Executive Commissioner's Commitment to
Improving Member and Provider Experience in Medicaid Managed Care

Executive Commissioner Chris Traylor held stakeholder meetings in 2015 to gather input on ways to improve the managed care landscape, from both the member and provider perspective. According to Executive Commissioner Traylor, the purpose was to improve provider experience in managed care and ultimately to ensure the 4.5 million people relying on the Medicaid and Children's Health Insurance Program (CHIP) programs have appropriate access to services to enable them to live strong, productive lives. He also shared thoughts that it is important as Texas evolves from fee-for-service (FFS) to managed care, to project future needs to create the best system possible.

After receiving recommendations, additional meetings were held with stakeholders on November 9, 2015, and December 8, 2015, to further discuss the ideas and potential next steps. Executive Commissioner Traylor explained that some recommendations the agency can handle administratively, some will require legislative action, and then there will be items on which the Health and Human Services Commission (HHSC) will not take any action. He committed to posting decisions made for each recommendation on the website along with an explanation of why action is or is not being taken, and he advised staff they should do everything possible to implement the stakeholder recommendation. Executive Commissioner Charles Smith is equally committed to improving member and provider experience in Medicaid Managed Care. Gary Jessee, Deputy Executive Commissioner of the Medical and Social Services division, holds responsibility for coordination and implementation of this project and monitoring its progress.

HHSC responses were shared directly with stakeholder groups in February 2016, updates were posted to the website on April 11, 2016 and July 22, 2016, and quarterly updates on items in progress or under discussion will continue to be shared on the website. This document contains items that were closed as of July 22, either as complete, no action to be taken, or other (issue to be addressed through another existing process). Questions about this project can sent to MedicaidManagedCare@hhsc.state.tx.us.

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Table 1: Explanation of Response Fields

Agenda / Division	The abbreviation of the agency and division leading this response. Responses include: • COS: Chief of Staff • FSD: Financial Services Division • MCD: Medicaid and CHIP Division • HHSC: Health and Human Services Commission
Status	The overall status of the activity. Choices include: • No action to be taken • Complete • In progress • Under consideration • Other (Issue to be addressed through another existing process.)
Number	The item number or numbers from the recommendation from the April 2016 update.
Recommendation	The summary language provided in the April 2016 update for the recommendation by the stakeholder. In general, it begins with a summary statement and then the full recommendation.
Additional Stakeholder Background	If additional information was provided by stakeholders in the subsequent stakeholder meetings or by email to the program or project manager, then this is included here with notes of the source of the information.
Category	The category for the type of recommendation assigned to the recommendation for the April 2016 update. Categories include alternative payment mechanisms, benefits, claims, communications, contract provisions, service coordination / member assistance, network adequacy / access to care, continuity of care, rates, and stakeholder engagement and feedback.
Provided By	The stakeholder group that provided the recommendation.
HHSC Response	A high-level summary of the response from the agency to this recommendation. The HHSC response previously shared on the HHSC website in April 2016 is included in black. New wording displayed in red, and red strikethrough indicates old wording that no longer applies.
Date Last Updated	The date when language for this item was last updated.
Major Milestones with Status Updates	The key steps planned to complete this item or to obtain a decision (if the item is under consideration).

Table 2: Abbreviations Used in Document

Acronym	Definition
ACA	Affordable Care Act
API	Atypical Provider Identifier
ASC	Ambulatory Surgical Center
BHIAC	Behavioral Health Integration Advisory Committee
CAHPS	Consumer Assessment of Healthcare Providers & Systems
CHAT	Children's Hospital Association of Texas
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CVO	Credentialing Verification Organization
DADS	Department of Aging and Disability Services
DD	Developmental Disability
DME	Durable Medical Equipment
DMO	Dental Maintenance Organization
DUR	Drug Utilization Review
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
FDA	Food and Drug Administration
FFS	Fee-for-service
FSD	Financial Services Division
HCBS	Home and Community Based Services
HDIS	Health, Developmental and Independence Services
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HMO	Health Maintenance Organization
HPM	Health Plan Management
HSRI	Human Services Research Institute
IDD	Intellectual and Developmental Disabilities
LARC	Long Acting Reversible Contraception
LIDDA	Local Intellectual and Developmental Disability Authorities
LTSS	Long-term Services and Supports
MCO	Managed Care Organization
MCS	Medicaid and CHIP Services (division)
MHPAEA	Mental Health Parity and Addictions Equity Act
MSS	Medical Social Services
NA	Not Applicable
NAIP	Network Access Improvement Project
NASUAD	National Association of States United for Aging and Disabilities
NCI-AD	National Core Indicators - Aging and Disabilities
NPI	National Provider Identifier
PA	Prior Authorization
PACSTX	Providers Alliance for Community Services of Texas
PCP	Primary Care Physician
PDL	Preferred Drug List
PPAT	Private Providers Association of Texas
PPS	Prospective Payment System
RRT	Research and Resolution

Acronym	Definition
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SRAC	System Redesign Advisory Committee
SSI	Supplemental Security Income
SSLC	State Supported Living Centers
STAR	State of Texas Access Reform
STP	Significant Traditional Provider
TAHP	Texas Association of Health Plans
TBD	To Be Determined
THA	Texas Hospital Association
THSteps	Texas Health Steps
TIERS	Texas Integrated Eligibility Redesign System
TMA	Texas Medical Association
TMHP	Texas Medicaid and Healthcare Partnership
TPI	Texas Provider Identifier
TPS	Texas Pediatric Society
TSHA	Texas Speech-Language-Hearing Association
UMCC	Uniform Managed Care Contract
UMCM	Uniform Managed Care Manual
VDP	Vendor Drug Program

