English-speaking groups. Spanish-speaking participants reported a lack of ongoing engagement.
- L&M's enrollee interviews found a correlation between enrollees' reported engagement with service coordinators and their perceived level of access to services.

5.1 Introduction

Improving the experience of beneficiaries who access Medicare- and Medicaid-covered services is one of the main goals of the demonstrations under the Financial Alignment Initiative. Many aspects of the Texas Dual Eligible Integrated Care Demonstration Project are designed expressly with this goal in mind, including emphases on working closely with beneficiaries to develop person-centered care plans, delivering all Medicare and Medicaid services through a single plan, providing access to new and flexible services, and aligning Medicare and Medicaid processes.

This section highlights findings from various sources that indicate the levels of beneficiary satisfaction with the demonstration overall; satisfaction with new or expanded benefits; satisfaction with medical and specialty services; satisfaction with care coordination services; experience with access to care; person-centered care and engagement; personal health outcomes and quality of life; experience of special populations; and beneficiary protections. For beneficiary experience, we draw on findings from the Consumer Assessment of Health Plan Survey, RTI focus groups, enrollee interviews by L&M Policy Research (see ***Section 1.1.3, Data Sources***), and stakeholder interviews. Please see ***Section 1.1.3, Data Sources***, for details. This section also provides information on beneficiary protections and data related to complaints and appeals.

5.2 Impact of the Demonstration on Beneficiaries

This section summarizes the findings of focus groups and stakeholder interviews reflecting beneficiary experiences with service delivery and quality of life under the Texas Dual Eligible Integrated Care Demonstration Project. Beneficiary experiences related to the early enrollment process, including experiences of beneficiaries who chose to opt in, opt out, or who were passively enrolled, are discussed as part of ***Section 3, Eligibility and Enrollment***.

5.2.1 Overall Satisfaction with the Texas Dual Eligible Integrated Care Demonstration Project

Most RTI focus group participants were unaware of the demonstration, but participants showed awareness of their health plans and benefits. Some appeared to understand that they were enrolled in integrated MMPs and believed integration was helpful.

> [Previously] I had Medicare and Medicaid separately. It changed this year, and now it's [a] dual program…It has worked better for me because if I need repairs or medication…if Medicaid cannot cover [a needed item or service], Medicare covers the other part for what I need.

In 2016, participants' reported satisfaction with MMP benefits was mixed in both the English and Spanish-speaking groups. In 2017, a majority across all groups rated their plans favorably, often citing reasons such as low out-of-pocket costs, zero copays for prescriptions, and service coordination.

> I feel my insurance give[s] me life…I am satisfied with the insurance…[and] all the coverage [the MMP] gives me.

L&M's 2017 enrollee interviews found that overall, both English- and Spanish-speaking participants were somewhat satisfied with their MMP coverage. Satisfaction was related to perceived access to providers, prescription drugs, and services or supplies (such as DME). A few were very satisfied, due to access to services they said they did not have previously, such as: service coordination; help with cleaning and housekeeping; and transportation services. Many of those who were dissatisfied indicated that they had little or no contact with service coordinators.

Sixty-four percent of MMP enrollees responding to the 2017 CAHPS survey rated their health plan a 9 or 10 on a scale of 0–10, an improvement over the 2016 ratings (see ***Table 8)***. The 2017 result is consistent with the national MMP average (63 percent) and the national average for Medicare Advantage (MA) plans (64 percent). Additionally, the percentage of MMP enrollees who rated their prescription drug plans a 9 or 10 in 2017 (66 percent) was slightly higher than the national average for MMPs (64 percent) and MA plans (63 percent) and also shows improvement over the 2016 ratings. MMP enrollees in 2017 reported higher rates of "usually" or "always" receiving the information they needed from their health plan compared with 2016. We provide MA benchmarks, where available, understanding that MA and demonstration enrollees may have different health and sociographic characteristics, and these differences could affect the results.

Table 8
Beneficiary overall satisfaction, 2016 and 2017

CAHPS survey item	Year	National distribution—all MA contracts	National distribution—all MMP contracts	TX distribution—MMP contracts	Amerigroup	HealthSpring	Molina	Superior	United
Percent rating health plan 9 or 10 on scale of 00 (worst) to 10 (best)	2016	61 (n=142,984)	59 (n=9,765)	—	50 (n=135)	72 (n=172)	60 (n=289)	57 (n=144)	52 (n=124)
	2017	64 (n=188,484)	63 (n=14,662)	64 (n=1,429)	66 (n=301)	68 (n=192)	62 (n=468)	70 (n=308)	56 (n=164)
Percent rating drug plan 9 or 10 on scale of 00 (worst) to 10 (best)	2016	61 (n=132,613)	61 (n=9,617)	—	57 (n=123)	72 (n=179)	60 (n=280)	57 (n=142)	57 (n=117)
	2017	63 (n=172,033)	64 (n=14,087)	66 (n=1,388)	65 (n=297)	70 (n=183)	65 (n=466)	72 (n=285)	58 (n=162)
Percent reporting that health plan "usually" or "always" gave them information they needed	2016	81 (n=42,677)	79 (n=3,669)	74 (n=625)	70 (n=54)	n/a	77 (n=90)	68 (n=46)	N/A
	2017	87 (n=84,304)	86 (n=8,234)	89 (n=817)	87 (n=152)	92 (n=115)	87 (n=265)	91 (n=202)	N/A

— = data were not available at the time of report production; CAHPS = Consumer Assessment of Healthcare Providers and Systems; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan.

NOTE: N/A indicates that too few beneficiaries responded to the question to allow reporting or the score had low reliability.

SOURCE: CAHPS data for 2016 and 2017.

5.2.2 New or Expanded Benefits

MMPs have the option of using capitation payments to offer flexible benefits at no additional cost to CMS, HHSC, or enrollees (Texas three-way contract, 2017, p. 53). Flexible benefits, which vary among plans and across counties, can include items such as: supplemental dental benefits; free cell phones with limited monthly minutes; smoking cessation services; transportation assistance; gift items such as a personal grooming kit, blanket, and first aid kit; incentives for completing specified screening tests; home fitness kits or fitness club memberships; and a limited monthly benefit for OTC health products (Texas HHS, n.d.-a). Beneficiary experience with access to dental and transportation benefits are discussed in ***Sections 5.2.3*** and ***5.2.5***.

Participants in both the English- and Spanish-speaking RTI focus groups were aware of flexible benefits. Some said they received coverage for OTC products, but others said their MMPs had eliminated or reduced this benefit. A few participants reported receiving gift cards for obtaining preventive care, and some said they had been offered smoking cessation or nutritional counseling.

> I was overweight…[and] I worked on losing…weight…It didn't take long, because [my MMP] [has] that…exercise program…Silver Sneakers…That helped…a whole lot.

According to MMP staff, dental, vision, OTC drug benefit cards, and emergency response services are popular flexible benefits.

5.2.3 Medical and Specialty Services

In 2016, many participants in the English-speaking RTI focus groups said they had been seeing the same PCP for at least 4 years, and most were satisfied with their PCP. However, others were surprised and unhappy that their providers were not included in MMP networks.

> I had a doctor who I was seeing for a long time. But once they changed [my health plan], you had to find a doctor in their network.

Participants in the Spanish-speaking groups expressed satisfaction with PCPs.

In 2017, a few participants in the English-speaking groups reported having to switch PCPs. Additionally, some participants said they had difficulty finding specialists in the MMP network or had to switch some of their specialists due to enrollment in the demonstration. Several participants in a Spanish-speaking group specifically mentioned challenges in access to podiatry, behavioral health services, and dental care.

In Dallas County, more than half of L&M interviewees said they had not experienced challenges accessing PCP or specialty care since enrolling in MMPs. In Hidalgo County, most participants reported that they continued seeing the doctors they had before enrolling. However, in Tarrant County (where there is just one MMP), most participants said they had to change PCPs and/or specialists following enrollment and had difficulty finding providers who accepted

their coverage. A few interviewees said they had challenges with access to prescription drugs because they were unable to find or visit specialists who could prescribe their medications.

5.2.4 Care Coordination Services

The vast majority of 2016 RTI focus group participants believed that they did not have service coordinators, and many in both the English- and Spanish-speaking groups did not know or were unsure of service coordinators' role. Some participants described challenges in connecting with service coordinators, and several participants said they often did not speak to the same person when they called to access service coordination. Most said they had not worked with service coordinators on goals or care plans, and none said they had received written service coordination plans.

> I don't think I have a specific [service] coordinator. It's just somebody calling and just checking…It's different people and it's just, "Are you okay? Are you having any...[needs]" …I don't know if I have a coordinator.

In 2017, most participants in both the English- and Spanish-speaking groups indicated that service coordinators had contacted them. In the English-speaking groups, participants' reports of whether they knew their service coordinators, how often they were contacted, and whether they received needed services varied widely. Some participants in the English-speaking groups said they had discussed personal goals with service coordinators, but none said their service coordinators had helped them achieve goals.

Participants in the Spanish-speaking groups generally indicated a lack of ongoing engagement with service coordinators. Instead, many described service coordinators' interaction with them as periodic check-ins to ask how they were doing, without much discussion. The majority of participants in the Spanish-speaking groups indicated that they had not discussed health goals with service coordinators. Instead, some reported discussing goals with a PCP, nutritionist, or family member. About half of the participants in one group said they did not believe that their care was being coordinated.

The majority of L&M interviewees were aware of their service coordinators, but the frequency of reported contact varied. Several participants could not remember any contact. The vast majority appeared to be unfamiliar with the process of developing care plans. Overall, participants who engaged with service coordinators described their experiences as positive and helpful.

As shown in ***Table 9***, the 2017 CAHPS survey found that 84 percent of MMP enrollees reported that their personal doctors were "usually" or "always" informed and updated about care received from specialists. This proportion is slightly lower than the national MMP average (86 percent) and the national MA average (87 percent). Data from the 2016 CAHPS survey are not included because too few beneficiaries responded to the question to allow reporting or the score had low reliability.

Table 9
Care coordination, 2017

CAHPS survey item	National distribution—all MA contracts	National distribution—all MMP contracts	Texas distribution–- MMP contracts	Amerigroup	HealthSpring	Molina	Superior	United
Percent reporting that in the past 6 months personal doctor "usually" or "always" was informed and up-to-date about care received from specialists	87 (n=103,052)	86 (n=6,942)	84 (n=635)	N/A	N/A	86 (n=206)	87 (n=151)	N/A

CAHPS = Consumer Assessment of Healthcare Providers and Systems; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan.

NOTE: N/A indicates that few beneficiaries responded to the question to allow reporting or the score had low reliability.

SOURCE: CAHPS data for 2017.

To increase enrollee awareness of and engagement with service coordinators, MMPs have distributed information sheets, refrigerator magnets, and/or service coordinators' business cards during home visits and as part of enrollee mailings. Additionally, MMPs have provided information about service coordination during general information meetings for new members and member appreciation events; had service coordinators distribute orientation brochures; and trained service coordinators to explain and reinforce their roles during discussions with beneficiaries. One MMP reported that enrollees receive service coordinator's direct phone numbers, as well as the MMP's toll-free service coordination number.

5.2.5 Beneficiary Access to Care and Quality of Services

Overall Access

In both 2016 and 2017, participants in both the English- and Spanish-speaking RTI focus groups described mixed experiences with access to services and supplies. Many were pleased with improved access to providers, reduced or no copays on medications, dental services, and vision care.

> For me, with that new [MMP] I have, getting to the dentist…that's been pretty helpful… [and having] no copay on my medicine.

Others reported increased copayments and difficulties with access to specialists (see ***Section 5.2.3***). A few expressed challenges because doctors had prescribed medications not on their MMPs' formularies. Some participants said they were able to obtain timely appointments, whereas others reported long waiting times for appointments. Some expressed frustration with delays in access to durable medical equipment, and a few reported problems with transportation services.

> …When I need the [wheel]chair, I have to wait months for it to be approved. Then to get the medical suppl[ies]…that takes a while.

L&M interview participants' reported experiences with access to PCPs and specialists varied by county (see ***Section 5.2.3***).

Behavioral Health

HHSC staff said they were not aware of demonstration-specific challenges related to behavioral health access. They noted a shortage of behavioral health providers in the State, particularly in rural areas, but indicated that the issue was less challenging in demonstration counties, which are largely urban. An HHSC official reported a variety of efforts to increase access to behavioral health services in all of its managed care programs, such as establishing time and distance standards for access to behavioral health providers; requiring service coordination team members to have expertise in behavioral health; and requiring coverage for telemedicine. The State also encourages all managed care organizations to contract with providers offering telemedicine to ensure access to outpatient behavioral health and other services.

Most L&M interview participants who reported having behavioral health service needs said they had seen psychiatrists a few times for prescriptions and/or medication adjustments but

had not seen other behavioral health providers. A few participants, who said they had not seen behavioral health providers while enrolled in MMPs, said they had stopped taking medications previously prescribed by behavioral health care providers.

LTSS

Delivery system challenges. According to HHSC staff, access to HCBS waiver services is a major challenge in the Medicaid program, because the fiscal year 2018 State budget did not fund additional waiver slots or increase LTSS provider payment rates to reflect growth in service costs. A beneficiary stakeholder expressed concern about a shortage of home attendant workers. According to the stakeholder, the shortage became worse after Hurricane Harvey (see ***Section 1.4.3***), which forced many Houston-area residents to leave the State; following the evacuations, many attendants found other jobs and were not available when beneficiaries returned home. However, State and MMP representatives said they had not noted increased shortages.

Most L&M interviewees who reported receiving LTSS appeared to be satisfied with these services and did not report access challenges.

Timeliness of service authorization. Provider representatives reported challenges in the timeliness of MMP authorization for both Medicare and Medicaid nursing facility services and Medicare-covered home health services. One provider representative said the challenge has been limited to two MMPs that have high service coordinator turnover (***Section 4.1.2, Care Planning Process***). However, another provider representative suggested that delays for authorizing nursing facility services were common across all plans.

According to a State official, providers accounted for about 80 percent of the complaints that had been submitted to HHSC as of November 2017 (see ***Section 5.2.9)***, and most provider complaints related to claims and authorization issues.[11] A provider stakeholder said providers generally have been reluctant to file complaints with HHSC about delays in prior authorization of LTSS, because they fear it will lead to termination of MMP contracts. However, the stakeholder said that some providers have submitted complaints after being encouraged to do so, and subsequently, timeliness has improved. An HHSC official was aware of provider concerns about MMP retaliation but said the State has not found evidence to support this concern.

According to a provider representative, some MMPs have established online prior authorization procedures in an effort to improve timeliness, and turnaround times have improved somewhat. MMPs reported that they have authorized services in a timely manner.

Quality of Services

Participants in the English-speaking RTI focus groups expressed mixed views about the quality of service received from primary care providers. Some expressed satisfaction with PCPs who were responsive, efficient, and attentive. Others were dissatisfied with PCPs who did not spend enough time with them or did not seem concerned about them. Most participants in the Spanish-speaking groups who commented on the quality of their doctors were satisfied.

[11] Data provided by the State did not indicate the proportion of complaints that were specific to LTSS.

As noted in ***Section 4.1.3, Efforts to Improve Service Coordination***, the CMT, as well as provider and beneficiary stakeholders, have identified a need for improvement in the quality of service coordination, and the CMT is working with MMPs to address the issue.

5.2.6 Person-centered Care and Patient Engagement

Participants in the English-speaking RTI focus groups cited mixed experiences with provider communication and engagement. Some participants said their providers listened and answered their questions, but many reported that providers did not spend enough time talking and explaining things to them.

> …My doctor…listens very [well] …If my doctor will say a word that I don't understand, he will explain it to me.

> My doctor…[doesn't] listen…[and] she can't tell me why or how or what's wrong…

The majority of Spanish-speaking focus group participants who commented on engagement said they felt like they were part of a care team that was available to meet their needs.

As shown in ***Table 8***, the percent of MMP enrollees reporting in the 2017 CAHPS survey that their health plans "usually" or "always" gave them information they needed (89 percent) was slightly higher than the national MMP average (86 percent) and the national average for MA plans (87 percent).

However, many participants in the English-speaking focus groups felt that the information they received from MMPs was too long and complex. Some participants in the Spanish-speaking group noted that information about their care and coverage (including information from the service coordinator) was being provided in English. It was unclear how many knew about or had requested interpreter services or written materials in Spanish. A few said the information they received was too complex or did not provide sufficient explanation. It was not clear whether the complexity was related to a language barrier; one participant noted that even the materials provided in Spanish were written in overly technical language.

All of the Spanish-speaking L&M interviewees indicated that they generally had access to Spanish-speaking health care providers or MMP staff, or that their MMPs provided professional interpreters. Participants generally seemed satisfied with interpretation services and felt that they were able to obtain needed information.

Health plan service coordinators serving the Medicaid population, including MMP service coordinators, are required to undergo training on person-centered care. HHSC staff reported during the 2017 site visit that an interdepartmental work group was standardizing efforts to promote person-centered planning across all State programs. Following the site visit, a State official reported that the work group's scope had narrowed to focus on development of "My Life Plan," a tool designed to identify enrollees' desired outcomes and enable them to direct care plans accordingly. A beneficiary advocate believed that the demonstration has helped advance

person-centered planning. The evaluation team will continue to monitor the impact of the work group's activities.

Self-Direction

In a self-directed care arrangement (an alternative to receiving personal care from agency-provided attendants or independent providers), enrollees recruit, hire, train, and supervise community-based LTSS providers. Self-directed care must include a person-centered planning process, a written care plan, and an individualized budget (CMS, n.d.).

According to the most recent data available from HHSC, as of 2016, approximately 6 percent of enrollees receiving home and community-based waiver services and 3–4 percent of those not receiving waiver services have chosen to self-direct care. MMP staff reported that many enrollees do not choose self-direction due to concerns about management and/or administrative responsibilities.

HHSC staff noted that information on self-direction is included in member handbooks, and service coordinators must inform members about the option during annual assessments and reassessments. However, a beneficiary stakeholder reported that many service coordinators do not understand self-direction, are unable are present it clearly, and/or have given enrollees erroneous information.

In response to finding that enrollees were not receiving consistent information about self-direction, in 2016, HHSC provided additional written guidance to MMPs on how to train service coordinators to discuss the option with Medicare-Medicaid beneficiaries. MMP representatives said they were working with advocacy groups and an academic center specializing in consumer-directed services on efforts to make the option more attractive to enrollees. Additionally, one MMP developed informational materials on self-direction for service coordinators to leave with enrollees. Staff of another MMP said enrollees are referred to organizations providing financial management services[12] for information on self-direction.

5.2.7 Personal Health Outcomes and Quality of Life

Most RTI focus group participants in 2016 and 2017 indicated that their health or quality of life had improved in the previous 2 years. Participants in the English-speaking groups attributed these improvements to factors such as new health benefits (e.g., dental, vision, and prescription drug coverage), access to providers, weight loss achieved through MMP programs, and reduced out-of-pocket costs. Participants in the Spanish-speaking groups reported feeling relieved and less financially stressed because they had access to care and did not have to struggle to meet their needs.

[12] CMS requires that all beneficiaries in self-directed HCBS arrangements have access to financial management services. Entities delivering these services provide help with: understanding billing and documentation responsibilities; performing payroll and other employer-related functions; purchasing approved goods and services; tracking and monitoring individual spending; and identifying spending that is over- or under-budget (https://www.medicaid.gov/medicaid/ltss/self-directed/index.html).

> [My quality of life is] better. I can get more things…All my medicines have been free. I was able to get my glasses at no cost…I get the help that I need.

Most L&M interview participants believed that their MMPs had little or no impact on their health or quality of life.

5.2.8 Experience of Special Populations

HHSC does not have data on differences in beneficiary experiences among special populations such as racial/ethnic/linguistic minorities, or persons with disabilities. Likewise, MMPs and stakeholders did not have information on differences among special populations. ***Sections 5.2.1*** to ***5.27*** and ***5.2.9*** highlight similarities and differences in experiences described by participants in the English-speaking and Spanish-speaking focus groups.

Enrollees with Alzheimer's and related dementia may receive additional services as a result of a 3-year pilot program, Texas Takes on Dementia, currently being planned for Harris and Tarrant Counties. Funded through a Federal grant from the Administration for Community Living, the initiative is intended to improve systems of care for persons with those conditions.

A CMS official reported that three MMPs were participating in the initiative in 2017, and others may join in the future. According to MMP staff, enrollees with dementia will receive specialized assessments in addition to HRAs, to facilitate delivery of appropriate support services. The evaluation team will continue to monitor the pilot project's implementation and impact on enrollees.

5.2.9 Beneficiary Protections

The demonstration provides beneficiary protection through specified grievance and appeals procedures, as well as services of HHSC's Office of the Ombudsman (see below). In this section, we review focus group participants' awareness of rights under the demonstration; describe the grievance, appeal, and ombudsman program options available to enrollees; review data on the number of grievances, appeals, and ombudsman inquiries and complaints filed; and summarize site visit informants' perspectives on these protections.

Participants in both the English- and Spanish-speaking RTI focus groups showed limited understanding of their rights under the demonstration. The vast majority had not heard of the ombudsman program. Two Spanish-speaking focus group participants said they had heard of the ombudsman program but did not know what it was. Though most of the English-speaking group participants knew they could change health plans, many did not know they could change at any time and instead thought they could change only once a year or during certain time periods.

Most L&M interviewees were unaware that they had coverage options other than their current MMPs. None were aware that they could opt out of the demonstration. Most participants were unfamiliar with State-based information resources (e.g., Office of the Ombudsman, the Texas Health Information, Counseling, and Advocacy Program) that could inform them about their rights and options.

Grievances

Enrollees may file internal grievances at any time with MMPs or providers; MMPs are responsible for handling grievances filed with providers. Enrollees also have the option of filing external grievances through 1-800 Medicare or HHSC. External grievances filed with HHSC are forwarded to the CMT and entered in to the CMS Complaint Tracking Module, which is accessible to MMPs. MMPs must maintain written records of all grievance activities and submit quarterly grievance reports to HHSC (Texas three-way contract, 2017, p, 145).

According to a State official, a cumulative total of 157 enrollee and provider complaints had been submitted to HHSC as of November 2017. Reported topics of enrollee complaints included issues such as access to care (e.g., difficulty finding providers in MMP networks, authorized service hours), balance billing, access to DME, and claims denials. The official said that complaints have declined since 2015.

The number of grievances per 1,000 enrollees varied by quarter across demonstration years (2015–2017), following an overall increasing trend. In the second quarter of 2015, there were 2.8 grievances per 1,000 enrollees. This number increased to a high of 6.2 in the third quarter of 2016 and then declined to 3.0 in the third quarter of 2017. In the fourth quarter of 2017, the number of grievances per 1,000 enrollees increased again to 5.3.[13]

In the first demonstration year (March 2015–December 2016), 144 complaints were reported to 1-800-MEDICARE. The highest proportion of these complaints were related to beneficiary enrollment and disenrollment, and benefits access and quality of care.[14] In the second demonstration year (January 2017–December 2017), 109 beneficiary complaints were reported; the highest proportion of beneficiary complaints were provider-specific, including improper, insufficient, or delayed claims payment. Enrollment and disenrollment issues represented the second highest proportion of reported complaints.[15]

According to a beneficiary advocate, the low volume of grievances and appeals is not unique to the demonstration; rather, it is consistent with experience in the Medicaid program. The advocate attributed the trend to beneficiaries' lack of awareness of their rights, willingness to accept the status quo, belief that they will be unable to resolve challenges, and concern that managed care plans will retaliate by terminating their benefits.

An HHSC representative believed that beneficiaries dissatisfied with any aspect of the demonstration typically choose to disenroll rather than pursuing grievance or appeal options:

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[13] Source: RTI analysis of MMP reported data for Core Measure 4.2, as of March 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

[14] Category includes grievances related to ability to obtain a Part D prescriptions, finding a network provider or pharmacy, quality of care received and concerns about denied claims.

[15] Source: RTI calculations on data from the CMS Complaint Tracking Module, covering March 2015–December 2017, Information Current as of March 6, 2018.

"They don't have to work through an issue. They don't have to yell about it. They just leave [the demonstration]."

An MMP representative believes that enrollees are aware of their grievance and appeal rights, which are described in the member handbook and during welcome calls to new members. The representative commented that some enrollee concerns can be addressed effectively through a phone conversation with member services staff and that the MMP coordinates with providers to resolve challenges.

Appeals

The demonstration uses a single, integrated notice to inform enrollees of adverse actions and all applicable demonstration, Medicare, and Medicaid appeal rights. Pursuant to the Medicaid managed care rule, as of September 2017, appeals must be filed first with MMPs; appeals of Medicaid-only services subsequently may be filed with the HHSC Appeals Division. Subsequent appeals for Medicare Part A and B services not fully in enrollees' favor will be forwarded automatically by the MMP to the Medicare Independent Review Entity (IRE) (Texas three-way contract, 2017, pp. 150–1).

If Medicare and Medicaid coverage of a service overlap, MMP appeals decisions that are not fully favorable to the enrollee are automatically forwarded to the IRE, and the enrollee may also request a fair hearing by HHSC. Any determination in favor of the enrollee is binding and requires payment for the service closest to the relief requested in the enrollee's appeal (Texas three-way contract, 2017, p. 151).

In 2015 and 2016, there was a general upward trend in the number of appeals per 1,000 enrollees, increasing from 0.75 appeals per 1,000 enrollees in the second quarter of 2015 to 4.3 in the second quarter of 2016, followed by a decline through the third quarter of 2017 to 3.5 appeals per 1,000 enrollees. The number of appeals per 1,000 enrollees increased in the fourth quarter of 2017 to 4.25, approximately the same level as before the decline in 2016. Across all quarters, a majority of appeals resulted in fully favorable outcomes for the beneficiaries. In all except two quarters, the percentage of fully favorable appeals exceeded 70 percent. In general, less than one-third of appeals resulted in adverse outcomes.[16] In the first year of the demonstration, 37 appeals were referred to the IRE; in the subsequent 2 years, over 200 appeals were referred to the IRE in each year. In the first year of the demonstration, a majority of the 37 appeals (73 percent) were upheld, and only 5 percent were overturned in favor of the beneficiary. In 2016 and 2017, the percentage of appeals overturned in favor of the beneficiary increased to 12 percent and 17 percent, respectively. Across all 3 years, the most common categories of appeals were related to practitioner services (25 percent), acute inpatient hospital services (23 percent), and clinic/lab/x-ray services (18 percent).[17]

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[16] Source: RTI analysis of MMP reported data for Core Measure 4.2, as of March 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

[17] Source: RTI calculations on IRE data from 2015, 2016 and 2017 as provided by CMS.

MMPs are required to report the number of critical incident and abuse reports among members receiving LTSS (CMS, 2017a). On average, about one-third of individuals enrolled in the demonstration each quarter received LTSS. In each quarter of the demonstration to date, there were 10 or fewer reports of critical incidents and abuse. This equates to less than 0.8 reports received per 1,000 members receiving LTSS in a quarter.[18]

Complaints to the Office of the Ombudsman

The State did not create a separate Ombudsman office for the demonstration. Instead, HHSC leveraged its existing Office of the Ombudsman, which also addresses complaints and inquiries related to Medicaid managed care and other health and human services programs. The State was eligible but did not apply for funding for Ombudsman and State Health Insurance Assistance/ADRC options counseling activities in support of the demonstration (see ***Section 1.4.4, Federal Financial Support***). Enrollees can contact the Ombudsman office via a toll-free phone number or the HHSC website.

Table 10 lists the total number of enrollee contacts with the Ombudsman office through November 2017. According to a State official, the office receives an average of 20 contacts (including complaints and inquiries) per month. About 20 percent of total contacts were classified as complaints. The volume of inquiries has declined significantly during the demonstration, whereas the volume of complaints was similar in 2015 and 2017.

According to a State official, common reasons for complaints to the Ombudsman included: access to LTSS; billing issues; a desire not to be enrolled in managed care; and authorization denials. Among the top reasons for inquiries were: a desire to change providers or plans; explanation of benefits; access to PCPs or desire to change PCPs; and access to LTSS.

HHSC staff reported that information on how to contact the Ombudsman office is included in enrollment materials, on enrollees' membership cards, and in MMPs' member handbooks. The official reported limited Ombudsman outreach for the demonstration and noted in November 2017 that the Ombudsman's community liaison position had been vacant since the spring due to a State hiring freeze.

Beneficiary stakeholder group representatives believe that the Ombudsman office is not sufficiently staffed and recommended that the State leverage organizations such as theirs to act as enrollee advocates. A provider stakeholder believes that fear of losing benefits and services prevented many enrollees from contacting the Ombudsman. The stakeholder added that many elderly enrollees "were raised not to complain" and believes that enrollees need "a lot of handholding" from providers and/or family members to submit complaints to the Ombudsman.

[18] Source: RTI analysis of MMP reported data for Texas-specific Measure TX 2.1, as of March 2018. The technical specifications for this measure are available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

Table 10
HHSC Office of the Ombudsman: Contacts from demonstration enrollees, 2015–2017

Type of contact	2015	2016	2017	Total
Complaints	81	67	79	227
Inquiries	511	212	187	910
Totals	**592**	**279**	**266**	**1,137**

SOURCE: HHSC Office of the Ombudsman.

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6. Stakeholder Engagement

Highlights

- HHSC chose to leverage its existing stakeholder advisory groups rather than create a new advisory group for the demonstration.
- Beneficiary and provider representatives reported that following HHSC's reorganization, communication with State officials became more challenging, due to departures of experienced staff.
- HHSC has conducted beneficiary and provider outreach through many venues and has engaged directly with nursing facility representatives on an ongoing basis to provide information and address concerns.
- Based on feedback from Enrollee Advisory Groups, MMPs have made changes such as expanding flexible benefits, modifying marketing materials, and aligning event times with enrollee preferences.

6.1 Overview

HHSC has engaged stakeholders largely by leveraging existing advisory groups, and the agency has worked closely with the nursing facility community to address particular operational challenges. According to beneficiary and provider representatives, staff departures associated with HHSC's reorganization in 2016–2017 created a loss of institutional knowledge that made engagement with State officials more difficult. MMPs noted challenges in obtaining sufficient participation in Enrollee Advisory Groups, but they reported that the groups have provided actionable feedback leading to a variety of changes.

6.2 Organization and Support

6.2.1 State Role and Approach

Beneficiary and Provider Outreach

Pursuant to the three-way contract (2017, p. 143), the State must use a variety of processes to obtain stakeholder participation and public comment. To obtain stakeholder input, HHSC chose not to form a demonstration-specific advisory council and instead leveraged several existing HHSC advisory entities, including the State Medicaid Managed Care Advisory Committee, the Medical Care Advisory Committee, the STAR+PLUS Quality Council, and the STAR+PLUS Nursing Facility Advisory Committee. HHSC staff said they made this decision to avoid unnecessary administrative burden, noting that they had learned from experience that coordinating quarterly meetings of multiple advisory committees requires considerable effort, and attending additional meetings can be a burden for stakeholder representatives.

According to State officials, feedback collected during stakeholder meetings led to several key implementation decisions. For example, based on stakeholder input, the

demonstration excluded from passive enrollment those members of MA plans whose parent organizations are not participating in the demonstration, because those beneficiaries had already made a plan selection for the year. State officials also said that stakeholder input influenced their decision to delay passive enrollment of nursing facility residents until August 2015 (see ***Section 3.2.2, Phases of Enrollment***). Additionally, a beneficiary advocate reported that HHSC had followed many of the group's recommendations on pre-implementation outreach, such as giving beneficiary groups informational materials to distribute through their own communication channels and conducting outreach events in beneficiary stakeholder group offices.

From February through July 2015, HHSC conducted a total of 170 outreach events in the six demonstration counties to educate beneficiaries about the demonstration. These events were held in locations such as senior centers, parks, community events, community organization meetings, and senior apartment complexes. At these events, the enrollment broker, MMPs, and Area Agency on Aging representatives provided information and answered questions. Throughout the demonstration, MMP and HHSC representatives have continued outreach by providing information at community events, social service organizations, and adult day care centers; by contacting enrollees to provide information 60 days prior to enrollment (see ***Section 3.2.3, Passive Enrollment Experience***); and by having service coordinators distribute informational brochures during in-person visits. Additionally, a State official reported engagement with beneficiary and provider stakeholders as part of planning the Texas Takes on Dementia pilot project, which may affect services for some demonstration enrollees (see ***Section 5.2.8, Experience of Special Populations***).

Despite the use of multiple outreach strategies and venues, MMP and provider representatives noted a widespread lack of awareness and confusion about the demonstration during the initial rollout. Staff of one MMP said this lack of understanding led to a significant decline in enrollment. A provider stakeholder believed the State had not conducted sufficient outreach or education and said that having service coordinators provide demonstration information during the assessment process would have been more effective than the outreach methods used.

Besides pursuing multistakeholder outreach efforts, the State has continued to engage directly with nursing facility representatives, who have expressed concerns about claims payment, authorization, and service coordination issues (see ***Section 2.2.2, Provider Arrangements and Services***, and ***Section 4.1.2, Care Planning Process***). In 2017, HHSC held a webinar for nursing facilities to provide general information about the demonstration and answer questions. Additionally, HHSC and provider representatives reported that nursing facility providers participated in its stakeholder work group to develop quality measures used for the Quality Incentive Payment Program (see ***Section 2.2.2***).

HHSC Reorganization

According to HHSC staff, as part of the agency's reorganization in 2016–2017 (see ***Section 1.4.1, Agency Reorganization***), some stakeholder groups were eliminated, and the STAR+PLUS stakeholder group was merged with the larger Medicaid Managed Care Advisory Committee. A State official noted that in conjunction with the reorganization, the number of stakeholder meetings has declined. Beneficiary and provider advocates reported that since the initial rollout, these meetings have included less discussion of demonstration-related issues. One

beneficiary advocate believed that the reduced focus on the demonstration at these meetings was appropriate in light of the State's and the stakeholder group's priorities.

Provider and beneficiary stakeholders reported that agency staff turnover associated with the reorganization made communication with State officials challenging, as key stakeholder contacts left the agency and institutional knowledge was lost. One provider stakeholder noted that the group had discussed several demonstration-related concerns with the Medicaid Director, who resigned in November 2017. At the time of the site visit, these discussions were on hold until they could be addressed with the new director. Stakeholders reported having to spend time orienting new HHSC staff on context for policy decisions and said they struggled to reach HHSC staff members who could address their concerns.

6.2.2 MMP Advisory Groups

Pursuant to the three-way contract (2017, p. 143), each MMP must establish an Enrollee Advisory Group to provide regular feedback to the governing board. Advisory Groups are composed of enrollees, family members, and other caregivers, and must reflect the diversity of the demonstration population, including individuals with disabilities. MMPs have flexibility on whether to establish advisory groups composed solely of MMP enrollees or whether to include STAR+PLUS as well as MMP members, and plans' approaches have varied. The groups must meet at least quarterly, and MMPs must make their best efforts to ensure that at least three enrollees attend each meeting.