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	2a
Recommendation:	Continue to explore ways to improve the MCO online directories, including how to improve access to and ease in use of the online directories. This includes HHSC continuing to 'ghost' call doctors in each MCO's directory. We recognize the challenges in trying to maintain the accuracy of the MCO Provider Directories, thus appreciate the recent efforts of HHSC and MCOs to improve the MCO Provider Directories. Although efforts are already underway to improve the directories, the need for the recommendation to remain in the forefront cannot be overstated. Even if the list of doctors is current and accurate, if it does not include a specialist one needs (such as a psychiatrist or neurologist) the directory is of no value. Directories also serve of no value if doctors for the type care one needs are not taking new patients, refuse to see persons with IDD or are too far away for a family and more importantly for an individual who may not tolerate long drives very well, followed by long waits in a doctor's office. This also places a burden on providers as having to travel out-of-town to take an individual to an appointment typically requires having another staff member present and available to ensure the other persons in a group home setting receive needed care. Such results in increased costs for which providers receive no reimbursement.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	PPAT				
HHSC Response:	The SB 760 workgroup has developed critical elements for the MCO online provider directories for inclusion in the UMCM. These will be proposed to MCOs in October 2016 for a November 2016 effective date. In addition, the HHSC EQRO is conducting "secret shopper" calls to MCO network providers in the MCOs' provider directories. HHSC solicited stakeholder comments on provider directory standards, including a stakeholder forum on 11/30/2015. These comments were incorporated into draft Provider Directory Standards released for additional comment in May 2016. The updated MCO provider directory standards will include new requirements for both print and online versions of MCO Provider directories. HHSC collected additional feedback during the subsequent SB760 stakeholder forum held on 6/6/2016. HHSC incorporated the additional comments into revised MCO provider directory standards as appropriate.				
Date Last Updated:	03/10/2017				

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Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Develop MCO online directory standards.	6/1/2016	Completed	
2	Conduct stakeholder forum to receive feedback on implementing SB 760.	6/6/2016	Completed	
3	Reassess and revise proposed standards based on stakeholder feedback.	8/15/2016	Completed	
4	Begin fielding 2016 Appointment Availability study.	8/23/16	Completed	
5	Complete 2015 Appointment Availability Study report.	11/1/16	Completed	
6	Amend managed care contracts and agency rules as necessary.	3/1/2017	Completed	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	2b
Recommendation:	Require managed care organizations (MCOs) to find doctors for long-term services and supports (LTSS) clients.				
Additional Stakeholder Background:	If one does not already exist, establish a policy placing the responsibility of finding a doctor on the MCO, not on LTSS providers or families. [Providers and families alike were told prior to the transition that under managed care their burdens in securing access to doctors and other healthcare professionals would be alleviated. To date such has not happened with providers and families spending inordinate amounts of time searching for healthcare providers.]				
Category:	Network Adequacy / Access to Care				
Provided By:	Private Providers Association of Texas (PPAT)				
HHSC Response:	HHSC contractually requires Medicaid MCOs to provide service management and coordination to members, including assistance in finding a provider. The HHSC Senate Bill (SB)760 workgroup is considering additional options to strengthen this requirement as described in response to recommendation 1e. Please see the response to 1e for additional information.				
Date Last Updated:	7/1/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	6a
Recommendation:	Streamline MCO prior authorization processes and standard authorization guidelines for targeted case management and mental health rehabilitation services. The Behavioral Health Integration Advisory Committee (BHIAC) developed recommendations to alleviate some of the administrative challenges providers often experience in a managed care environment. The recommendations includes creating uniform prior authorization processes, requiring prompt prior authorization decisions, and requiring MCOs to follow standardized authorization guidelines for targeted case management and mental health rehabilitation services.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Council of Community Centers				
HHSC Response:	HHSC staff appreciates the time the BHIAC took to craft these recommendations. Based on this feedback, HHSC has standardized the prior authorization process for mental health targeted case management and mental health rehabilitative services. HHSC has leveraged Texas Department of Insurance (TDI) Standard Prior Authorization Request Form and detailed specific guidance within managed care contracts on how this form is to be used for mental health targeted case management and mental health rehabilitative services. Further, HHSC has issued specific guidance related to maximum timeframes MCOs have to respond to and approve requested services. HHSC monitors infractions of this policy and addresses them as needed. As recommended, HHSC is continuing to address the challenges of this workforce and is committed to working with all stakeholders on effective solutions to reduce administrative requirements.				
Date Last Updated:	04/11/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	6b
Recommendation:	Challenges with different MCO processes. With the recent State of Texas Access Reform (STAR) Kids program awards, HHSC now contracts with 20 MCOs throughout the State, many of which have different requirements for credentialing and service authorization. In addition, many of the MCOs subcontract behavioral health services to behavioral health organizations that also have with different processes.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Council of Community Centers				
HHSC Response:	In order to offer choices to our clients in their managed care plan, HHSC contracts with a large number of MCOs. We are committed to finding ways to help providers navigate the differences and are working toward modernizing and streamlining our enrollment and credentialing systems. HHSC is working towards these goals through the implementation SB 1150 (83R), the Texas Association of Health Plans (TAHP) uniform credentialing process, and TDI's standard prior authorization as described below. **SB 1150** Following the passage of SB 1150 (83R), HHSC developed the following Provider Protection Plan, which was added to the Uniform Managed Care Contract (UMCC) and all managed care contracts, effective September 2013. **UMCC 8.1.4.12 Provider Protection Plan** The MCO must comply with HHSC's provider protection plan requirements for reducing the administrative burdens placed on Network Providers, and ensuring efficiency in Network enrollment and reimbursement. At a minimum, the plan must comply with the requirements of Texas Government Code § 533.0055, and: • Provide for timely and accurate claims adjudication and proper claims payment in accordance with Uniform Managed Care Manual (UMCM) Chapters 2.0 through 2.3. • Include Network Provider training and education on the requirements for claims submission and appeals, including the MCO's policies and procedures (see also Section 8.1.4.6, "Provider Relations Including Manual, Materials and Training.") • Ensure Member access to care, in accordance with Section 8.1.3, "Access to Care," and the UMCM's Geo-Mapping requirements (see UMCM Chapters 5.14.1 through 5.14.4.)				