Some MMP staff reported challenges in recruiting enrollees to participate in advisory groups. One MMP representative noted the population's mobility limitations, and another suggested that some enrollees were unresponsive to MMP outreach due to mistrust and reluctance to engage with health plans. To increase participation, MMPs have provided incentives, such as transportation and meals, and they have held meetings in a variety of community locations, such as food banks, gyms, community centers, and adult care facilities. One MMP held separate meetings in English and Spanish and enabled participation by videoconference; another offered a dial-in option.

MMPs have used Advisory Group meetings to provide demonstration-related information and obtain enrollee feedback, and MMP staff reported making a variety of changes based on advisory groups' input. These include modifying a marketing brochure, setting the time of events according to member preferences, and modifying flexible benefits. Additional benefits added to reflect beneficiary preferences included incentive payments for obtaining preventive care; coverage of certain OTC products; and increased vision, dental, and hearing coverage.

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7. Financing and Payment

Highlights

- MMPs have reported profits throughout the demonstration and therefore have been required to pay experience rebates to the State. HHSC staff reported that profit levels have declined due to annual increases in the demonstration's savings rate, but they do not believe that MMPs have experienced financial hardship. MMP representatives' perspectives on the adequacy of rates varied.
- In 2017, HHSC and MMP staff reported challenges in implementation of the quality withhold system and indicated that withhold payments for Demonstration Year 1 had not yet been distributed. In spring 2018, CMS released quality withhold results for calendar years 2015 and 2016 and made payments based on these results in July 2018. Results will be described in the next evaluation report.
- State and MMP representatives reported continued challenges with the timeliness and accuracy of MMPs' encounter data submissions, particularly those for Medicare acute-care services and crossover claims.

7.1 Rate Methodology

All demonstration-covered services are financed through prospective capitated payments to STAR+PLUS MMPs. Monthly capitation rates include three components: a payment from CMS for services covered under Medicare Parts A and B; a CMS payment for Medicare Part D-covered benefits; and a payment from HHSC for Medicaid-covered services (Texas three-way contract, 2017, pp. 206, 207). This section describes the rate methodology of the demonstration and findings relevant to early implementation.

7.1.1 Rating Categories and Risk Adjustments

Medicare payments for Parts A, B, and D are risk-adjusted using the existing CMS Hierarchical Condition Categories (HCC) and RxHCC methodologies for those programs (Texas three-way contract, 2017, p. 206). Medicaid payments are based on the rate cell structure used in the STAR+PLUS program (see ***Table 11***) and vary by county (Dial et al., 2017). MMPs are at risk for all costs that exceed the capitation payment, with the exception of Part D costs (Texas three-way contract, 2017, p. 207), for which the standard Part D risk sharing and payment reconciliations apply.

Table 11
STAR+PLUS rate cells

Rating category	Description
Home and Community-based Services (HCBS)	• Receive Medicaid State Plan services, as well as Section 1115(a) HCBS STAR+PLUS waiver services; and • Are elderly or adults with disabilities who qualify for a nursing facility level of care but do not reside in a nursing facility
Other Community Care	• Receive State Plan services only; and • Do not reside in a nursing facility
Nursing Facility	• Receive State Plan services only; and • Reside in a nursing facility

SOURCE: Three-way contract, 2017, p. 208.

7.1.2 Savings Percentage

Payments for Medicaid and Medicare Parts A and B reflect the application of aggregate savings percentages applied to baseline spending amounts for each year of the demonstration. The savings percentage is not applied to the Part D component of the rate (Texas three-way contract, 2017, pp. 207, 210). As shown in ***Table 12***, savings percentages increase annually through Year 3 and then remain the same in the demonstration's last 2 years.

Table 12
Saving rates by demonstration year

Demonstration year	Period covered	Savings rate
Year 1.a	March 1–December 31, 2015	1.25%
Year 1.b	January 1–December 31, 2016	2.75%
Year 2	January 1–December 31, 2017	3.75%
Year 3	January 1–December 31, 2018	5.5%
Year 4	January 1–December 31, 2019	5.5%
Year 5	January 1–December 31, 2020	5.5%

SOURCE: Three-way contract, 2017, pp. 207, 210.

7.1.3 Performance Incentives

Quality Withholds

In addition to the savings percentage built into the capitated payments, CMS and Texas withhold a percentage of their respective components of the rate to be paid to MMPs for meeting specified quality thresholds (see ***Section 8.1.1, Quality Measures***). The quality withhold is not applied to the Medicare Part D component of the capitation (Texas three-way contract, 2017, pp. 224–8). Quality withholds likewise increase through Year 3 and then remain the same for the remainder of the demonstration (see ***Table 13***).

Table 13
Quality withhold percentages by demonstration year

Demonstration year	Period covered	Withhold percentage
Year 1.a.	March 1–December 31, 2015	1
Year 1.b.	January 1–December 31, 2016	1
Year 2	January 1–December 31, 2017	2
Year 3	January 1–December 31, 2018	3
Year 4	January 1–December 31, 2019	3
Year 5	January 1–December 31, 2020	3

SOURCE: Three-way contract, 2017, pp. 224–6.

HHSC staff reported challenges in developing the withhold system, which is a significant departure from the pay-for-quality program that HHSC uses to promote health plan accountability in STAR+PLUS. HHSC staff believed that the withhold system was overly complicated and not warranted, and that the State system was a preferable means of accomplishing the same goal.

Staff of one MMP said that early in the demonstration, it was challenging to find all of the withhold measure information and ensure that they had the most current version; staff added that specifications for withhold measures were in separate State and CMS documents that were not released simultaneously, and the documents they received often were not up-to-date. Another MMP reported that it recently had received proposed changes to the withhold system (e.g., in the all-cause readmissions measure and the blood pressure control measures) that would be applied retroactively and indicated that these changes have created operational challenges. Following the 2017 site visit, State and MMP representatives reported that quality withhold payments for Year 1 had not yet been distributed.[19]

7.1.4 Experience Rebates

The demonstration uses a one-sided experience rebate system for risk mitigation, similar to the system used in STAR+PLUS. The rebate is intended to limit MMP profits to a reasonable percent of total revenue and encourage use of revenues for services rather than administrative expenses. If an MMP's net income before taxes exceeds 3 percent of total revenue, the plan must rebate a portion of the net income to the State and CMS based on a tier system. Savings generated by the experience rebate are shared between the State and CMS in proportion to their contributions to the capitation payments (Texas three-way contract, 2017, pp. 211–2).

[19] CMS released quality withhold results for calendar years 2015 and 2016 in spring 2018, and it made payments based on these results in July 2018. Aggregate withhold results will be described in the next evaluation report.

7.2 Financial Impact

7.2.1 Early Implementation Experience

Encounter Data

Reliable and complete financial data are necessary for rate setting and determining experience rebates. The State verifies financial data submitted by MMPs through quarterly internal reconciliation of expenditures with encounters and an annual data certification performed by the External Quality Review Organization (EQRO), see ***Section 8.2.3, Independent Quality Management Structures and Activities***). On at least a monthly, basis, MMPs are required to submit accurate and complete encounter data to HHSC and CMS in a prescribed format. Pharmacy data must be submitted no later than 25 calendar days after the date of claims adjudication (Texas three-way contract, pp. 199, 200). As discussed in ***Section 8.2.1, State and CMS Quality Management Structures and Activities***, the three-way contract includes provisions for corrective action if MMPs submit inaccurate or incomplete encounter data.

State and MMP representatives have reported continued challenges with MMPs' encounter data submissions. In 2016, HHSC staff reported that as a result of ongoing systems challenges, MMPs' encounter data submissions were delayed, and these submissions often did not align with medical expense data reported in MMPs' financial statistical reports (FSRs). Additionally, State and MMP staff have reported challenges with MMPs' submission of crossover claims, due to confusion about whether claims should be reported as Medicare or Medicaid expenditures, as well as changes in requirements for allocation of each type of expense.

In 2017, a State official raised questions about the accuracy of Medicare encounter data and said HHSC had found significant variations in MMPs' methods of reporting encounter data for acute care services.

An HHSC representative noted differences in State and CMS encounter data submission requirements and believes that the State policy is more stringent. For example, CMS gives MMPs the flexibility to establish "a reasonable methodology" for attribution of claims to payers, subject to CMS and State review, whereas the State has more specific standards for submission of accurate and timely encounter data across all programs. A State official reported that because of this difference and concerns about accuracy, MMPs have had to resubmit encounters for the demonstration more often than MCOs have had to resubmit for other State programs. The official noted that the State generally has incurred added costs due to the additional data runs needed for obtain MMPs' updated data.

Although the three-way contract was amended to allow the State to assess liquidated damages on MMPs under specified circumstances (see ***Section 1.3***), in 2017, HHSC officials expressed frustration that CMS had not agreed to use liquidated damages in the same manner they have been used in the STAR+PLUS program to promote improvements in encounter data submission (see ***Section 9.2.1***). CMS officials indicated that they have continued to discuss the issue with HHSC representatives.

Adequacy of Payment

HHSC staff described MMPs' profits in the demonstration's first year as "huge" and as "much higher in the dual demonstration than…in [the] STAR+PLUS programs for the same time periods." State and MMP representatives reported that profits have been attributable to the Medicare component of the demonstration.

In 2016, HHSC indicated that all MMPs had paid the required experience rebates (see ***Section 7.1.4***) to the State. Following the 2017 site visit, CMS reported that it was continuing to finalize the analysis needed to calculate CMS portion of the required rebates. Therefore, this share of the rebates had not yet been paid.

According to HHSC staff, most MMPs' profits decreased each year from 2015–2017. The official believes that annual increases in the demonstration's savings rate (see ***Section 7.1.2***) have been a significant factor in the reduced profitability. Despite the reported decline in profitability, HHSC officials believe that the combined impact of the savings assumptions and withholds in future years of the demonstration would be unlikely to create financial hardship for MMPs. HHSC staff anticipated that monthly passive enrollment (see ***Section 3.2.3, Passive Enrollment Experience***) would help boost MMPs' financial sustainability and expressed confidence that all MMPs would continue participation throughout the demonstration.

MMPs' perspectives on the adequacy of rates varied. In 2016, representatives of two MMPs raised questions about the long-term adequacy of rates under the demonstration, and one believed that savings assumptions under the demonstration were "a little bit higher than what [they] should have been." In 2017, one MMP reported that it had paid an experience rebate in 2016 and expected to do so in 2017. However, another MMP reported that substantial increases in utilization of personal attendant services had significantly increased Medicaid LTSS costs. An MMP representative said these costs have led to significant losses on Medicaid services, and as a result, the MMP was "barely at positive net income" overall in 2017. Therefore, the MMP official expressed concern about the increase in the demonstration's savings rate to 5.5 percent in 2018. The evaluation team will continue to monitor MMP's financial status as the demonstration continues.

7.2.2 Cost Experience

Early in the demonstration, State officials and MMP representatives noted that Texas had achieved significant progress in rebalancing LTSS spending from nursing facilities to home- and community-based settings through the STAR+PLUS program. Therefore, they anticipated that savings achieved through the demonstration would likely be in the area of Medicare- rather than Medicaid-covered services. As of 2017, the State did not have data to identify or quantify any cost savings attributable to demonstration activities such as service coordination

MMPs likewise did not have cost savings data but reported trends—such as declines in preventable admissions and a shift away from acute and emergency services utilization to outpatient and PCP services—which could ultimately lead to cost savings. The evaluation team will continue to provide updates on cost experience under the demonstration.

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8. Quality of Care

Highlights

- MMPs' performance on the 13 HEDIS measures was mixed relative to Medicare HMO. For three measures, most plans that reported data performed better than the national Medicare HMO average benchmark value. For one measure, two plans performed better than the Medicare HMO benchmark value, and for the remaining measures, the majority of plans performed below the benchmark value.
- Early in the demonstration, State reviews of MMPs and STAR+PLUS plans found a need for improvement in needs assessments, alignment of care plans with identified needs, and timeliness of initiating services for enrollees receiving HCBS. State officials have reported some progress toward the identified goals, as well as a need for continued improvement.
- HHSC seeks to collect liquidated damages from MMPs to promote compliance with the demonstration's encounter data submission requirements. However, CMS members of the CMT have not agreed to use liquidated damages in the same manner as they have been used in STAR+PLUS. The State and CMS are continuing to discuss the issue.

8.1 Quality Measures

8.1.1 Quality Measures

The Texas Dual Eligible Integrated Care Demonstration Project requires MMPs to report standardized quality measures. These measures include:

- A set of core measures specific to all capitated Financial Alignment Initiative demonstrations that address domains of access, assessment, care coordination, enrollee protection, organization structure and staffing, performance and quality improvement, provider network, and systems and service utilization (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html).

- A set of State-specific measures selected by HHSC staff in consultation with CMS after considering feedback from stakeholders. These include a variety of structure, process, and outcome measures spanning a range of service areas. (See link above.)

CMS and the State use reporting and performance data on several of the core and State-specific measures to determine what portion of the capitation rates retained by CMS and the State as a "quality withhold" will be repaid to the MMPs.

The demonstration also utilizes quality measures required of Medicare Advantage (MA) plans, including applicable measures from the Part C and Part D Reporting Requirements such as appeals and grievances, pharmacy access, payment structures, and medication therapy management.

MMPs are required to submit three additional measure sets as part of the MA requirement:

- A modified version of the MA Prescription Drug Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that, in addition to the core survey used by MA plans, includes and 8 supplemental questions proposed by HHSC and 10 supplemental questions proposed by the RTI Evaluation Team to capture beneficiary experience specific to integration, behavioral health and LTSS (see ***Section 5*** for CAHPS findings);

- The subset of Selected Medicare Healthcare Effectiveness Data and Information Set (HEDIS) measures, a standard measurement set used extensively by managed care plans, that are and required of all MA plans; and

- Selected Health Outcomes Survey (HOS) measures based on a recurring survey of a random sample of Medicare beneficiaries to assess physical and mental health outcomes (Texas three-way contract, 2014).

Data related to core and State-specific measures are discussed in relevant sections of this report.

In addition, the RTI Aggregate Evaluation Plan identified a set of quality measures that will be calculated by the RTI Team using encounter and fee-for-service data. Many of these measures are part of the HEDIS measurement set and are largely clinical in nature (e.g., preventive screens, follow-up care) or related to service use (e.g., avoidable hospitalizations, emergency department [ED] use) (Walsh et.al., 2013, pp. 77–85).

8.1.2 HHSC and MMP Experience

Performance measures for the demonstration were developed jointly by CMS and HHSC, using CMS's operations support contractor (NORC). HHSC sought to align specifications for performance measures used in the demonstration with those used in STAR+PLUS.

MMP representatives reported that implementation of the performance measures generally has proceeded smoothly. One MMP representative commented that use of standardized measures that plans already were using, such as National Committee for Quality Assurance (NCQA) measures, helped facilitate the process. The representative said that although timelines for reporting of the measures initially created administrative challenges, the plan was able to make the changes needed to comply with demonstration requirements.

HHSC staff reported difficulties working with Medicare data needed for performance measurement, due to challenges with the reliability and completeness of Medicare encounter

data, as well as differences in CMS and State policy for attribution of claims to Medicare and Medicaid (see ***Section 7.2.1, Early Implementation Experience***).

Quality Withholds

As noted in ***Section 7.1.3, Performance Incentives***, State and MMP representatives have reported challenges in implementation of the withhold system, and withhold payments for Year 1 have been delayed.

Quality Incentive Payment Program for Nursing Facilities

Nursing facilities participating in QIPP receive quarterly payments from plans based on performance improvements on four measures from CMS's Star Rating system (CMS, 2017b): high-risk residents with pressure ulcers; percent of long-stay residents who received antipsychotic medications; residents experiencing one or more falls with major injury; and residents who were physically restrained (Dial et al., 2017). The performance benchmark is the most recent CMS-published national rate for each measure, and incentive payments are based on meeting quarterly improvement targets (Texas HHS, n.d.-g).

As noted in ***Section 6.2.1, State Role and Approach***, provider representatives said they participated in the process of determining the QIPP's performance metrics. HHSC, MMP, and nursing facility representatives reported that the program generally was running smoothly. A provider representative reported some payment delays and challenges with submission of required documentation early in the program, but believed that the issues had been resolved. The representative commented that the State has worked with providers to address concerns in a timely manner. The evaluation team will continue to monitor the initiative's continued implementation and any implications for demonstration enrollees.

8.2 Quality Management Structures and Activities

8.2.1 State and CMS Quality Management Structures and Activities

Compliance Monitoring/Contract Monitoring

As noted in ***Section 2.1, Joint Management of the Demonstration***, the CMT provides a forum for HHSC and CMS to conduct joint compliance monitoring. The CMT is authorized to pursue remedies for noncompliance (Texas three-way contract, 2017, p. 251).

According to HHSC staff, the main issues addressed by the CMT during this time period include: MMPs' health risk assessment (HRA) rates (see ***Section 4.1.1, Assessment***); misalignment of Medicare and Medicaid enrollment systems (see ***Section 3.2.5, Integration of Medicare and Medicaid Enrollment Systems***); strategies to improve service coordination (see ***Section 4.1.3, Efforts to Improve Service Coordination***); reasons for grievances (see ***Section 5.2.9, Beneficiary Protections***); and tools to promote compliance with encounter data requirements (see below). CMS reported that the CMT had issued a total of four compliance notices against two MMPs in 2015 and 2016. Compliance issues included failure to provide accurate evidence of coverage documents, failure to make timely coverage determinations, failure to issue an accurate Annual Notice of Change, and failure to upload drug claim Explanation of Benefits (EOB) in the Health Plan Management System prior to use.

HHSC staff noted that their perspectives on demonstration issues sometimes have differed from those of CMS. The State seeks to make demonstration requirements consistent with STAR+PLUS standards, whereas CMS perspectives are grounded in standard MA policy. Despite the reported challenges sometimes associated with CMT discussions, HHSC and CMS staff view the CMT as a valuable forum. State officials said they have maintained open lines of communication with CMS staff and that the agencies' relationship has improved during the demonstration.

As discussed in ***Section 7.2.1, Early Implementation Experience***, HHSC and CMS have had different perspectives on how to address challenges with MMPs' submission of encounter data. HHSC staff have faced difficulties in ensuring the accuracy, consistency, and timeliness of MMPs' encounter data, particularly for Medicare services. The CMT has discussed strategies to promote MMP compliance with encounter data requirements, but State officials indicated that they have been unable to resolve the issue satisfactorily.

Under the three-way contract (2017, p. 201), MMPs may be subject to liquidated damages if there is more than a 2 percent variance in their Medicaid quarterly encounter reconciliation report, which reconciles paid claims as indicated in State FSRs against payments reported to a State data warehouse. The contract specifies steps to be taken if MMPs' encounter data are not complete and accurate, including development of a corrective action plan and timeline for resolution, and participation in a validation study a year following implementation of the corrective action plan, to determine whether encounter data are complete and accurate (pp. 200, 201).

The contract also entitles CMS and HHSC to monetary damages, including liquidated damages, resulting from an MMP's breach of contract (p. 252). Pursuant to the contract, liquidated damages will be assessed if the CMT determines that the failure to meet contract requirements and/or performance standards is the fault of the MMP (including its contractors or agents) and is not materially caused by HHSC, CMS, or their agents. The CMT reserves the right to waive liquidated damages, which are not intended to be punitive, but rather are intended to be reasonable estimates of losses or damages to CMS and HHSC. The contract specifies the amount of liquidated damages, as follows: up to $5,000 per calendar day for each incident of noncompliance; up to $7,500 per calendar day for failure to provide covered services described in the contract; up to $250 per calendar day for reports and/or deliverables that are not submitted in a timely manner or that are incomplete or inaccurate; up to $1,000 if a report and/or deliverable is not submitted in the required format or template; and up to $250 per calendar day until the report and/or deliverable is submitted as required (pp. 252, 253).

Although the contract does not specify that the corrective action plan and validation study described above must be performed prior to imposition of liquidated damages, a State official's comments suggested that HHSC was interpreting it this way. HHSC reported that the allowable compliance remedies prescribed by CMS include: notices of noncompliance; notices of noncompliance with business plans; warning letters; action plans; and corrective action plans. Thus, the State believes that it can collect liquidated damages only "after a sixth occurrence" of noncompliance. HHSC staff commented that the required compliance process "is extremely difficult to track," requires additional staffing and resources, and is inconsistent with the approach used in the State's Medicaid managed care programs. The State views liquidated

damages as "one of the most important tools that Texas has in [its] tool box to ensure compliance…"

As of November 2017, the State and CMS were continuing to discuss the issue. The evaluation team will provide updates in future reports.

State Oversight

HHSC conducts ongoing oversight of MMPs and STAR+PLUS plans, including legislatively mandated annual reviews of assessments, enrollment, and service delivery for beneficiaries receiving HCBS waiver services. In 2015, reviews found need for improvement in enrollees' needs assessments, alignment of care plans with identified needs, and timeliness of initiating services. Therefore, the State required MMPs/MCOs' service coordinators and nursing staff to undergo training on these topics. Training included a series of eight webinars, each with participation by approximately 500–650. The State also provided technical assistance to MCOs through in-person presentations and discussions, as well as distribution of a frequently-asked-questions document. In 2016, HHSC reported preliminary findings suggesting that its training and technical assistance had led to notable improvements (Texas HHSC, 2016).

In 2017, the State found improvements in the timeliness and accuracy of assessments and care plans but said MCOs/MMPs continued to face challenges in initiating services and following up on identified needs, including nursing services and durable medical equipment. Based on these findings, HHSC recommended that MMPs/MCOs establish internal processes to follow up on assessed service needs, identify enrollees in the HCBS waiver program who are not receiving services in a timely manner, and "provide a full-circle approach to…service coordination, from the assessment to verification of service delivery" (Texas HHSC, 2017). HHSC staff indicated that the reports' findings and recommendations applied to both MMP and STAR+PLUS products.

HHSC indicated that the increase in required service coordinator training (see ***Section 1.3, Changes in Demonstration Design***, and ***Section 4.1.3, Efforts to Improve Service Coordination***) was implemented in response to these results. Additionally, as noted in ***Section 1.3***, a 2017 amendment to the three-way contract (p. 52) requires MMPs to have policies and procedures that ensure delivery of authorized services, and the CMT has initiated several strategies to improve service coordination (see ***Section 4.1.3***).

8.2.2 MMPs' Quality Management Structure and Activities

HHSC and CMS jointly oversee MMPs' implementation of quality improvement/ performance improvement projects (hereafter referred to as QIPs) according to specified protocols (Texas three-way contract, 2017, p. 167). HHSC, with the EQRO, identified the topic for each MMP's QIP and submitted the topics to CMS for review. For streamlining purposes, HHSC allows MMPs to conduct and report on a single QIP for both STAR+PLUS and the demonstration. HHSC reported that QIPs began in 2016; pursuant to CMS requirements, they will operate for 3 years (CMS, 2017c). According to HHSC staff, four of the five MMPs chose to conduct QIPs on improving care coordination and care transitions to reduce preventable, behavioral health-related hospital admissions and readmissions. One MMP is conducting a QIP

on improving access to care and management of chronic obstructive pulmonary disease (COPD) to reduce preventable, COPD-related hospital readmissions.

As of January 2018, MMPs are no longer required to submit QIPs to CMS for review (CMS, 2017c). However, QIPs are subject to review by HHSC, which is required to share copies with CMS. A State official reported that two of the plans did not pass their QIP reviews in 2017 and will be required to choose different topics. A State official reported that subsequently, these plans submitted new QIP topics and passed their reviews. They will be required to submit progress reports to HHSC in July 2019.

MMPs reported that their chronic care improvement projects (CCIPs)[20] were addressing topics such as adherence to statins and adherence to anti-hypertension medications. One plan uses interactive voice response (IVR) to promote timely refills of prescriptions for hypertension drugs, as well as comprehensive medication review for patients with specified chronic conditions who take multiple maintenance medications.

8.2.3 Independent Quality Management Structures and Activities

External Quality Review

HHSC's External Quality Review Organization must conduct annual validation of the program's performance measures. Additionally, every 3 years, it must review compliance with Federal standards for access, structure and operations, and quality of care and services provided to enrollees (Texas three-way contract, 2017, p. 168).

The EQRO conducts annual administrative reviews, as well as MMP site visits every 3 years to assess challenges in demonstration implementation, as well as approaches to addressing challenges. According to HHSC staff, reviews have focused on issues such as service coordination and care transition planning for enrollees using LTSS services. HHSC reported that no actions have been taken based on EQRO findings.

HHSC Office of the Ombudsman

As discussed in Section ***5.2.9, Beneficiary Protections***, HHSC's Office of the Ombudsman responds to enrollee complaints and inquiries about the demonstration, Medicaid managed care, and other health and human services programs.

8.3 Results for Selected Quality Measures

8.3.1 HEDIS Quality Measures Reported for MMPs

Thirteen Medicare HEDIS measures for MMP enrollees are reported in ***Table 14***. RTI identified these measures for reporting in this Evaluation Report after reviewing the list of

[20] CCIPs are required for all MA plans: See https://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Downloads/CMS-MA-QIP-CCIP-Resource-Doc-2017-2018.pdf. As of 2016, CMS no longer requires plans to submit data on their projects.

measures we previously identified in RTI's Aggregate Evaluation Plan[21] as well as the available HEDIS data on these measures for completeness, reasonability, and sample size; 2016 calendar year data were available for all five Texas MMPs. Detailed descriptions of the measures can be found in the RTI Aggregate Evaluation Plan. Results were reported for measures where sample size was greater than 30 beneficiaries. In addition to reporting the results for each MMP, the mean value for MA plans for each measure is provided for comparison.

We provide national benchmarks from MA plans, where available, understanding that MA enrollees and demonstration enrollees may have different health and sociographic characteristics which would affect the results. Previous studies on health plan performance reveal poorer quality ratings for plans serving a higher proportion of dual eligible beneficiaries and beneficiaries with disabilities. HEDIS measure performance, in particular, is slightly worse among plans active in areas with lower income and populations with a higher proportion of minorities (Office of the Assistant Secretary for Planning and Evaluation, 2016). Benchmarks should be considered with that limitation in mind. These findings on Texas MMP HEDIS measure performance represent the early experience in the demonstration, and are likely to change over time as MMPs gain more experience in working with enrollees. Monitoring trends over time in MMP performance may be more important than the comparison to the National MA plans given the population differences. Several years of HEDIS results are likely needed to know how well MMPs perform relative to each other and whether they perform above or below any potential benchmark.

Reporting of HEDIS data remained consistent across the MMPs. Results reported below are comparing five plans, with the exception of some measures where sample size was less than 30 beneficiaries. For each measure, results across all plans vary, and there was not a consistent trend across measures for one MMP versus the other.

For three measures reported (annual monitoring of patients on persistent medication, follow-up after hospitalization for mental illness and initiation and engagement of alcohol and other drug (AOD) dependence treatment), a majority of the plans that have reported data performed better than the national Medicare HMO benchmark value. For one measure (outpatient visits per 1,000 members), two plans performed better than the Medicare HMO benchmark value, which is desirable.

For the remaining measures, the majority of plans performed below the benchmark value. These measures are related to adults' access to preventive/ambulatory health service, adult body mass index (BMI) assessment, antidepressant medication management, blood pressure control, breast cancer screening, colorectal cancer screening, comprehensive diabetes care, disease modifying anti-rheumatic drug therapy in rheumatoid arthritis, and ED visits.

[21] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf

Table 14
Selected HEDIS measures for Texas Dual Eligible Integrated Care Demonstration Project Plans, 2016

Measure	National Medicare Advantage Plan Mean	Amerigroup	Cigna	Molina	Superior	United
Adults' access to preventive/ ambulatory health services	94.7%	83.3%	89.7%	86.0%	87.8%	82.9%
Adult BMI assessment	93.9%	69.4%	88.3%	94.9%	93.4%	75.9%
Ambulatory care (per 1,000 members)						
Outpatient visits	9,181.9	7,940.4	10,501.4	11,443.8	8,863.3	6,487.3
Emergency department visits (higher is worse)	637.8	696.8	444.1	652.7	766.6	772.5
Annual monitoring for patients on persistent medications						
Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	92.4%	93.3%	98.8%	94.6%	96.3%	93.7%
Annual monitoring for members on digoxin	57.3%	59.2%	66.7%	60.0%	56.8%	82.6%
Annual monitoring for members on diuretics	92.9%	94.0%	99.4%	94.4%	96.1%	93.7%
Total rate of members on persistent medications receiving annual monitoring	92.1%	93.3%	98.7%	94.2%	95.8%	93.5%
Antidepressant medication management						
Effective acute phase treatment[1]	69.3%	71.1%	67.2%	60.8%	61.8%	79.6%
Effective continuation phase treatment[2]	54.3%	52.7%	45.7%	42.4%	46.8%	70.9%
Blood pressure control[3]	69.0%	N/A	45.3%	49.9%	52.6%	37.5%
Breast cancer screening	71.6%	49.0%	66.2%	66.7%	58.8%	49.2%
Colorectal cancer screening	66.2%	37.0%	65.5%	63.4%	53.9%	49.2%
Comprehensive diabetes care						
Received Hemoglobin A1c (HbA1c) testing	93.4%	85.0%	95.7%	88.9%	89.5%	88.1%
Poor control of HbA1c level (>9.0%) (higher is worse)	27.2%	56.0%	41.0%	47.2%	43.3%	45.7%

(continued)

Table 14 (continued)
Selected HEDIS measures for Texas Dual Eligible Integrated Care Demonstration Project Plans, 2016

Measure	National Medicare Advantage Plan Mean	Amerigroup	Cigna	Molina	Superior	United
Good control of HbA1c level (<8.0%)	62.2%	35.4%	45.8%	44.6%	44.3%	44.3%
Received eye exam (retinal)	70.0%	50.5%	78.7%	63.6%	63.5%	55.7%
Received medical attention for nephropathy	95.6%	93.3%	98.9%	95.6%	95.4%	93.9%
Blood pressure control (<140/90 mm Hg)	69.0%	28.9%	64.2%	58.5%	55.7%	34.6%
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	76.6%	73.6%	71.4%	54.1%	73.6%	61.9%
Follow-up after hospitalization for mental illness	53.2%	52.3%	N/A	54.3%	57.0%	81.3%
Initiation and engagement of alcohol and other drug (AOD) dependence treatment						
Initiation of AOD treatment[4]	32.3%	41.3%	N/A	54.1%	42.0%	54.4%
Engagement of AOD treatment[5]	3.5%	6.0%	N/A	6.2%	4.6%	10.4%
Plan all-cause readmissions (Average adjusted probability total**)** (higher is worse)	N/A	22.0%	N/A	25.0%	26.0%	25.0%

[1] Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

[2] Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

[3] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for members 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for members 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for members 60–85 years of age.

[4] Represents percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

[5] Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

NOTES: N/A = not available or the number of enrollees in the plan's provided HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size. Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf.

SOURCE: RTI analysis of 2016 HEDIS measures.

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9. Cost Savings Calculation

Highlights

- RTI conducted a preliminary estimate of Medicare savings using a difference-in-differences analysis examining beneficiaries eligible for the demonstration in the Texas demonstration area and comparison areas.
- The results of the preliminary cost analyses of beneficiaries eligible for the demonstration indicate Medicare savings in the first demonstration period.

As part of the Texas capitated model demonstration under the Financial Alignment Initiative, Texas, CMS, and health plans have entered into a three-way contract to provide services to Medicare-Medicaid enrollees (CMS, 2013). Participating health plans receive prospective blended capitation payment to provide both Medicare and Medicaid services for enrollees. CMS and Texas developed risk adjusted capitation rates for Medicare Parts A, B, and D, and Medicaid services to reflect the characteristics of enrollees. The Medicare component of the payment is risk-adjusted using CMS' hierarchical risk-adjustment model. The rate development process is described in greater detail in the Memorandum of Understanding and the three-way contract, and a description of the risk adjusted Medicare components of the rate are described in the Final Rate Reports (CMS and State of Texas, 2013b).

The capitation payment incorporates savings assumptions over the course of the demonstration. The same savings percentage is prospectively applied to both the Medicare and Medicaid components of the capitation payment, so that both payers can recognize proportional savings from this integrated payment approach, regardless of whether the savings is driven disproportionately by changes in utilization of services typically covered by Medicare or Medicaid. The goal of this methodology is to minimize cost shifting, to align incentives between Medicare and Medicaid, and to support the best possible outcomes for enrollees.

This chapter presents preliminary Medicare Parts A and B savings calculations for the first 22 months of the demonstration period using an intent-to-treat (ITT) analytic framework that includes beneficiaries eligible for the demonstration rather than only those who enrolled. Approximately 155,000 Medicare-Medicaid beneficiaries in Texas were eligible for and approximately 43,000 (28 percent) enrolled in the demonstration as of November 2017.

The Medicare calculation presented here uses the capitation rate that CMS pays to Texas MMPs for beneficiaries enrolled in the demonstration, and not the actual payments that plans made to providers for services, so the savings are calculated from the perspective of the Medicare program. A similar approach will be applied to the Medicaid savings calculation when data is available. Part D costs are not included in the savings analysis.

The results shown here reflect quality withhold repayments for the period March 2015 to December 2016. Note that Medicare and Medicaid savings calculations will be conducted by RTI for each year of the demonstration as data are available.

The following sections discuss the analytic approach and results of these analyses.

9.1 Evaluation Design

To assess the impact of the demonstration on Medicare costs for Medicare-Medicaid enrollees, RTI used an ITT approach comparing the population eligible for the Texas demonstration with a comparison group not affected by the demonstration (see ***Appendix A*** for the comparison group identification methodology). An ITT approach diminishes the potential for selection bias and highlights the effect of the demonstration on all beneficiaries in the demonstration eligible population. All Medicare-Medicaid enrollees eligible for the demonstration constitute the evaluation sample, regardless of whether they enrolled in the demonstration or actively participated in the demonstration care model. Therefore, the analyses presented here cover demonstration eligible beneficiaries including those who opted out, or who participated but subsequently disenrolled; who were eligible but were not contacted by the State or participating plans; and those who enrolled but did not seek services.

Beneficiaries eligible for the demonstration were identified using quarterly files submitted by the State of Texas. These files include information on all beneficiaries eligible for the demonstration, as well as indicators for whether each beneficiary was enrolled.

A comparison group was identified in two steps. First, RTI identified comparison areas that are most similar to Texas with regard to area-level measures of health care market characteristics such as Medicare and Medicaid spending and State policy affecting Medicaid-Medicare enrollees. Second, beneficiaries were selected using a propensity score model (described in further detail below).