	• Ensure prompt credentialing, as required by Section 8.1.4.4, "Provider Credentialing and Re-credentialing." • Ensure compliance with state and federal standards regarding prior authorizations, as described in Sections 8.1.8, "Utilization Management," and 8.1.21.2, "Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies." • Provide 30 days' notice to Providers before implementing changes to policies and procedures affecting the prior authorization process. However, in the case of suspected fraud, waste, or abuse by a single Provider, the MCO may implement changes to policies and procedures affecting the prior authorization process without the required notice period. • Include other measures developed by HHSC or a provider protection plan workgroup, or measures developed by the MCO and approved by HHSC. HHSC also established an SB 1150 workgroup, which held its first meeting in May 2014. The workgroup helped HHSC develop instructions for ambulance prior authorizations to accompany the standard prior authorization form developed by TDI. **TAHP Credentialing Process** TAHP is working on developing a statewide credentialing verification organization (CVO) for Medicaid MCOs. The concept for a statewide CVO emerged from discussions that began in 2014, between TAHP and Medicaid health plans, aimed at streamlining the administrative process for providers joining health plan networks. The CVO is intended to reduce administrative time and burden for providers seeking to deliver quality care to Texans enrolled in a Medicaid health plan. TAHP is in negotiations with potential vendors and has not announced an award yet. Further updates will be provided in response to recommendation 10 a-b. **TDI Standard Prior Authorization Form** Effective 9/1/2015, MCOs are required to accept the Texas Standard Prior Authorization Request Form for Health Care Services developed by TDI. A copy of the form can be found here: http://www.tdi.texas.gov/forms/lhlifehealth/nofr001.pdf.
Date Last Updated:	7/1/2016

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Submit proposed UMCM changes for quarterly reports from MCOs.	6/30/2016	Completed	
2	Develop "Pharmacy Clinical Prior Authorization Assistance Chart" sample, and share with TMA and TPS for feedback.	9/1/2016	Completed	
3	Meet with TMA and TPS to obtain feedback on responses.	9/1/2016	Completed	TMA and TPS did not have changes, and there was agreement that this was useful as a first step in this process.
4	Add Pharmacy Clinical Prior Authorization Assistance chart to VDP website.	9/1/2016	Completed	
5	Develop processes to consolidate quarterly MCO reports into a single document.	9/15/2016	Completed	
6	Review options to update or replace the existing "Texas Medicaid Pharmacy Prior Authorization" video to include better clinical prior authorization information.	9/30/2016	Completed	
7	Review and correct MCO first quarterly report.	10/10/2016	Completed	
8	Compile and post first MCO quarterly report.	10/15/2016	Completed	
9	Obtain examples from other states of PDL document.	11/1/2016	Completed	
10	Obtain feedback from TMA and TPS on the examples from other states.	11/15/2016	Completed	
11	Research into options of working with an existing vendor to implement changes.	11/15/2016	Completed	
12	Meet with TMA and TPS to discuss timelines.	11/15/2016	Completed	
13	Work with PDL contractor to develop timeline for site revisions.	11/30/2016	Completed	
14	Begin quarterly MCO Clinical PA reporting process.	11/30/2016	Completed	
15	Replace "Texas Medicaid Pharmacy Prior Authorization" video on the vendor drug website with one-page document explaining the process as an interim step until video can be updated.	12/15/2016	Completed	

16	Incorporate Clinical PA links into PDL document.	2/1/2017	Completed	
17	Work with TMA and TPS to obtain feedback from providers and administrators to test the revised tutorial (to replace the previous video).	3/1/2017	Complete	
18	Work with TMA and TPS to identify providers and administrators to test the revised PDL document prior to full launch.	3/17/2017	On Target	
19	Work with THSteps to update and revise tutorial to include clinical prior authorizations in the explanation of the drug authorization process.	3/15/2017	On Target	Delayed by two weeks.
20	Share draft document with TMA/TPS for feedback from the associations and a sampling of providers. This will be the draft revision of the PDL document incorporating links to clinical prior authorization criteria.	5/1/2017	On Target	
21	Fully launch revised PDL document incorporating links to clinical prior authorization criteria.	6/1/2017	On Target	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	11b
Recommendation:	Limit changing drugs from preferred to non-preferred status on the PDL to annual revisions.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with TMA and TPS on 8/10/2016, and it was clarified that drugs are only reviewed once per year but the review date is not clear to providers. It was agreed that providers would benefit from additional information about the date when the drug was reviewed and when it will be reviewed again. In addition, easier access to the review schedule would be helpful.				
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	With few exceptions, individual drug classes are only reviewed and changed once per year. Semi-annual updates to the PDL only affect half the drugs. State law requires quarterly reviews of drugs for the PDL. HHSC staff agreed to revise the PDL to include the date of review, and date when the drug will be reviewed again, and to make the review schedule easier to locate on the website.				
Date Last Updated:	3/9/2017				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Revise the PDL to include the date when a drug was last reviewed, and the date when it will be reviewed again.	2/1/2017	Completed	
2	Revise the PDL website to make the review schedule easier to find.	2/1/2017	Completed	
3	Review communications regarding the DUR meeting and related notices to improve clarity around the drug review schedule and review process.	2/1/2017	Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	11c
Recommendation:	Provide rationale for changing a drug status from preferred to non-preferred.				
Additional Stakeholder Background:	When a drug's status on the preferred list is changed (e.g. from preferred to non-preferred), provide the rationale for the change so that physicians understand HHSC's justification for the revision.				
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	Currently, a limited explanation of the rationale for the change is posted for every reviewed drug class. The information posted explains the primary clinical or fiscal factors that the committee considered in making their recommendation. HHSC will work with its PDL vendor and DUR Board to explore options for enhancing the published rationale without divulging confidential information.				
Date Last Updated:	3/9/2017				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Capture rationale at next DUR Board Meeting.	07/29/2016	Completed	
2	Develop sample document to share rationale for next meeting.	10/1/2016	Completed	
3	Share sample document with TMA and TPS, and obtain feedback from TMA and TPS.	11/15/2017	Completed	
4	If new descriptions are developed to explain the rationale for changes, the new descriptions will be included in the next PDL (effective January 2017).	2/1/2017	Completed	Note: The addition of the three-columns to the PDL recommendation document should meet this expectation. PDL Recommendations are published within 10 business days of every board meeting. Next meeting Jan. 27.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other:X (See explanation in HHSC Response)	**Number:**	11d
Recommendation:	Improve access to clinical edits in Epocrates.				
Additional Stakeholder Background:	For physicians using Epocrates, establish electronic mechanism to convey whether a drug/drug class is subject to an additional clinical edit, provide a mechanism to easily and quickly access the edit, and indicate which HMOs use the same edit.				
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	The VDP formulary is currently available to providers via Epocrates and each drug includes a link to inform prescribers whether it is subject to additional clinical PA criteria. An Epocrates limitation prevented the link from working on iOS products, but has recently been upgraded. Additionally, VDP will review the provided clinical PA criteria for added ease of use. Epocrates is a third party tool. It does not provide sufficient space to include information about each MCO's clinical PA criteria. HHSC contacted its Prospective DUR vendor that manages the Texas Medicaid Epocrates contract. The Epocrates product will not be modified, but actions taken in response to recommendation 11a will provide this information in the PDL. Technical issues for users of the product through iPhone and other Apple products have been addressed.				
Date Last Updated:	3/9/2017				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Consult with Epocrates regarding feasible options.	8/31/2016	Completed	
2	Develop scope of work and obtain high-level estimate from Prospective DUR vendor.	9/30/2016	NA	Epocrates declined our request to make these changes at this time.
3	Contact MCOs to find out if they are using Epocrates as required, and if not why.	10/31/2016	Completed	
4	Follow up with Epocrates regarding work around for broken links, and obtain an estimate on when this will be addressed.	11/30/2016	Completed	
5	Technical issues with Epocrates for iPhone users addressed.	11/30/2016	Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	11e
Recommendation:	Implement expedited communications to notify MCOs and physicians of drug shortages.				
Additional Stakeholder Background:	If there is a drug shortage, adopt an expedited communication plan so that HHSC and HMOs can quickly communicate with network physicians what product to use instead. This issue was discussed in a meeting with TMA and TPS on 8/10/2016, and it was clarified that this issue relates to specific situations where there are changes during a public health emergency or heavy flu season.				
Category:	Communications				
Provided By:	TMA / TPS				
HHSC Response:	When HHSC makes off-cycle formulary or PDL changes to address sudden shortages or other industry problems, the agency's GovDelivery service is used to notify subscribers by e-mail. HHSC will review this situation and determine changes needed based on the clarification received.				
Date Last Updated:	3/9/2017				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Review this issue with the VDP Contractor Performance Management and Formulary teams to understand issue and identify what changes need to be made.	10/1/2016	Completed	
2	Develop internal process.	10/31/2016	Completed	
3	Share process with external stakeholders and seek feedback (include meeting, if needed).	3/01/2017	Completed	
4	Finalize and implement process.	3/01/2017	Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**Number:**	11f
Recommendation:	Revise requirements managing drug benefit to the package insert instead of indication. Legacy Food and Drug Administration (FDA) reviews of drugs excluded pediatric, obstetric and geriatric patients, meaning many drugs do not have official FDA approval for treatment of those populations. This creates unnecessary hassles for physicians who may be required to obtain prior approval to use a drug for a non-label population even though there is clinical evidence supporting such usage.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	Federal law allows state Medicaid programs to go beyond the FDA indications of a drug when setting its coverage criteria. It allows states to use evidence from medical compendia; especially to support appropriate off-label use. HHSC relies on this medical evidence to expand access to treatments. HHSC will make contact with TMA/TPS to gain clarification on this recommendation. This item will be closed until further information is received.				
Date Last Updated:	3/9/2017				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Schedule meeting with TMA/TPS to discuss this issue.	7/31/2016	Completed	
2	Obtain examples of this issue from TMA and TPS.	12/1/2016		TMA and TPS working with members to obtain examples.
3	Review examples to determine next steps.	2/1/2017		