RTI used a difference-in-differences (DID) approach to evaluate the impact of the demonstration on Medicare costs. DID refers to an analytic strategy whereby two groups—one affected by the policy intervention and one not affected by it—are compared on an outcome of interest before and after the policy intervention. The predemonstration period included 2 years prior to the start of the Texas demonstration (March 1, 2013–February 28, 2015) and the first demonstration period (demonstration year 1) included the first 22 months of the demonstration (March 1, 2015–December 31, 2016).

To estimate the average treatment effect on the demonstration eligible population for monthly Medicare expenditures, RTI ran generalized linear models (GLMs) with a gamma distribution and a log link. This is a commonly used approach in analysis of skewed data or in cases where a high proportion of observations may have values equal to zero. The model also employed propensity score weighting and adjusted for clustering of observations at the county level.

The GLM model included indicators for demonstration period, an indicator for assignment to the demonstration group versus the comparison group, and an interaction term for demonstration period and demonstration assignment. The model also included demographic variables and area level variables. The interaction term represents the combined effect of being part of the demonstration eligible group during the demonstration periods and is the key policy variable of interest. The interaction term is a way to measure the impact of both time and

demonstration group status. Separate models were run to distinguish between overall savings (predemonstration versus postdemonstration) as well as savings for each demonstration period. Because the difference-in-difference variable was estimated using a non-linear model, RTI employed a post-estimation procedure to obtain the marginal effects of demonstration impact. The aggregation of the individual marginal effects represents the net demonstration impact and are reported below.

- Demographic variables included in the model were:
  - gender,
  - race, and
  - ESRD status.
- Area level variables included in the savings model were:
  - Medicare spending per Medicare-Medicaid enrollee age 19 or older
  - Medicare Advantage penetration rate
  - Medicaid-to-Medicare fee for service (FFS) fee index for all services
  - Medicaid spending per Medicare-Medicaid enrollee age 19 or older
  - Proportion of Medicare-Medicaid enrollees using
    - Nursing facilities age 65 or older
    - Home and community-based services (HCBS) age 65 or older
    - Personal care age 65 or older
    - Medicaid managed care age 19 or older

Additional area-based variables—such as the percent of adults with a college degree and proximity to hospitals or nursing facilities—were used as proxies for sociodemographic indicators and local area characteristics. Note that these variables were also used in the comparison group selection process. Individual beneficiary demographic characteristics are controlled for in the models and are also accounted for in the propensity score weights used in the analysis.

In addition to the variables noted here, the propensity score weights used in the cost savings analyses also include Hierarchical Condition Category (HCC) risk score. HCC risk score is not included as an independent variable in the regression models predicting costs because HCC risk score is directly related to capitated payments. Due to the potential for differences in diagnoses coding for enrollees compared to beneficiaries in FFS after the start of the demonstration, the HCC risk score used to calculate the weights was "frozen" to the value at the

start of the demonstration period. Diagnoses codes are the basis for risk score calculations, and by freezing the score prior to any potential impact of the demonstration, we are able to control for baseline health status using diagnosis codes available prior to the demonstration. Note that data anomalies in the CMS administrative data for Texas observations in November 2015 were identified. To adjust for this data anomaly, average expenditures for October 2015 and December 2015 were used in place of the expenditures identified in November 2015. This data anomaly was limited to Texas observations in this month alone and the same adjustment was made to Texas observations in the demonstration group and in the comparison group.

9.2 Medicare Expenditures: Constructing the Dependent Variable

RTI gathered predemonstration and demonstration monthly Medicare expenditure data for both the demonstration and comparison groups from two data sources. Capitation payments paid to Medicare Advantage plans in the predemonstration and demonstration periods and paid to STAR+PLUS plans during the demonstration period were obtained from CMS Medicare Advantage and Prescription Drug system (MARx) data. The capitation payments were the final reconciled payments paid by the Medicare program after taking into account risk score reconciliation and any associated retroactive adjustments in the system at the time of the data pull (April 2017). Medicare claims were used to calculate Medicare Parts A and B expenditures for fee-for-service beneficiaries. ***Table 15*** summarizes the data sources for Medicare expenditure data.

Table 15
Data sources for monthly Medicare expenditures

Group	Predemonstration March 1, 2013–February 28, 2015	Demonstration period March 1, 2015–December 31, 2016
Demonstration	• Medicare FFS • Medicare Advantage Capitation	• Medicare FFS for non-enrollees • Medicare Advantage Capitation for non-enrollees • STAR+PLUS Capitation for enrollees
Comparison	• Medicare FFS • Medicare Advantage Capitation	• Medicare FFS • Medicare Advantage Capitation

FFS = fee for service.

A number of adjustments were made to the monthly Medicare expenditures to ensure that observed expenditures variations are not due to differences in Medicare payment policies in different areas of the country or the construction of the capitation rates. ***Table 16*** summarizes each adjustment and the application of the adjustments to FFS expenditures or to the capitation rate.

The capitation payments MARx reflect the savings assumptions applied to the Medicare Parts A and B components of the rate (1.25 percent for March 1, 2015–December 31, 2015 and 2.75 percent for January 1, 2016–December 31, 2016), but do not reflect the quality withhold amounts (withhold of 1 percent in the first demonstration period). The results shown here reflect quality withhold repayments for the first demonstration period.

Table 16
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
FFS	Indirect Medical Education (IME)	Capitation rates do not include IME	Do not include IME amount from FFS payments
FFS	Disproportionate Share Hospital (DSH) Payments and Uncompensated Care Payments (UCP)	Capitation rates reflect DSH and UCP adjustments	Include DSH and UCP payments in total FFS payment amounts.
FFS	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013 (reflected in the claims data). Because the predemonstration period includes months prior to April 1, 2013 it is necessary to apply the adjustment to these months of data so that any observed changes are not due to sequestration.	Reduced FFS claim payments incurred before April 2013 by 2% so all claims reflect this adjustment.
Capitation rate (MA and MMP)	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013. Sequestration is not reflected in the capitation rates.	Reduced capitation rate by 2%
Capitation rate (MA)	Bad debt	The capitation rate includes an upward adjustment to account for bad debt. Bad debt is not part of FFS claim payment amount and therefore needs to be removed from the capitation rate for the savings analysis. (Note, “bad debt” is reflected in the hospital “pass through” payment separate from the total claim payment amount)	Reduced capitation rate to account for bad debt load (historical bad debt baseline percentage). This is 0.91 for CY13, 0.89 for CY14, 0.89 for CY15, and 0.97 for CY16.

(continued)

Table 16 (continued)
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
Capitation rate (MMP)	Bad debt	The capitation rate includes an upward adjustment to account for bad debt. Bad debt is not part of FFS claim payment amount and therefore needs to be removed from the capitation rate for the savings analysis. (Note, "bad debt" is reflected in the hospital "pass through" payment separate from the total claim payment amount)	Reduced blended capitation rate to account for bad debt load (historical bad debt baseline percentage). This is 0.91 for CY13, 0.89 for CY14, 0.89 for CY15, and 0.97 for CY16. Reduced the FFS portion of the capitation rate by an additional 1.71% for CY 2015, and by an additional 1.73% for CY 2016 to account for the disproportional share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS.
FFS and capitation rate (MA and MMP)	Average Geographic Adjustments (AGA)	The Medicare portion of the capitation rate reflects the most current hospital wage index and physician geographic practice cost index by county. FFS claims also reflect geographic payment adjustments. In order to ensure that change over time is not related to differential change in geographic payment adjustments, both the FFS and the capitation rates were "unadjusted" using the appropriate county-specific AGA factor.	Medicare expenditures were divided by the appropriate county-specific AGA factor for each year. Note that thru 2016, a single year-specific AGA factor based on claims paid in the year, rather than the AGA factor used in Medicare Advantage (based on 5 years of data and lagged 3 years) was used to account for year specific policies. Note also that the AGA factor applied to the capitated rates for 2014 reflected the 50/50 blend that was applicable to the payment year.

(continued)

Table 16 (continued)
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
Capitation rate (MA and MMP)	Education user fee	No adjustment needed.	Capitation rates in the MARX database do not reflect the education user fee adjustment (this adjustment is applied retrospectively). Education user fees are not applicable in the FFS context and do not cover specific Part A and Part B services. While they result in a small reduction in the capitation payment received, we did not account for this reduction in the capitated rate.
Capitation rate (MMP)	Quality withhold	A 1% quality withhold was applied in the first demonstration year but the withholds are not reflected in the capitation rate used in the analysis.	Final quality withholds and repayments were incorporated into the dependent variable construction for the first demonstration year.
Capitation rate (MMP)	Experience rebates	Experience rebates may be paid to CMS and the State by MMPs if net income before taxes exceeds 3 percent of total revenue.	Experience Rebate payments to CMS/the State are not included in the cost savings analysis in this report given the timing of finalizing this analysis though they will be incorporated in a future evaluation report as they become available.[22]

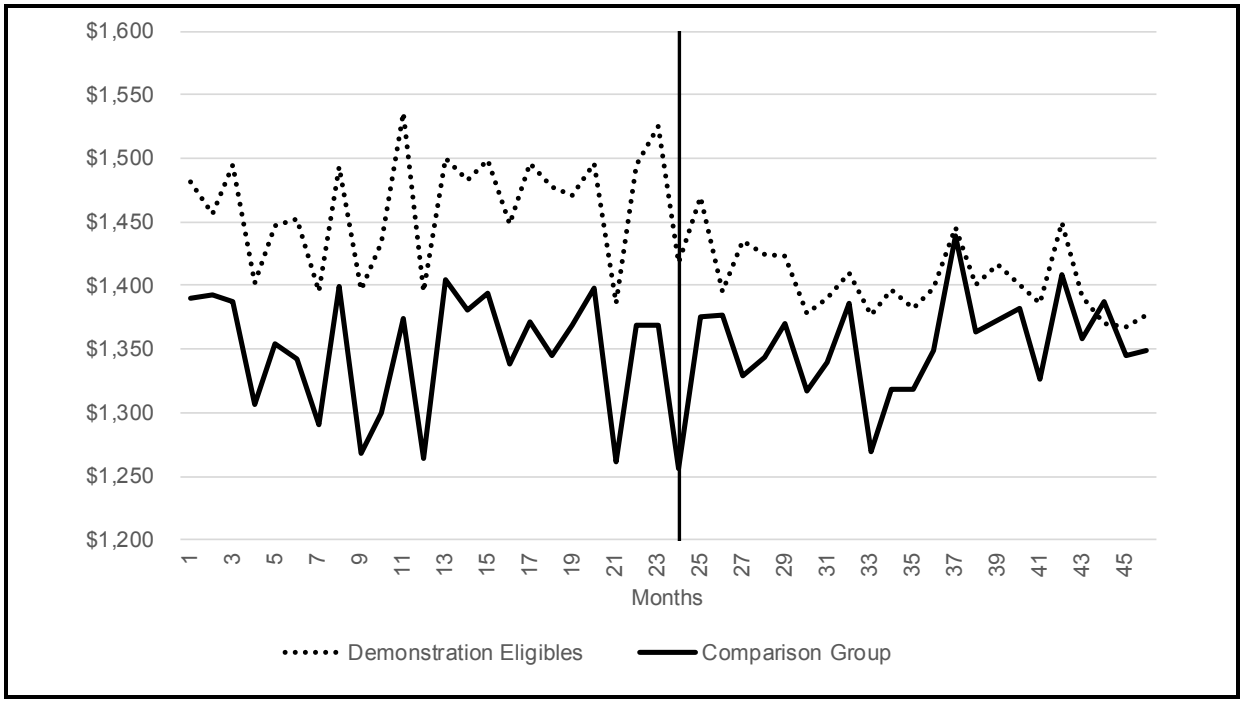
CY = calendar year; FFS = fee for service; MMP = Medicare-Medicaid Plan.

[22] Although the STAR+PLUS MMPs Experience Rebate analysis is not yet final, preliminary findings suggests payment of approximately $33 million from the MMPs to CMS/Texas for SFY15, $102 million for SFY16, and $45 million for SFY17, with the Medicare portion of this close to $100 million across these three years.

9.3 Results

The first step in the analysis was to plot the unweighted mean monthly Medicare expenditures for both the demonstration group and the comparison group. ***Figure 1*** indicates that the demonstration group and the comparison group had parallel trends in mean monthly expenditures during the 24-month predemonstration period, which is an important assumption to the DID analysis.

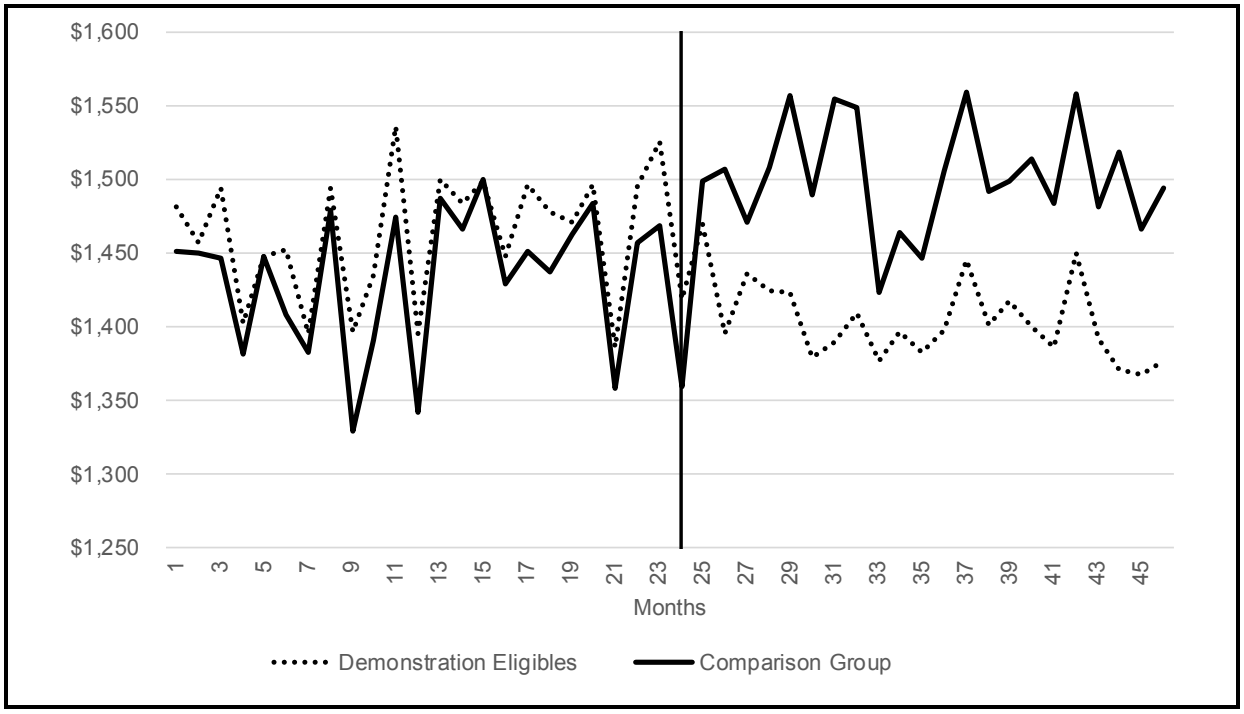
Figure 1
Mean monthly Medicare expenditures, predemonstration and demonstration period, Texas demonstration eligible and comparison group, March 2013–December 2016



SOURCE: RTI Analysis of Texas demonstration eligible and comparison group Medicare data (program: TX_CS_0500_12DEC2018).

Figure 2 demonstrates the same plot of mean monthly Medicare expenditures for both the demonstration group and the comparison group, after applying the propensity weights and establishes the parallel trends for both groups.

Figure 2
Mean monthly Medicare expenditures (weighted), predemonstration and demonstration period, Texas demonstration eligibles and comparison group, March 2013–December 2016



SOURCE: RTI Analysis of Texas demonstration eligible and comparison group Medicare data (program: tx_cs_0500_12DEC2018)

Table 17 show the mean monthly Medicare expenditures for the demonstration group and comparison group in the predemonstration and each demonstration period, unweighted. The unweighted table shows a decrease in mean monthly Medicare expenditures during demonstration period 1 for the demonstration group and an increase for the comparison group. The unweighted mean change in demonstration period 1 was a $43.40 decrease for demonstration eligible beneficiaries and an $10.30 increase for the comparison group. A decrease was also shown for demonstration period 1 for the demonstration group and an increase was also shown for the comparison group in the weighted table (***Table 18***).

The DID values in each table represent the overall impact on savings using descriptive statistics. These effects are descriptive in that they are arithmetic combinations of simple means, without controlling for covariates. The change in the demonstration group minus the change in the comparison group is the DID value. This value would be equal to zero if the differences between predemonstration and the demonstration period were the same for both the demonstration group and the comparison group. A negative value would indicate savings for the demonstration group, and a positive value would indicate losses for the demonstration group. The weighted DID value in demonstration period 1 is negative and statistically significant (illustrated by the 95 percent confidence intervals that do not include 0).

Table 17
Mean monthly Medicare expenditures for Texas demonstration eligibles and comparison group, predemonstration period and demonstration period 1, unweighted

Group	Predemonstration period Mar 2013–Feb 2015	Demonstration period 1 Mar 2015–Dec 2016	Difference
Demonstration group	$1,457.63 ($1,378.31, $1,536.94)	$1,414.22 ($1,341.84, $1,486.60)	−$43.40 (−$108.51, $21.71)
Comparison group	$1,346.20 ($1,304.43, $1,387.97)	$1,356.49 ($1,316.87, $1,396.12)	$10.30 (−$6.88, $27.47)
Difference-in-difference	—	—	−$53.70 (−$120.43, $13.03)

— = data not available.

NOTE: 95 percent confidence intervals are shown in parentheses below estimates.

SOURCE: RTI Analysis of Texas demonstration eligible and comparison group Medicare data (program tx_cs_0500_12DEC2018).

Table 18
Mean monthly Medicare expenditures for Texas demonstration eligibles and comparison group, predemonstration period and demonstration period 1, weighted

Group	Predemonstration period Mar 2013–Feb 2015	Demonstration period 1 Mar 2015–Dec 2016	Difference
Demonstration group	$1,457.63 ($1,378.31, $1,536.94)	$1,414.22 ($1,341.84, $1,486.60)	−$43.40 (−$108.51, $21.71)
Comparison group	$1,429.61 ($1,383.68, $1,475.54)	$1,503.23 ($1,458.99, $1,547.46)	$73.62 ($50.38, $96.85)
Difference-in-difference	—	—	−$117.02 (−$186.14, −$47.91)

— = data not available.

NOTE: 95 percent confidence intervals are shown in parentheses below estimates.

SOURCE: RTI Analysis of Texas demonstration eligible and comparison group Medicare data (program: tx_cs_0500_12DEC2018).

9.3.1 Regression Analysis

While the descriptive statistics are informative, to get a more accurate estimate of savings, RTI conducted a multivariate regression analysis to estimate savings controlling for beneficiary and area level characteristics. Given the structure of the data, RTI used the GLM procedure in Stata with a gamma distribution and a log link, and adjusted for clustering at the county level.

In addition to controlling for beneficiary and market area characteristics, the model included a time trend variable (coded as months 1–46), a dichotomous variable for whether the

observation was from the predemonstration or demonstration period ("Post"), a variable to indicate whether the observation was from a beneficiary in the comparison group or the demonstration group ("Intervention"), and an interaction term ("Intervention*Post") which is the difference-in-differences estimate in the multivariate model for the net effect of demonstration eligibility.

Table 19 shows the main results from the DID analysis for demonstration year 1, controlling for beneficiary demographics and market characteristics. To obtain the effect of the demonstration from the non-linear model we calculated the marginal effect of coefficient of the interaction term. The marginal effect of the demonstration for the intervention group over the first demonstration period in aggregate was negative (−78.90) and these savings were significant at p=0.0537, indicating savings to Medicare of $78.90 per member per month as a result of the demonstration using the ITT analysis framework. The significance at p=0.0537 is very close to statistical significance at the 95 percent level and well within significance at the 90 percent level. Note that this estimate of savings does not include experience rebate payments to CMS and the State which are likely to increase the savings estimate. Experience rebate payments will be included in future analyses as they become available.

Table 19
Demonstration effects on Medicare savings for eligible beneficiaries—Difference-in-difference regression results, Texas demonstration eligibles and comparison group

Covariate	Adjusted coefficient DID	*p*-value	95% confidence interval	90% confidence interval
Intervention*Demo Period (March 2015–December 2016)	−78.90	0.0537	−159.04, 1.25	−146.16, −11.64

SOURCE: RTI Analysis of Texas demonstration eligible and comparison group Medicare data (program tx_cs_0480_GLM_12DEC2018).

Table 20 shows the magnitude of the DID estimate relative to the adjusted mean outcome value in the predemonstration and demonstration periods. The second and third columns represent the post-regression, mean predicted savings or loss for each group and period, based on the composition of a reference population (the comparison group in the demonstration period). These values show how different the two groups were in each period, and the relative direction of any potential effect in each group over time. The remaining columns show the difference-in-differences estimate (the coefficient on Intervention*Post), the *p*-value demonstrating significance, and the relative percent change of the difference-in-differences estimate compared to the mean monthly Medicare expenditures for the comparison group in the entire demonstration period.

The adjusted mean for monthly expenditures increased between the predemonstration and demonstration period for comparison groups and decreased for the demonstration group. The DID estimate of -78.90 (the coefficient on Intervention*Post) is negative and the savings are statistically significant at p=0.0537, indicating savings in Medicare Parts A and B from the demonstration, using the ITT analysis framework. The DID estimate for demonstration year 1 in aggregate reflected an annual relative cost decrease of 5.17 percent.

Table 20
Adjusted means and overall impact estimate for eligible beneficiaries in the demonstration and comparison groups, Texas demonstration eligibles and comparison group

Group	Adjusted mean for predemonstration period	Adjusted mean for demonstration period	Relative difference (%)	Adjusted coefficient DID	*p*-value
Demonstration group	$1,493.80 ($1,412.87, $1,574.73)	$1,483.38 ($1,417.73, $1,549.04)	−5.17%	−78.90 95% CI: (−159.04, 1.25) 90% CI: (−146.16, −11.64)	0.0537
Comparison group	$1,458.66 ($1,408.73, $1,508.59)	$1,526.54 ($1,482.96, $1,570.13)			

CI = confidence interval; DID = difference-in-differences

SOURCE: RTI Analysis of Texas demonstration eligible and comparison group Medicare data (program tx_cs_0490_RPct_12DEC2018).

In addition to the cost savings analysis on all eligible beneficiaries (ITT approach), RTI conducted several sensitivity analyses to provide additional information on potential savings or losses associated with the demonstration overall and for the subset of beneficiaries enrolled in the demonstration. These sensitivity analyses included (1) simulating capitated rates for eligible enrollees not enrolled in the demonstration and comparing these rates to actual FFS expenditures; (2) predicting FFS expenditures for beneficiaries enrolled in the demonstration and comparing to the actual capitated rates; and (3) calculating a DID estimate based on a subgroup of beneficiaries enrolled in the demonstration with at least 3 months of eligibility in the baseline period. The results of these analyses are presented in ***Appendix B***.

The findings of the sensitivity analyses indicate that the predicted capitated rates are statistically significantly lower than actual FFS expenditures for eligible but not enrolled beneficiaries and that predicted FFS expenditures are higher than actual capitated rates for enrollees. The enrollee subgroup DID analysis does not indicate savings compared to a comparison group, but this finding is not statistically significant. Note that these analyses do not control for unobservable characteristics that may be related to the decision to enroll in the demonstration. The enrollee subgroup DID analysis was conducted to learn more about the potential impact of the demonstration on the subset of beneficiaries touched by the demonstration for at least 3 months. Note that similar 3-month eligibility criteria were applied to the comparison group for the baseline and demonstration periods for this analysis and weights were recalculated. The enrollee subgroup analysis is limited by the absence of person-level data on characteristics that potentially would lead an individual in a comparison area to enroll in a similar demonstration, and thus the results should be considered in the context of this limitation.

9.4 Discussion

The results of the preliminary multivariate analyses presented here indicate Medicare savings during the first 22 months of the Texas demonstration. This finding is significant at p=0.0537, very close to statistical significance at the 95 percent level and well within

significance at the 90 percent level. The savings calculated here are based on capitation rates that CMS pays to Texas MMPs and the FFS expenditures and Medicare Advantage capitation rates for eligible beneficiaries that did not enroll in the demonstration. The savings estimate does not take into account actual payments for services incurred by enrollees and paid by the Texas MMPs.

The preliminary nature of these results is important to note, as they do not include experience rebate payments. Texas has completed analysis of the STAR+PLUS MMPs Experience Rebate data for State fiscal years (SFY) 2015–2017 (covering the period from the demonstration start through August 2017). For all years examined, all MMPs owe funds to Texas and CMS given their gains under the Experience Rebate parameters. Although this analysis is not yet final as CMS is currently reconciling plan-reported Medicare revenue, it suggests payment of approximately $33 million from the MMPs to CMS and Texas for SFY 2015, $102 million for SFY 2016, and $45 million for SFY 2017, with the Medicare portion of this close to $100 million across these 3 years. CMS anticipates that these figures will change slightly upon final reconciliation, but that the payments to CMS and the State will ultimately be quite substantial. Experience Rebate payments to CMS and the State are not included in the cost savings analysis in this report given the timing of finalizing this analysis.

Once Medicaid data become available to the Federal evaluator, and a similar calculation can be conducted on the Medicaid costs, it will be possible to have a more complete understanding of potential savings from the first year of the Texas Dual Eligible Integrated Care Project. In the meantime, preliminary estimates provided by the State of Texas indicate Medicaid savings as a result of the demonstration. The State of Texas projects savings for the first demonstration period that align with contractual savings percentages (1.25 percent and 2.75 percent during the first demonstration period).[23]

It is important to note that given the ITT framework used to calculate Medicare savings, all eligible beneficiaries, regardless of their enrollment status were included in the calculation. Additional Medicare and Medicaid savings calculations will be conducted by the evaluation contractor for each year of the demonstration as data are available, and future reports will show updated results for the first year of the demonstration based on data reflecting additional claims runout, risk score reconciliation, and any retroactive adjustments.

[23] Estimates are assessed and provided by the State of Texas and are independent from the analyses presented in this evaluation report. CMS has not validated this estimate.

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10. Conclusions

10.1 Implementation Successes, Challenges, and Lessons Learned

The Texas Dual Eligible Integrated Care Demonstration Project has faced significant challenges associated with nursing facility payment, service coordination, enrollment, agency reorganization, stakeholder engagement, and encounter data collection. The State, CMS, and MMPs have taken an active approach to addressing these issues. As a result, some nursing facility payment processes improved; the number of enrollment discrepancies has declined; and health risk assessment (HRA) completion rates have increased since the demonstration's first year.

Early in the demonstration, regular meetings between the nursing facility community, MMPs, and State officials, combined with MMP systems changes and the State's ongoing guidance to nursing facilities, led to improvements in the timeliness and accuracy of routine nursing facility payments. However, in 2017, providers reported additional payment-related challenges, which they believe State officials are not addressing as effectively or quickly as they had previously.

The demonstration's enrollment rate was slightly higher following implementation of ongoing monthly passive enrollment than it was at the same time in the previous year, and it reached 28 percent in November 2017. Stakeholders, MMP, and State officials believe that beneficiary concern about losing access to PCPs and specialists, as well as a general reluctance to make changes in service delivery remain key factors in opt-outs and disenrollment.

The State has worked closely with the enrollment broker on an ongoing basis to reconcile discrepancies in Medicare and Medicaid enrollment data and reported that the volume of discrepancies has declined significantly.

With ongoing monitoring and guidance from the CMT, MMPs have implemented a variety of strategies—such as use of community connectors; unannounced, in-person visits; and robust internal tracking systems—to increase the proportion of beneficiaries whose HRAs have been completed within 90 days of enrollment. Completion rates have fluctuated but overall have increased since the first year. As of the fourth quarter of 2017, 67 percent of MMP enrollees had HRAs completed within 90 days; in the previous two quarters, the completion rate reached 86 percent.

Despite the progress in boosting HRA completion rates, State officials and stakeholders have identified a need for additional improvements in service coordination. Workforce issues, including a limited supply of qualified staff and high turnover, remain challenging. HHSC and CMS have pursued several strategies to address the issue, including increased training requirements, identification of best practices in care planning, and a survey designed to examine MMPs' service coordination processes. Results of these efforts are yet to be determined.

Reorganization of HHSC has created challenges for demonstration operations and stakeholder engagement. Many staff with responsibilities in key areas—such as enrollment, MMP oversight, and encounter data collection—have moved to other areas of HHSC or left the

agency, and new CMT members were being on-boarded in the demonstration's third year. Though the reorganization has the potential to increase the efficiency of State operations, it also could limit the State's ability to resolve persistent challenges. Provider and beneficiary advocates have reported difficulties in finding and communicating with staff on issues of concern, less timely responses from State officials, less frequent engagement with stakeholders, as well as less attention to demonstration-related issues during multistakeholder meetings.

The lack of complete and potentially reliable encounter data, particularly those associated with Medicare services, complicates efforts by the State, CMS, and the evaluation team to measure the demonstration's impact on quality and service utilizations. MMPs are continuing to work with CMS to submit all encounter data. State and CMS officials have expressed differing perspectives on the most effective approach to improve MMP compliance with encounter data requirements, and they continue to discuss the issue.

State officials cited the need for ongoing communication and collaboration with MMPs, CMS, and stakeholders as an important lesson learned from implementation experience. Even as HHSC's reorganization has created additional hurdles, the State's ongoing commitment to engagement could help advance efforts to address the demonstration's continuing challenges. Open lines of communication, flexibility, and willingness to try new approaches will be critical to finding effective solutions in the months ahead.

10.2 Demonstration Impact on Service Utilization and Medicare Cost Analysis

It was not possible to conduct utilization analysis for this report because RTI was unable to deem demonstration year one encounters complete. Analysis of 2015 and 2016 encounter data, if available and deemed complete, will be included in the Texas Second Evaluation Report.

The results of the preliminary multivariate analyses presented here indicate Medicare savings during the first 22 months of the Texas demonstration. The Medicare savings calculated here are based on capitation rates that CMS pays to Texas MMPs for enrollees and the FFS expenditures and Medicare Advantage capitation rates for eligible beneficiaries that did not enroll in the demonstration. The estimates do not take into account actual payments for services incurred by enrollees and paid by the demonstration plans. RTI will continue to examine these results and will rerun the analyses when experience rebate data become available. Once Medicaid data become available for the first demonstration period and a similar calculation can be conducted on the Medicaid costs, it will be possible to have a more complete understanding of potential savings from the Texas demonstration. Additional Medicare and Medicaid savings calculations will be conducted by the evaluation contractor for each year of the demonstration as data are available.

10.3 Next Steps

The RTI evaluation team will continue to collect information on a quarterly basis from Texas officials through the online State Data Reporting System, covering enrollment statistics and updates on key aspects of implementation. The team will continue conducting quarterly calls with demonstration staff and will request the results of any evaluation activities conducted by the

State or other entities, such as results from the Consumer Assessment of Healthcare Providers and Systems survey and State-specific demonstration measures the plans are required to report to CMS. RTI will conduct additional qualitative and impact analyses over the course of the demonstration.

The next report will include a qualitative update on demonstration implementation and will include regression-based analyses of quality and utilization measures for those eligible for the demonstration and for an out-of-State comparison group pending data availability. As noted previously, Texas received an extension from CMS to continue the demonstration through December 2020. The additional 2 years of implementation will provide further opportunities to evaluate the demonstration's performance.

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Appendix A
Comparison Group Methodology for Texas Demonstration Year 1

CMS contracted with RTI International to monitor the implementation of demonstrations under the Financial Alignment Initiative (FAI) and to evaluate their impact on beneficiary experience, quality, utilization, and cost. This appendix presents the comparison group selection and assessment results for the FAI demonstration in the State of Texas. The appendix focuses primarily on all beneficiaries eligible for the demonstration, with a brief discussion of demonstration enrollees in subsection A.5 of this appendix.

This appendix lists the geographic comparison areas for Texas, provides propensity model estimates, and shows the similarities between the comparison and demonstration groups in terms of their propensity score distributions. Separate analyses were conducted for three time periods for the Texas demonstration: baseline year 1 (March 1, 2013–February 28, 2014), baseline year 2 (March 1, 2014–February 28, 2015), and demonstration year 1 (22 months from March 1, 2015–December 31, 2016). Analyses were conducted for each period because eligible beneficiaries are identified separately for each time period.

The Texas demonstration included dual eligible beneficiaries age 21 and over. We included beneficiaries who had been attributed to another federal Medicare shared savings initiative. Attribution to other savings initiatives was ascertained using the beneficiary-level version of the CMS' Master Data Management (MDM) file. Beneficiaries in the demonstration group during the demonstration period were identified from quarterly finder files of participants in Texas's Dual Eligible Project Demonstration. Beneficiaries qualified for the demonstration group if they participated for at least one month during the demonstration period. During the two baseline years, all beneficiaries meeting dual eligibility criteria and metropolitan statistical area (MSA) residency requirements were selected for the demonstration and comparison groups. Beneficiaries were omitted from further analyses if they had missing geography data; passed away before the beginning of the analysis period; had zero months of eligibility as a dual eligible; lived in both a demonstration area and a comparison area during the analysis period; or missing Hierarchical Condition Code (HCC) risk scores during a year.

A.1 Comparison Areas

The Texas demonstration area consists six counties that are part of five MSAs (El Paso, San Antonio-New Braunfels, McAllen-Edinburg-Mission, Dallas-Fort Worth-Arlington, and Houston-The Woodlands-Sugar Land). The comparison area is comprised of 25 MSAs drawn from six states: Illinois, Kentucky, New Jersey, Pennsylvania, Wisconsin, and Texas itself. The pool of states was limited to those with timely submission of Medicaid data to CMS as of 2013. All comparison MSAs are listed in ***Table A-1***.

Table A-1
Comparison areas in 6 comparison states

Texas MSAs
- Amarillo
- Austin – San Marcos
- Beaumont – Port Arthur
- Brownsville – Harlington – San Benito
- Corpus Christi
- Dallas – Fort Worth – Arlington (part)
- Houston – The Woodlands – Sugar Land (part)
- Killeen – Temple
- Laredo
- Lubbock
- San Antonio – New Braunfels (part)
- Victoria
- Waco

Illinois MSAs
- Davenport-Rock Island – Moline
- Peoria – Pekin
- Rockford
- St. Louis

Kentucky MSAs
- Cincinnati
- Louisville

New Jersey MSAs
- New York-Newark – Jersey City

Pennsylvania MSAs
- Erie
- Gettysburg
- Harrisburg – Lebanon – Carlisle

Wisconsin MSAs
- Green Bay
- Janesville – Beloit

Table A-2 shows the distribution of beneficiaries by comparison state in the first baseline year. New Jersey contributed the largest share of comparison beneficiaries, followed by comparison areas within Texas. State shares were very similar in baseline year 2 and demonstration year 1. The total number of comparison beneficiaries was comparatively stable throughout the three time periods (289,114 in baseline year 1, 294,592 in baseline year 2, and 331,127 in demonstration year 1).