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	16
Recommendation:	HHSC should encourage MCOs to "gold star" provider practices that can show a history of proper utilization of medical services and waive certain prior authorization requirements.				
Additional Stakeholder Background:	Prior authorizations can be replaced with retroactive reviews of a physician's services provided followed by education when needed.				
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	Health plans currently are able to utilize this practice. HHSC will coordinate with TAHP to survey the health plans and determine whether changes can be implemented to appropriately address this recommendation. TAHP surveyed health plans about this activity and shared information with HHSC that some MCOs are doing this, and others are addressing this issue through alternative methods. HHSC will identify steps to be taken to encourage adoption of practices that reduce the administrative burden for, and encourage utilization of, providers that can show a history of proper utilization of medical services.				
Date Last Updated:	3/15/17				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Review contract and manual language to determine whether clarifications are needed to encourage this process.	9/30/2016	Completed	
2	Develop plan to address this recommendation.	3/1/2017	Completed	HHSC has developed new MCO contract language related to alternative payment models (APM) and APM targets for FY18. The new provisions categorize this kind of administrative relief (i.e. Gold Carding a provider) as an APM. This may have the effect of incentivizing more MCOs to explore this practice.

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	17
Recommendation:	Eliminate pre-authorization for simple procedures in the office.				
Additional Stakeholder Background:	Eliminate pre-authorization for simple procedures in the office. Examples include performing an ear lavage when it is necessary to determine whether a patient has an ear infection, chemical cautery for umbilical granulomas, or treating molluscum contagiosum warts.				
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	At this time, HHSC cannot mandate to MCOs which benefits require prior authorization or that MCOs follow the same processes for prior authorization. HHSC will continue to explore other opportunities to help providers better understand MCO processes.				
Date Last Updated:	4/11/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

Executive Commissioner's Commitment to
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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X This recommendation is addressed through an existing process. See details below.	**Number:**	26
Recommendation:	Texas Medicaid coverage of Health & Behavior codes should be expanded to include services provided in the tertiary care environment. Since April 1, 2014, health and behavior assessment and intervention has been a Texas Medicaid benefit for clients who are 20 years of age and younger when the services are provided by a licensed practitioner of the healing arts (LPHA) who is co-located in the same office or building complex as the client's primary care provider.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	Children's Hospital Association of Texas (CHAT)				
HHSC Response:	HHSC has an existing process for reviewing Medicaid medical benefits. Stakeholders can submit a topic nomination form with evidence to support their request. Information about how to submit a topic nomination form can be found on the HHSC webpage: http://www.hhsc.state.tx.us/medicaid/MPR/index.shtml. Once a topic nomination form is submitted, HHSC staff will scan policy and the policy nomination will be considered and prioritized. A fiscal estimate will need to be completed before a decision can be made to implement the policy change. If the fiscal estimate exceeds $500,000, the Legislative Budget Board will have to approve the funding associated with the policy change. Timeline is dependent upon prioritization within the medical policy review process. HHSC staff contacted CHAT to provide the form, and confirmed awareness of the process.				
Date Last Updated:	June 17, 2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

Executive Commissioner's Commitment to
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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	27
Recommendation:	Texas Medicaid coverage should be expanded to include coverage for services provided by Psychology predoctoral interns and postdoctoral fellows who are in the process of acquiring the supervised experience required for independent licensure as a Psychologist, when these services are supervised by a Licensed Psychologist who is a Medicaid provider. Under chapter 501 of the Texas Occupations Code, a licensed psychologist may delegate psychological services to a provisionally licensed psychologist, a newly licensed psychologist who is not eligible for managed care panels, a person who holds a temporary license, and a person who is in the process of acquiring the supervised for independent licensure – which includes predoctoral interns and postdoctoral fellows. However, Texas Medicaid does not allow the supervising Licensed Psychologist to bill for the services of trainees at either the predoctoral or postdoctoral levels. Importantly, such services are provided within the context of accredited training programs that entail rigorous supervisory requirements, and under the close supervision of a licensed provider (as mandated by Texas Law under the Texas State Board of Examiners of Psychologists). Moreover, psychology predoctoral interns and postdoctoral fellows under supervision have typically exceeded both the educational requirements and the hours of supervised clinical experience than are required for independent licensure for LPCs and LCSWs.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	CHAT				
HHSC Response:	The policy was posted on HHSC's Medical Policy Review webpage for stakeholder comments: https://hhs.texas.gov/services/health/medicaid-and-chip/about-medicaid/draft-medicaid-medical-and-dental-policies. HHSC received feedback from stakeholders on the proposed policy and reviewed all comments. Stakeholders requested that HHSC consider extending the delegation to include postdoctoral fellows, as this would align with the occupational code. This is part of the outpatient behavioral health policy that will be implemented January 2017. A rate hearing will be required to implement the policy changes.				
Date Last Updated:	02/02/2017				

Executive Commissioner's Commitment to
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Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Finalize fiscal analysis.	TBD	Completed	
2	Schedule briefing with leadership.	TBD	Completed	
3	Conduct rate hearing.	11/16/2016	Completed	
4	Policy Implemented	01/01/17	Completed	

Executive Commissioner's Commitment to
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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	28
Recommendation:	Texas Medicaid should include coverage for services without the patient present for clients under the age of 20 (e.g., 90846). It is standard of care for services provided to children and adolescents to have sessions with parents in which the child or adolescent is not present. In fact, evidence-based interventions require sessions of this type (e.g., Parent Management Training for disruptive behavior). Currently, Texas Medicaid will not cover services in which the child or adolescent patient is not physically present (e.g., 90846). This deprives children and adolescents who are Medicaid recipients of the highest quality, most evidence-based assessment and treatment services.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	CHAT				
HHSC Response:	The policy was posted on HHSC's Medical Policy Review webpage for stakeholder comments: https://hhs.texas.gov/services/health/medicaid-and-chip/about-medicaid/draft-medicaid-medical-and-dental-policies. HHSC received feedback from stakeholders on the proposed policy and reviewed all comments. This is part of the outpatient behavioral health policy that will be implemented January 2017. A rate hearing will be required to implement the policy changes.				
Date Last Updated:	02/02/2017				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Finalize fiscal analysis.	TBD	Complete	
2	Conduct leadership review.	TBD	Complete	
3	Conduct rate hearing.	11/16/2016	Complete	
4	Policy Implemented	01/01/17	Complete	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X This recommendation is addressed through an existing process. See details below.	**Number:**	29
Recommendation:	Texas Medicaid should include coverage for HSAT for clients under 20. Currently, Texas Medicaid does not reimburse for HSAT in this age group. We strongly believe that this should be reconsidered in order to provide the most effective patient care in the most efficient, timely manner. Dr. David Gozal's recent report in the journal of CHEST (August 2015) recommends home testing with at least a type 3 portable monitor as an alternative in healthy children with moderate to severe OSA, particularly in settings where access to polysomnography is limited or unavailable. We strongly encourage reconsideration of coverage for this procedure in healthy adolescents and teenagers to facilitate the management of OSA in these individuals. HSAT for this population will improve timely access to in-laboratory studies for younger, higher-acuity children, which is currently delayed due to limited in-laboratory infrastructure.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	CHAT				
HHSC Response:	HHSC has an existing process for reviewing Medicaid medical benefits. Stakeholders can submit a topic nomination form with evidence to support their request. Information about how to submit a topic nomination form can be found on the HHSC webpage: http://www.hhsc.state.tx.us/medicaid/MPR/index.shtml. Once a topic nomination form is submitted, HHSC staff will scan policy and the policy nomination will be considered and prioritized. A fiscal estimate will need to be completed before a decision can be made to implement the policy change. If the fiscal estimate exceeds $500,000, the Legislative Budget Board will have to approve the policy change. Timeline is dependent upon prioritization within the medical policy review process. HHSC staff contacted CHAT to provide the form, and confirmed awareness of the process.				
Date Last Updated:	6/17/2016				

Executive Commissioner's Commitment to
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Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X This recommendation is addressed through an existing process. See details below.	**Number:**	30
Recommendation:	Texas Medicaid coverage should include mask sensitization. Mask sensitization is a service that includes techniques for gradual initiation of CPAP, BPAP along with mask fitting by a certified technologist. The visit includes education about PAP therapy and allows families to ask questions about their mask and device. This service is ideal for patients who have developmental delay, sensorineural problems, patients with claustrophobia or anxiety, etc.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	CHAT				
HHSC Response:	HHSC has an existing process for reviewing Medicaid medical benefits. Stakeholders can submit a topic nomination form with evidence to support their request. Information about how to submit a topic nomination form can be found on the HHSC webpage: http://www.hhsc.state.tx.us/medicaid/MPR/index.shtml. Once a topic nomination form is submitted, HHSC staff will scan policy and the policy nomination will be considered and prioritized. A fiscal estimate will need to be completed before a decision can be made to implement the policy change. If the fiscal estimate exceeds $500,000, the Legislative Budget Board will have to approve the policy change. Timeline is dependent upon prioritization within the medical policy review process. HHSC staff contacted CHAT to provide the form, and confirmed awareness of the process.				
Date Last Updated:	6/17/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**Number:**	37
Recommendation:	Eliminate prior authorization for medical drug screens. Texas Medical Board rules regarding chronic pain specify physicians must conduct random drug screens. By requiring prior approval, physicians cannot fulfill that requirement for Medicaid patients. This limits physicians' ability to properly screen patients at high risk for opioid abuse. Further, we have received information that when physicians do attempt to follow Medicaid requirements, the form requires individual authorization for each component of the drug test rather than allowing the entire panel to be completed. This is a non-standard approach -- physicians do not bill for individual components for these tests. Thus codes are not easily obtained.				
Additional Background:					
Category:	Benefits				
Provided By:	TMA / TPS				
HHSC Response:	HHSC will work with stakeholders to identify which drug screens are not being covered and circumstances where prior authorization may have been inappropriately applied. In FFS Medicaid, there is no prior authorization requirement for drug screens. HHSC requested additional information from TMA and TPS to identify drug screens that are not being covered and circumstances where prior authorization may have been inappropriately applied. This item will be closed until further information is received.				
Date Last Updated:	3/9/2017				

Executive Commissioner's Commitment to
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Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Obtain examples from TMA/TPS of this issue occurring.	8/1/2016	In Progress	TMA will revisit this issue and the others submitted at their annual meeting in the fall to determine if these issues have been resolved since they were originally submitted, and to identify the issues that are highest priority to address.