Table A-2
Distribution of comparison group beneficiaries for the Texas demonstration, first baseline year, by comparison state

Comparison states	Percent of comparison beneficiaries
New Jersey	38.3
Texas	37.1
Illinois	10.9
Kentucky	6.7
Pennsylvania	3.6
Wisconsin	3.4
Number of beneficiaries	289,114

A.2 Propensity Score Estimates

RTI's methodology uses propensity scores to examine initial differences between the demonstration and comparison groups and then to weight the data to improve the match between them. The comparability of the two groups is examined with respect to both individual beneficiary characteristics as well as the overall distributions of propensity scores. This section describes the results of the model that generates propensity scores and future sections show how weighting eliminates initial differences between the groups.

A propensity score (PS) is the predicted probability that a beneficiary is a member of the demonstration group conditional on a set of observed variables. Our propensity score models include a combination of beneficiary-level and region-level characteristics measured at the ZIP code (ZIP Code Tabulation Area) level. Region-level covariates were drawn from a factor analysis of ZIP-based variables for the adult population. These covariates capture features of the age, employment, marital, and family status of households in each region. Measures of the distance to hospitals and nursing homes were also included.

The logistic regression coefficients, standard errors, and z-values for the covariates included in the propensity model for Texas are shown in ***Table A-3***. These coefficients and the underlying data are used to generate propensity scores for each beneficiary. In general, individual covariates had similar effects in each period. The coefficients for several variables reflected some important differences between the demonstration and comparison groups. The magnitude of these differences may also be seen in the unweighted standardized differences in ***Tables A-1*** to ***A-3***. Relative to the comparison group, demonstration eligibles had a higher percentage of Black and Hispanic beneficiaries; were less likely to qualify for Medicare on the basis of disability; and lived in areas with smaller shares of households with members over 60, larger shares of households with members under 18; and larger shares of adults with a self-care limitation.

Table A-3
Logistic regression estimates for Texas propensity score models

Characteristic	Base year 1			Base year 2			Demo period		
	Coef.	Std. err.	z-score	Coef.	Std. err.	z-score	Coef.	Std. err.	z-score
Age (years)	0.000	0.000	−8.00	−0.002	0.000	−7.80	0.000	0.000	−5.97
Died during year	0.013	0.003	4.80	0.076	0.015	5.22	0.007	0.003	2.48
Female (0/1)	−0.044	0.001	−30.42	−0.240	0.008	−31.9	−0.044	0.001	−30.51
Black (0/1)	0.083	0.002	44.08	0.409	0.009	43.61	0.079	0.002	42.82
Hispanic (0/1)	0.116	0.002	61.57	0.536	0.009	57.90	0.110	0.002	58.68
Disability (0/1) as reason for original Medicare entitlement	−0.083	0.002	−41.57	−0.417	0.010	−40.18	−0.081	0.002	−41.02
ESRD (0/1)	0.037	0.004	10.47	0.176	0.018	10.04	0.045	0.004	12.43
HCC risk score	0.005	0.001	8.97	0.028	0.003	9.01	0.006	0.001	10.43
Share mos. elig. during period (prop.)	0.091	0.002	38.47	0.478	0.013	37.86	0.074	0.002	32.1
MDM	−0.052	0.002	−32.18	−0.295	0.009	−33.93	−0.062	0.002	−39.99
% of pop. living in married household	0.001	0.000	14.60	0.004	0.000	11.67	0.001	0.000	20.40
% of households w/member >= 60 yrs.	−0.010	0.000	−101.83	0.042	0.000	94.48	0.008	0.000	93.16
% of households w/member < 18 yrs.	0.009	0.000	103.25	−0.063	0.001	−109.30	−0.011	0.000	−114.31
% of adults with college education	−0.003	0.000	−39.65	−0.013	0.000	−35.46	−0.003	0.000	−44.76
% of adults w/self-care limitation	0.039	0.000	92.45	0.213	0.002	92.81	0.043	0.000	99.80
Intercept	0.186	0.007	25.57	−1.096	0.038	−28.7	0.239	0.007	32.77

A.3 Propensity Score Overlap

Propensity score weighting is used to mitigate the potential for selection bias by increasing the equivalence between the demonstration and comparison groups. Any beneficiaries who have estimated propensity scores below the smallest estimated value in the demonstration group are removed from the comparison group. This resulted in the removal of 127, 85, and 0 comparison beneficiaries in each of the 3 years, respectively.

The distributions of propensity scores by group are shown for each time period in Figures 3a to 3c before and after propensity score weighting. Estimated scores covered nearly the entire probability range in both groups. In each period, demonstration group scores were less skewed to the right than the unweighted comparison beneficiary scores, which show sharp skew to the right.

The figures show that Inverse Probability of Treatment Weighting (IPTW) pulls the distribution of weighted comparison group propensity scores (dotted line) much closer to that of the demonstration group (solid line). Weighting shifted the comparison group distribution to the right, greatly increasing the comparability of the demonstration and comparison groups.

Figure A-1
Distribution of beneficiary-level propensity scores in the Texas demonstration and comparison groups, weighted and unweighted, March 2013–February 2014

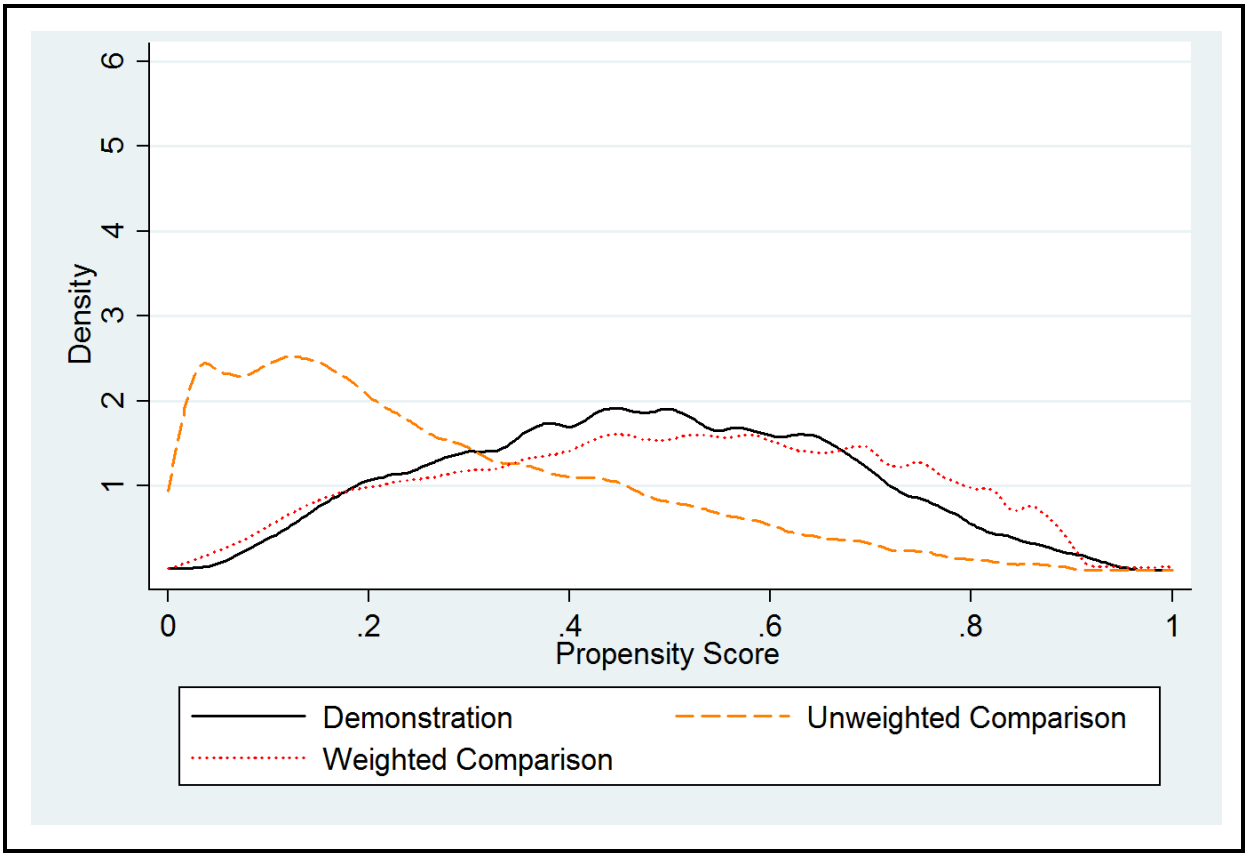


Figure A-2
Distribution of beneficiary-level propensity scores in the Texas Demonstration and comparison groups, weighted and unweighted, March 2014–February 2015

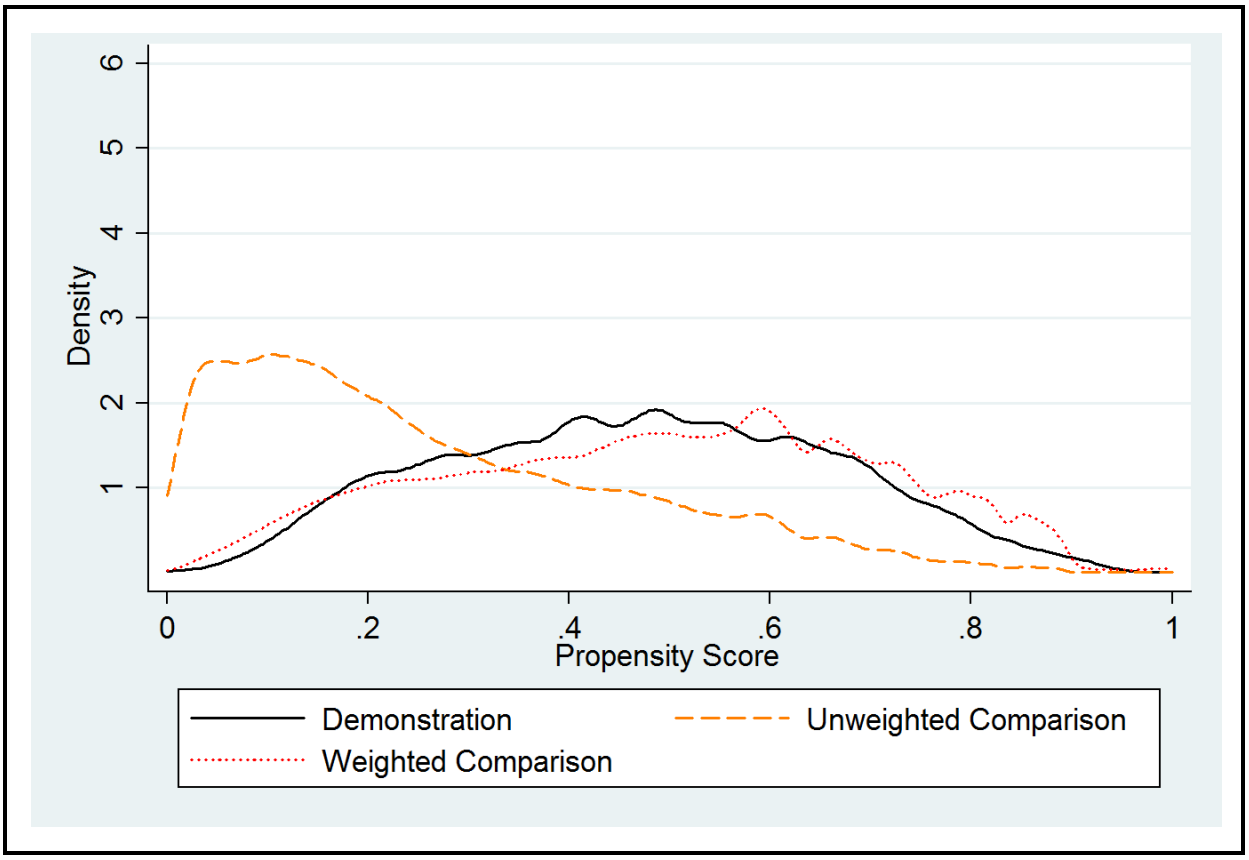
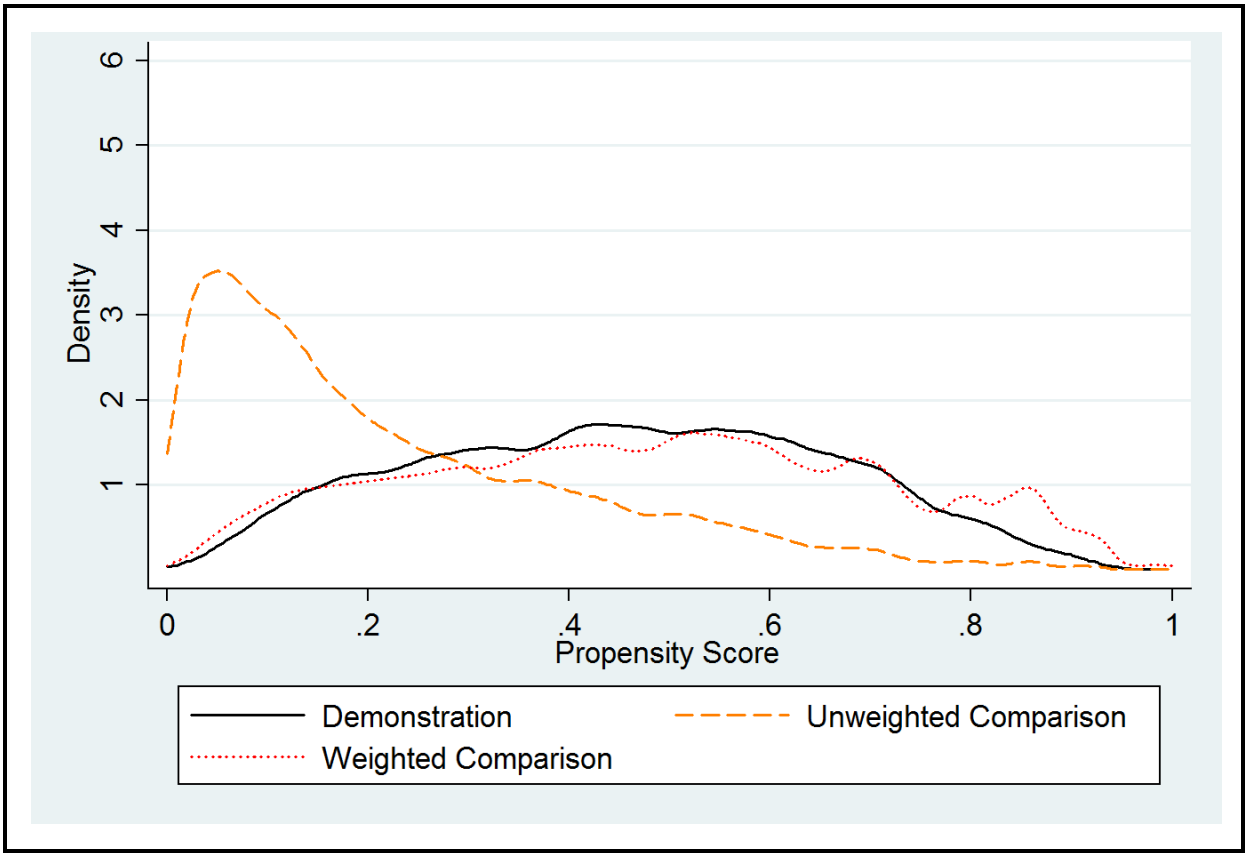


Figure A-3
Distribution of beneficiary-level propensity scores in the Texas demonstration and comparison groups, weighted and unweighted, March 2015–December 2016



A.4 Group Comparability

Covariate balance refers to the extent to which the characteristics used in the propensity score are similar (or "balanced") for the demonstration and comparison groups. Group differences are measured by a standardized difference (the difference in group means divided by the pooled standard deviation of the covariate). An informal standard has developed that groups are considered to be comparable if the standardized covariate difference is less than 0.10 standard deviations.

The group means and standardized differences for all beneficiary characteristics are shown for each time period in ***Tables A-4*** to ***A-6*** The columns of unweighted standardized differences indicates that several of these variables were not balanced before running the propensity model. This was especially the case for individual race/ethnicity variables as well as ZIP code area-level variables, which consistently exhibited standardized differences greater than the criterion value of 0.1.

The results of propensity score weighting for Texas are illustrated in the far right columns (weighted standardized differences) in ***Tables A-4*** to ***A-6***. In each period propensity weighting

pulled comparison group means closer to the demonstration group means, thereby reducing the standardized differences and improving the match between the two groups. Propensity weighting reduced the standardized differences of all the variables that initially had standardized difference greater than absolute value of 0.1 to below that level with only one exception—the share of the population married in the zip codes where beneficiaries lived in the first baseline year, where the weighted difference was .105, just above the criterion value.