Executive Commissioner's Commitment to
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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**Number:**	45
Recommendation:	Ensure Texas Medicaid recognizes all appropriate claims modifiers. If a modifier is not covered, the Medicaid FFS or MCO provider manual should list any modifiers that are not recognized. Reducing physician frustration and practice costs.				
Additional Stakeholder Background:	During the November 9, 2015 stakeholder meeting with Executive Commissioner Traylor, Dr. John Holcomb, TMA, provide the following additional information: Dr. Holcomb noted that Medicaid in the past has not recognized add-on services that Medicare has recognized. If add-on codes are not allowed, a physician does two procedures the same day, but only gets paid for one which is unfair. If the physician cannot get paid for both, it should at least be recognized.				
Category:	Claims				
Provided By:	TMA / TPS				
HHSC Response:	All adjudication entities are required to use HIPAA code values in communicating with providers. Information should be made available by the adjudicator that specifies allowable modifiers for claims processing. To address this issue in FFS would take a significant amount of resources and time. It is not cost effective to do so at this time with the transition to managed care. This item will be closed until further information is received.				
Date Last Updated:	3/9/2017				

Executive Commissioner's Commitment to
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Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Reach out to TMA/TPS	8/1/2016	Completed	TMA will revisit this issue and the others submitted at their annual meeting in the fall to determine if these issues have been resolved since they were originally submitted, and to identify the issues that are highest priority to address.

Executive Commissioner's Commitment to
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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	47
Recommendation:	Require MCOs to directly communicate changes in rates, codes, practices etc. at least 60 days in advance of effective date. Current examples: Adjustment of rates to reflect increase in attendant wage on 9-1-15 not communicated, Community First Choice code and rates not communicated. Implementation of CFC in Star Plus waiver changed without notice. Communications simply by a website posting is inadequate.				
Additional Stakeholder Background:					
Category:	Communications				
Provided By:	Coalition of Texans with Disabilities				
HHSC Response:	The relationship between an MCO and a provider is governed by the contract between the parties. A provider could request this provision in its contract with the MCO. After researching the current examples, HHSC determined these examples are not the fault of the MCO, but an issue from HHSC: • Attendant wage rates for SFY2016 were not published until mid-October. HHSC instructed the MCOs to reprocess eligible claims back to 9/1/2016 and every MCO reported they had completed this by February. If a provider experienced something different, HHSC encourages that they file formal complaints and move through the formal grievance process for HHSC to track systemic issues. • HHSC changed the Community First Choice codes and modifiers and changed the STAR+PLUS billing matrix to include CFC for children. HHSC directed MCOs to reauthorize services with the appropriate codes and modifiers, as this is the only way to track CFC services for federal reporting requirements. HHSC published this information in the STAR+PLUS Handbook, which is available publicly. • HHSC directed MCOs to change the delivery of personal assistance services (PAS) and emergency response services (ERS) from STAR+PLUS HCBS to CFC in such a way that members would experience no disruption in services. This direction could have resulted in some confusion. HHSC is still working through issues related to the implementation of CFC with MCOs including additional training for their staff and training for providers and provider associations. HHSC established a list of contacts for STAR+PLUS MCO provider relations departments to facilitate the communication of urgent information to providers. Additional efforts to improve timeliness of communications are ongoing. HHSC is working with MCOs to ensure changes like those cited happen less frequently.				
Date Last Updated:	6/22/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

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	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	48
Recommendation:	HHSC should require Dental Maintenance Organizations (DMOs) to share their client outreach efforts with the dentist provider so that both can work together to help remove barriers that prevent clients from utilizing their dental benefits and missing appointments. Clients breaking dental appointments are a problem for dentist providers and the DMOs. Both DMOs allow providers to log a client's broken appointment into the DMO provider portal. However, that is where the information sharing stops. The DMOs do not communicate with the provider about efforts to help the client keep appointments. Broken appointments are a costly and unnecessary expense for providers and a concern for the state about client benefit utilization.				
Additional Stakeholder Background:	During the December 8, 2016 stakeholder meeting with Executive Commissioner Traylor, Ms. Diane Rhodes, Texas Dental Association, provided the following additional information: Broken appointments continue to be an issue for providers, and DMOs have systems where providers can log broken appointments. The recommendation is for increased coordination between DMOs and providers about the information collected, so both can work together to eliminate broken appointments by addressing the individual reasons a patient may not be making appointments.				
Category:	Communications				
Provided By:	Texas Dental Association				
HHSC Response:	Providers have the ability to refer a patient who frequently misses appointments to the THSteps Outreach & Informing Unit for follow-up. DMOs are required by contract to train providers about the availability of the THSteps Outreach & Informing Unit's services. DMO member handbooks emphasize the importance of keeping or properly rescheduling appointments. And DMO member advocates conduct activities to identify members who miss appointments so they can help minimize barriers to care. HHSC will work with the DMOs to identify possibilities for sharing information on outreach activities to reduce missed appointments. HHSC will review procedures utilized by the THSteps Outreach and Informing Unit to better inform the review of the DMOs' operational procedures regarding frequently missed appointments. HHSC will then review the issue with the DMOs to determine if operational refinements can be made to achieve improved communication. Based on review of operational procedures for reporting missed appointments utilized by the DMOs and THSteps, it was determined that existing procedures are adequate to address this concern. Missed appointments are of concern to dental as well as medical providers. For members who miss appointments, often there are factors such as lack of transportation or child care that interfere with a member's ability to keep appointments. The responsibility to manage their personal				

	medical appointments ultimately rests with the member. In lieu of implementing tracking and reporting that could represent an additional administrative burden on providers, HHSC recommends that providers actively utilize the following options to address this concern: • Notify the member's dental plan of members who regularly miss appointments. The dental plan's Member Services department can assist with member education and case management, including coordinating travel arrangements. • Notify the Texas Health Steps Outreach and Informing Unit of Texas Health Steps patients who miss appointments, need help scheduling appointments, or coordinating transportation. Providers can contact Texas Health Steps at 1-877-THSteps (847-8377) or submit a referral at this website: http://www.dshs.texas.gov/thsteps/POR.shtm • Promote awareness among patients of the Medicaid Transportation Program (MTP). This program provides free transportation for Texas Health Steps patients and most others who use Medicaid medical and dental services. Providers and patients can obtain information about MTP at 1-877-633-8747 or www.hhsc.state.tx.us/medicaid/mtp/. MTP also provides educational materials such as posters that providers can use in-office to promote patient awareness of the program. • Help patients understand the importance of keeping scheduled appointments, and send timely reminders of upcoming appointments.
Date Last Updated:	3/7/2017