Table A-4
Texas dual eligible beneficiary covariate means by group before and after weighting by propensity score, baseline period 1: March 2013–February 2014

	Demonstration group	Comparison group	PS-weighted comparison group	Unweighted standardized difference	Weighted standardized difference
Baseline period 1	**Mean**	**Mean**	**Mean**		
Age	67.887	66.420	68.119	0.083	−0.013
Died	0.067	0.077	0.068	−0.038	−0.003
Female	0.628	0.632	0.627	−0.007	0.004
Black	0.219	0.181	0.216	0.096	0.006
Hispanic	0.245	0.122	0.269	0.323	−0.054
Disability as reason for original Medicare entitlement	0.332	0.422	0.323	−0.187	0.020
ESRD	0.046	0.032	0.047	0.072	−0.007
HCC score	1.474	1.453	1.472	0.017	0.002
Share mos. elig. during period	0.854	0.813	0.855	0.140	−0.007
MDM	0.177	0.229	0.168	−0.130	0.026
% of households w/member >= 60 yrs.	30.781	33.940	30.504	−0.378	0.035
% of households w/member < 18 yrs.	42.508	36.240	42.763	0.648	−0.024
% of adults w/college education	17.628	23.865	17.672	−0.444	−0.003
% of adults w/self-care limitation	4.077	3.395	4.232	0.324	−0.062
% of pop. living in married household	63.785	67.778	62.437	−0.309	0.105

Table A-5
Texas dual eligible beneficiary covariate means by group before and after weighting by propensity score, baseline period 2: March 2014–February 2015

Baseline period 2	Demonstration group Mean	Comparison group Mean	PS-weighted comparison group Mean	Unweighted standardized difference	Weighted standardized difference
Age	67.868	66.324	68.017	67.868	−0.009
Died	0.068	0.077	0.068	0.068	0.000
Female	0.626	0.627	0.622	0.626	0.007
Black	0.221	0.181	0.221	0.219	−0.001
Hispanic	0.243	0.124	0.263	0.244	−0.044
Disability as reason for original Medicare entitlement	0.337	0.428	0.329	0.337	0.016
ESRD	0.045	0.030	0.046	0.045	−0.005
HCC score	1.431	1.410	1.425	1.430	0.005
Share mos. elig. during period	0.845	0.810	0.848	0.845	−0.010
MDM	0.186	0.259	0.175	0.187	0.029
% of households w/ member >= 60 yrs.	31.149	34.609	30.868	31.260	0.036
% of households w/ member < 18 yrs.	42.125	35.991	42.305	42.100	−0.017
% of adults w/college education	17.904	24.397	18.097	17.902	−0.015
% of adults w/self-care limitation	4.008	3.315	4.059	3.975	−0.022
% of pop. living in married household	63.365	67.486	62.101	63.373	0.099

Table A-6
Texas dual eligible beneficiary covariate means by group before and after weighting by propensity score, demonstration period 1: March 2015–December 2016

Demonstration period 1	Demonstration group	Comparison group	PS-weighted comparison group	Unweighted standardized difference	Weighted standardized difference
	Mean	Mean	Mean		
Age	69.255	66.775	69.299	0.143	−0.003
Died	0.024	0.033	0.025	−0.052	−0.001
Female	0.626	0.620	0.625	0.012	0.001
Black	0.221	0.178	0.223	0.109	−0.005
Hispanic	0.238	0.115	0.251	0.326	−0.030
Disability as reason for original Medicare entitlement	0.319	0.433	0.313	−0.237	0.012
ESRD	0.048	0.033	0.051	0.078	−0.014
HCC score	1.532	1.461	1.525	0.060	0.006
Share mos. elig. during period	0.692	0.715	0.689	−0.073	0.007
MDM	0.169	0.296	0.158	−0.303	0.029
% of Households w/ member >= 60 yrs.	31.720	35.365	31.237	−0.446	0.062
% of Households w/ member < 18 yrs.	41.777	35.557	42.016	0.662	−0.023
% of adults w/college education	17.936	25.036	18.050	−0.497	−0.009
% of adults w/self-care limitation	4.013	3.242	4.081	0.393	−0.029
% of pop. living in married household	62.880	67.835	61.698	−0.391	0.093

A.5 Enrollee Results

In addition, we performed propensity score weighting on a subgroup of demonstration enrollees (approximately 41 percent of the eligible demonstration population). We define the enrollee group, as well as its comparison group, as follows: (1) The demonstration enrollees are those with at least three months of enrollment during the 1-year demonstration period as well as three months of eligibility during the 2-year baseline period, and (2) The corresponding comparison group beneficiaries are those with at least three months of eligibility in both the 1-year demonstration period and the 2-year baseline period. The propensity score weighting analysis on enrollees and their associated comparison group yielded better results than our analysis of all eligible beneficiaries. Propensity score weighting lowered the weighted standardized differences to below the 0.10 threshold for all covariates in every period.

A.6 Summary

Our analyses revealed differences before balancing between the Texas demonstration and comparison groups with regard to race/ethnicity and ZIP-code based demographic characteristics. However, the propensity score-based weighting process reduced these disparities to standardized differences of less than 0.10 for all but one ZIP-code based measure in one year (the percent of adults who were married in the first baseline year). The propensity score covariates may also be incorporated in the multiple regression models used to estimate demonstration effects for key outcomes to further reduce the potential for biased estimates.

The weighted score distributions were similar for the two groups, with propensities covering a wide range of probabilities in both groups. The weighted data reduce the risk that selection bias will contaminate outcome analyses of the Texas demonstration.

Further analysis of the enrollee group similarly showed that propensity score weighting reduced standardized differences between the demonstration and comparison groups. Indeed, the enrollee results had no standardized differences exceeding the 0.10 threshold.

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Appendix B
Sensitivity Analysis Tables

Tables in ***Appendix B*** present results from sensitivity analyses focusing on the Texas demonstration cost saving models.

B.1 Predicting Medicare Capitated Rates for Non-Enrollees

The goal of this analysis was to identify beneficiaries eligible for the Texas demonstration in the first demonstration period (March 2015–December 2016) and to look at what the Medicare capitation rate would have been (had they enrolled) compared to their actual fee-for-service (FFS) expenditures in the demonstration period.

B.1.1 Sample Identification

- Eligible but non-enrolled Texas beneficiaries in demonstration period 1 (March 1, 2015–December 31, 2016). Predicted Medicare capitated rates were calculated using the beneficiary risk score and the county of residence.

B.1.2 Calculating the Medicare Capitated Rate for Eligible but Not Enrolled Beneficiaries

- Predicted Medicare capitated rates were calculated using the monthly beneficiary risk score (final resolved) and the base rate associated with the beneficiary's county of residence.

- Mean predicted Medicare capitated rates were compared to mean FFS expenditures (non-Winsorized). Note that bad debt was removed from the capitated rate as this is not reflected in FFS payments. Sequestration was reflected in both the FFS payments and the capitated payment. Disproportionate share hospital payments and uncompensated care payment amounts were included in the FFS expenditures, as these amounts are reflected in the capitated rates.

- The predicted Medicare capitated rate was $1,775.79 compared to actual FFS expenditures of $1,930.85 suggesting potential Medicare savings for the eligible but not enrolled beneficiary population had this population been enrolled during demonstration period 1 (see ***Table B-1***).

Table B-1
Observed FFS and predicted capitated rates for eligible but not enrolled beneficiaries

Variable	Obs	Mean	Std. err.	Std. dev.	[95% conf. interval]	
Predicted cap	838,153	$1,775.79	$2.05	$1,878.439	$1,771.77	$1,779.82
Observed FFS	838,153	$1,930.85	$7.06	$6,465.442	$1,917.01	$1,944.70
Difference	838,153	−$155.1	$6.8	$6,189.7	−$168.3	−$141.8

FFS = fee for service.

NOTES: RTI also tested the accuracy of the predicted capitated rate by generating a predicted capitated rate for enrollees and comparing it to the actual capitated rate from the plan payment files. RTI's mean predicted capitated rate for enrollees was $1,246.6 compared to an actual capitated rate of $1,244.1 (difference of $2.5). Observed FFS and predicted capitated values reflect parallel adjustments.

B.2 Predicting FFS Expenditures for Enrollees

The goal of this analysis is the converse of what is presented in ***Table B-1***. Here, we look at predicted FFS expenditures for enrollees based on a model predicting FFS expenditures for eligible but not enrolled beneficiaries.

B.2.1 Methods

A data set with observations from base year 2 and from demonstration year 1 was created from the full data set to allow us to look at expenditures between the two periods. Beneficiary expenditures were summed across all months of each period and then "annualized" to represent the full 12 months of base year 2 (or 22 months of demonstration year 1).

The estimation process involved two steps. First, using non-enrollees, we regressed demonstration year 1 expenditures on base year 2 expenditures, base year 2 Hierarchical Condition Category (HCC) score, and a set of base year 2 demographic and area level variables. ***Table B-2*** shows the mean values of the model covariates for enrolled beneficiaries and eligible but not enrolled beneficiaries. We used an unlogged dependent variable and ran ordinary least squares (OLS) models without propensity score weights. The data were clustered by Federal Information Processing Standards (FIPS) code. This model explained 23.1 percent of the variation in expenditures for non-enrollees.

In the second step, we used the covariate values estimated in the OLS non-enrollee model (from step 1) to calculate predicted expenditures for enrollees. We compared the predicted expenditure values for enrollees to the actual Medicare capitated payments made under the demonstration.

B.2.2 Results

Enrollees had lower expenditures in base year 2 ($1,249 for enrollees vs. $1,906 for non-enrollees) and a lower mean HCC score (1.350 for enrollees vs. 1.597 for non-enrollees) (see ***Table B-2***).

Actual capitated payments for enrollees were, on average, $815.53 per month lower than the predicted mean expenditures for enrollees in demonstration year 1 (***Table B-3***). Mean predicted expenditures for enrollees were $489.17 per month lower than actual expenditures for non-enrollees (not shown).

Table B-2
Mean values of model covariates by group

Covariate	Eligible but not enrolled (N= 31,703)	Enrolled (N = 63,502)
FFS expenditures in base year 2	$1,906	$1,249
HCC score	1.597	1.350
Age	69.579	68.009
Also in another CMS demonstration	0.397	0.168
Female	64%	63%
Black	21%	20%
Asian	11%	8%
Other	2%	2%
Hispanic	21%	27%
Disabled	6%	4%
ESRD	29%	30%
Patient care physicians per 1,000 population	0.573	0.571
% of households w/ member >= 60 yrs.	31.068	31.370
% of households w/ member < 18 yrs.	42.479	42.597
% of those aged <65 years with college education	18.320	17.573
% of those aged <65 years with self-care limitation	4.043	4.170
Fraction of duals with Medicaid managed care, ages 19+	0.526	0.505
Medicare Advantage penetration rate, all enrl	0.328	0.336
% of pop. living in married household	64.252	63.376
Population per square mile, all ages	1,854.475	1,767.910
Medicaid spending per dual, ages 19+	11,953.780	11,805.200
Medicare spending per dual, ages 19+	21,650.460	21,418.610
Fraction of duals using nursing facilities, ages 65+	0.864	0.844
Fraction of duals using personal care, ages 65+	0.010	0.011
Distance to nearest hospital (miles)	4.613	4.605
Distance to nearest nursing home (miles)	3.446	3.359

ESRD = end-stage renal disease; FFS = fee for service; HCC = Hierarchical Condition Category.

RTI Program: predictingFFS_TX4: Summary statistics: mean by categories of enrollee.

Table B-3
Expenditure prediction results from an unweighted OLS model

Enrollee observations = 38,081	Mean expenditures over the first year of the demonstration (22 months)	95% confidence interval	
Predicted FFS for enrollees	$45,050	$44,721	$45,378
Actual PMPM for enrollees	$27,108	$26,847	$27,369
Difference	$17,942	$17,693	$18,191
	($811.73 a month)	P = 0.0000	

FFS = fee for service; OLS = ordinary least squares; PMPM = per member per month.

RTI program: predictFFS_TX4 unweighted FFS3a

B.3 Enrollee-Subgroup Analyses

The enrollee-subgroup analyses focused on a subgroup of beneficiaries identified as enrolled for at least 3 months in the demonstration period and with at least 3 months of baseline eligibility. Note that a subset of the comparison group developed for the ITT analysis was used in the enrollee subgroup analyses. Comparison group beneficiaries used in the enrollee subgroup analyses were required to have at least 3 months of eligibility in the demonstration period (March 1, 2015–December 31, 2016) and at least 3 months of eligibility in the predemonstration period (March 1, 2013–February 28, 2015), analogous to the criteria for identifying enrollees. Descriptive statistics (weighted) are shown in ***Table B-4***. The regression results indicate additional costs associated with enrollees but this finding is not statistically significant (***Table B-5***). This enrollee sub-group analysis is limited by the absence of person-level data on characteristics that potentially would lead an individual in a comparison area to enroll in a similar demonstration, and thus the results should be considered in the context of this limitation.

Table B-4
Texas demonstration, mean monthly Medicare expenditures, revised enrollee subgroup analysis, predemonstration period and demonstration period, weighted

Group	Predemonstration period March 2013–Feb 2015	Demonstration Period 1 March 2015–Dec 2016	Difference
Demonstration group	$990.97	$1,240.85	$249.88
	($904.42, $1,077.51)	($1,181.81, $1,299.88)	($178.03, $321.73)
Comparison group	$1,036.93	$1,317.53	$280.60
	($991.71, $1,082.15)	($1,259.90, $1,375.15)	($256.87, $304.32)
Difference-in-difference			−$30.71
			(−$103.07, $41.65)

SOURCE: RTI Analysis of Texas demonstration eligible and comparison group Medicare data (program: tx_cs_0510_13DEC2018).

Table B-5
Demonstration effects on Medicare savings, revised enrollee subgroup analysis, difference-in-difference (DID) regression results, Texas demonstration (weighted)

Covariate	Adjusted coefficient DID	*p*-value	95% confidence interval	90% confidence interval
Intervention*Demo Period (March 2015–December 2016)	14.43	0.7768	−85.33, 114.19	−69.29, 98.15

NOTE: Adjusted coefficient greater than zero are not indicative of Medicare savings.

SOURCE: RTI Analysis of Texas demonstration eligible and comparison group Medicare data (program: tx_cs_0510_13DEC2018).

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Appendix C
Demonstration Design Features

Key features	Predemonstration	Demonstration
Summary of covered benefits		
Medicare	Parts A, B, and D benefits	Parts A, B, and D benefits
Medicaid	Medicaid State Plan and HCBS waiver services	Medicaid State Plan and HCBS waiver services
Payment method (capitated/FFS/MFFS)		
Medicare	FFS and capitated	Capitated
Medicaid (capitated or FFS)		
Primary/medical	Capitated	Capitated
Behavioral health	Capitated through the MCOs, except in Dallas County where behavioral health services were capitated through the NorthSTAR program	Capitated through the MMPs, including Dallas County
Nursing facility services	FFS[1]	Capitated
HCBS waiver services	Capitated	Capitated
Care coordination/case management		
Care coordination for medical, behavioral health, or LTSS and by whom	MCO service coordinators are available to all enrollees and are responsible for coordinating with enrollees' PCPs and service providers, including non-network PCPs and providers of non-covered services.	MMP service coordinators are available to all enrollees and are responsible for coordinating with enrollees' PCPs and service providers, including coordination of covered services with non-covered services.
Care coordination for nursing facility residents	MCOs provide service coordination for members during the first 4 months after entry into a nursing facility.	MMP service coordinators provide care coordination to all demonstration enrollees residing in nursing facilities.
Targeted Case Management	Case managers employed by mental health provider agencies assist individuals who have a severe and persistent mental illness and receive mental health rehabilitative services in accessing and coordinating services. MCO service coordinators coordinate with TCM providers to address integration of behavioral and physical services.	No change. Case managers employed by mental health provider agencies assist individuals who have a severe and persistent mental illness and receive mental health rehabilitative services in accessing and coordinating services. MMP service coordinators coordinate with TCM providers to address integration of behavioral and physical health services.

(continued)

Key features	Predemonstration	Demonstration
Enrollment/assignment		
Enrollment method	Mandatory enrollment into a STAR-PLUS MCO for receipt of Medicaid services. Beneficiaries who do not select an MCO are auto-enrolled into an MCO. Medicaid managed care enrollment is not integrated with Medicare Advantage enrollment.	Initial period of opt-in-only enrollment into MMPs, followed by passive enrollment with opt-out (opt-in enrollment remains available). Enrollees may disenroll at any time and return to Medicare FFS or select a different Medicare Advantage plan. Enrollment is mandatory for receipt of Medicaid benefits.
Attribution/assignment method	N/A	N/A
Implementation		
Geographic area	N/A	Six urban counties: Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant.
Phase-in plan	N/A	The first effective date for opt-in enrollments was March 1, 2015. Passive enrollment for community residents began April 1, 2015, ended August 1, 2015, and was limited to a maximum of 5,000 beneficiaries per month per MMP in Harris County, and 3,000 beneficiaries per month per MMP in the other counties. Passive enrollment of nursing facility residents began August 1, 2015 and ended October 1, 2015. Opt-in enrollment remains available.
Implementation date		March 1, 2015.

FFS = fee for service; HCBS = home and community-based services; LTSS = long-term services and supports; MCO = managed care organization; MFFS = managed fee for service; MMP = Medicare-Medicaid Plan; PCP = primary care provider; N/A = not applicable; TCM = targeted case management.

[1] On March 1, 2015, the STAR+PLUS Medicaid managed care program was expanded to include Medicaid beneficiaries residing in nursing facilities.

NOTE: Information related to the demonstration in this table is from the Texas Memorandum of Understanding, 2014; STAR+PLUS Expansion Request for Proposals, n.d.-c; and the Texas Uniform Managed Care Contract (Texas HHSC, n.d.-e).