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Research THSteps Outreach & Informing Unit policies and procedures.	3/7/17	Completed	
2	Based on results of research, review DMO operational procedures by DMOs to determine if procedures can be refined further.	3/7/17	Completed	

Executive Commissioner's Commitment to
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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	49
Recommendation:	Ensure that the "authorized representative" designation is shared with the DMO and can be accessed by the client as needed to avoid interruption of care in situations where the primary head of household is not available to accompany the client to the dentist's office. Previously, only the client's head of household could change a client's primary dentist or managed care dental plan. Many times, the client's grandparent or other family member will bring to them to the dental visit instead of the head of household. In situations where a change in the main dentist needs to happen for treatment to occur, the accompanying family member is not authorized to make such a change, and unless the dentist can make verifiable contact with the head of household, the dentist has to send the client home until the head of household or guardian is available.				
Additional Stakeholder Background:					
Category:	Communications				
Provided By:	Texas Dental Association				
HHSC Response:	HHSC staff reviewed this issue and determined that the authorized representative is currently shared with DMOs. HHSC will review the process of sharing names of authorized representatives to identify areas where changes can be made to improve the process. HHSC received feedback from the Texas Dental Association that there are not specific examples available, but that providers have given feedback that this issue is occurring. HHSC reviewed this issue and identified system changes that may be impacting the transfer of this information. These issues were addressed and resolved and this should improve the transfer of data. However, the SSI file will continue to override any information in the authorized user field as this is considered more accurate. This is the one situation in which the authorized representative designated in TIERS may not be transferred.				
Date Last Updated:	3/9/2017				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Obtain examples from Texas Dental Association of this issue occurring.	8/1/2016	Complete	

2	Further explore system processes to confirm that information is transferring to DMOs as expected.	12/1/2016	Completed	
3	Develop recommended solution based on system information received.	1/1/2017	Completed	
4	Modify system to address issues of data transfer.	3/1/2017	Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	52b
Recommendation:	Require MCOs to promptly notify physicians when the practice's assigned provider representative has changed. We frequently receive calls from physicians who have attempted to resolve complaints with a plan, but were stymied because their provider representative kept changing, often without notice, requiring the practice to start again with the resolution process.				
Additional Stakeholder Background:					
Category:	Communications				
Provided By:	TMA / TPS				
HHSC Response:	HHSC will propose a contract amendment to address this recommendation.				
Date Last Updated:	03/12/2017				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Develop a proposed amendment for the managed care contracts including the proposed requirement.	9/9/2016	Completed	
2	Contract change reviewed by MCOs.	10/4/2016	On Target	
3	Contract change submitted to CMS for review.	Winter 2016	On Target	
4	Contract change effective.	3/1/2017	Complete	The contract change requires any MCO to notify a provider in writing within five days of a change to a designated provider relations representative, including the name and contact information of the new representative.

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	53
Recommendation:	Establish measures for growth of consumer directed services (CDS) and cover support consultation services. CDS continues to be undersubscribed. Examine support consultation in CDS in practice (or not). Support consultation is a service required to be made available from Financial Management Services Agencies, yet there seems to be no mechanism for authorization, no billing code and no provider rates.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	Coalition of Texans with Disabilities				
HHSC Response:	HHSC is gathering information about CDS utilization in managed care and will continue to report this information publicly and to share information with the Consumer Direction Advisory Committee. HHSC is working with MCOs to ensure individuals are well informed about the CDS option. For example, HHSC recently published training for MCO service coordinators to ensure they are able to accurately and more completely explain the CDS option for both STAR+PLUS and STAR Kids. Services like support management provided through Community First Choice and some assessments are also not reimbursable, and are considered part of the cost of doing business. Developing reimbursement mechanisms for services like support consultation would require legislative direction and corresponding appropriations.				
Date Last Updated:	7/1/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	54
Recommendation:	Clarify the responsibilities of all subcontractors regarding Electronic Data Interchange transactions within the MCO contracts. MCOs that are using transportation logistic companies are not contracting with companies who can receive and accept ANSI electronic files. Establishes continuity of electronic reporting from subcontractors to contractors who are required to report data electronically to HHSC. Also reduces the administrative burden for transportation providers (ambulance and other entities).				
Additional Stakeholder Background:					
Category:	Contract provisions				
Provided By:	Acadian Ambulance Service of Texas				
HHSC Response:	The HHSC contract requires the MCOs, and, by extension, their subcontractors, to comply with all state and federal regulations. HHSC believes that applies in the case of transportation companies specifically with regard to ANSI/HIPAA formatting for their electronic remittances. In addition, the Uniform Managed Care Contract was amended to make clear that the MCO must provide a provider portal that supports functionality to reduce administrative burden on Network Providers at no cost to the Providers and functionality must include the following: • Client eligibility verification • Submission of electronic claims • Prior Authorization requests • Claims appeals and reconsiderations • Exchange of clinical data and other documentation necessary for prior authorization and claim processing				
Date Last Updated:	3/9/2017				

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Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Schedule meeting with Acadian Ambulance Service of Texas.	8/1/2016	Complete	Meeting occurred on 9/28/2016.
2	Determine next steps.	12/1/2016	Complete	

Executive Commissioner's Commitment to Improving Member and Provider Experience in Medicaid Managed Care

Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X This recommendation is addressed through an existing process. See details below.	**Number:**	56
Recommendation:	Amend Section 8.1.4.2 of the Texas Medicaid UMCC to give Medicaid and Children's Health Insurance Program (CHIP) MCOs the option to enroll advanced practice registered nurses (APRNs) as primary care providers (PCPs) in their networks, regardless of whether or not the delegating physician is in-network. By law, Texas Medicaid and CHIP MCOs are required to use APRNs as PCPs to increase the availability of these providers in the organization's provider network. The requirement of an in-network supervising physician for APRNs not only prevents compliance with these laws, but also greatly hinders the use of APRNs in MCO healthcare networks where provider shortages and medical need are the greatest. (Relevant Code: CHIP - §62.1551, Health and Safety Code; Fee For Service - §32.024(gg), Human Resource Code; Managed Care - §533.005(a)(13), Government Code).				
Additional Stakeholder Background:					
Category:	Contract Provisions				
Provided By:	Texas Nurse Practitioners				
HHSC Response:	In 2014 HHSC discussed the ability of MCOs to contract with APRNs whose supervising physician is not a member of the MCO's network with TAHP. TAHP consulted with several MCOs about this requested change. At that time, TAHP identified the following concerns, and HHSC decided not to make contract changes at that time. • Issues with out-of-network referrals, linkages back to PCP, and potential balance billing • From a quality of care perspective and a best practice—MCOs should be assured that the supervising physician is clear with the National Practitioner Data Bank (NPDB) and Medical Board if she/he is going to be supervising mid-levels that are seeing MCO's members. Should the need of the member require escalation of the supervising physician, the MCO would want this physician credentialed and contracted. • Potential liability issues—if there is an instance when an APRN who misdiagnoses something, the APRN, the supervising physician, and the MCO will possibly held liable. If the supervising physician is in the MCO's network, the MCO will have reviewed their credentials, potentially adding protection for member. HHSC continuously strives to not only improve access to care, but also streamline delivery of services and quality care. After evaluating feedback from multiple stakeholder groups, HHSC has decided not to take further action on this issue without legislative direction.				
Date Last Updated:	6/30/2016				

Executive Commissioner's Commitment to
Improving Member and Provider Experience in Medicaid Managed Care

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	57
Recommendation:	Require that the dental maintenance organizations (DMOs) submit proposed administrative changes to their respective "provider advisory committees" for input and then to HHSC health plan operations for approval before they are implemented. During this year, both DMOs tried to institute administrative changes that were in fact changes to Medicaid benefits and not within their authority to execute. Only the state may change Medicaid policy including changes to benefits. Particularly disturbing, one of the DMOs misrepresented AAPD policy in an attempt to support their administrative change. Subsequently, AAPD sent a letter to HHSC explaining that the DMO misinterpreted its policy. Every time erroneous administrative changes occur, it results in frustration and confusion for the dentist providers until the matter is resolved. It can also result in clients not being able to access their legally entitled dental benefits.				
Additional Stakeholder Background:					
Category:	Contract provisions				
Provided By:	Texas Dental Association				
HHSC Response:	DMOs must offer Medicaid benefits to the same amount, duration, and scope as the fee-for-service (FFS) benefits. DMOs, however, have the contractual latitude to mandate different prior authorization or pre-payment review requirements. Prior authorization or pre-payment review are within the scope of the DMOs' business operations. One DMO initiated an administrative change that was determined to be allowable within the scope of its contract. The administrative change by the other DMO was determined to be a misinterpretation of a benefit limitation and has since been appropriately addressed by HHSC.				
Date Last Updated:	4/11/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division:	HHSC-MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	59
Recommendation:	Incorporate contract provisions requiring MCOs to move down the path of value (quality) based contracting with providers. Quality Based Contracting – TAHC&H views quality-based contracting in managed care as the alternative solution to the across-the-board rate reductions we have seen over the years in managed care. Managed care companies seek to control costs and minimize their administrative burden by contracting with fewer providers. Indiscriminate, sweeping rate cuts have been the result when managed care seeks the lowest bidder. Rather than trimming the network in this way, TAHC&H would like to see managed care companies contracting based on quality and outcomes. For this to occur, much work will need to be done to identify which quality measures are going to accurately represent good care and ultimately any preferred contracting scenario.				
Additional Stakeholder Background:					
Category:	Alternative Payment Mechanisms				
Provided By:	Texas Association for Home Care & Hospice				
HHSC Response:	For the past three fiscal years, HHSC has incorporated contract provisions requiring MCOs to move down the path of value-based contracting with providers. Each MCO submits to HHSC an annual inventory of their value-based contracting initiatives with providers. This effort is further reinforced during quarterly one-on-one web-based meetings with MCOs where value-based payments are a standing agenda item. MCOs are also strongly encouraged to seek ways to evaluate and, if feasible, integrate high-value DSRIP projects into their networks. Based on the MCO deliverables and through HHSC discussions with MCOs, there are observable increases in the numbers of providers who are being paid via such value-based contracting arrangements. HHSC has observed MCOs often tend to adopt HHSC's Pay-for-Quality Program measures for their value-based contracting with providers. HHSC is continuing to work with the MCOs to encourage the use of value-based purchasing with providers. HHSC met internally to discuss what changes should be made for the fiscal year 2017 contract. It was determined that the contract language that is in place will be sufficient for next contract cycle. However, the deliverable associated with the contract provision (MCO submitted tracking tool and narrative description of their payment models) is being modified to help ensure accurate data collection. This will further enable HHSC to track MCO progress in this area. For future updates on the status of this activity, please see the response to recommendation 23. In addition, the value based purchasing (VBP) summary document for 2015 will be posted on the VBP webpage http://www.hhsc.state.tx.us/hhsc_projects/ECI/Value-Based-Payments.shtml.				
Date Last Updated:	6/20/2016				

Executive Commissioner's Commitment to
Improving Member and Provider Experience in Medicaid Managed Care

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

Executive Commissioner's Commitment to
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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	60
Recommendation:	Reward quality care through payment incentives. Quality Based Payments – Since SB 7 passed in the 83rd Texas Legislative Session (and even before then), Texas has been striving toward the ideal of rewarding quality care through payment incentives. But as the Sunset Commission alluded to in their report on the HHS enterprise, such endeavors have been somewhat uncoordinated. The new Office of Policy and Performance, as directed by SB 200 (84th regular session) should help with this. We would like to see health plan management staff work closely with Policy and Performance to gradually encourage the key system elements of a quality based payment system in managed care. Furthermore, for QBP to work for LTSS the state will need to continue its efforts to develop unique LTSS quality measures. TAHC&H would be grateful to continue our participation on this project.				
Additional Stakeholder Background:					
Category:	Alternative Payment Mechanisms				
Provided By:	Texas Association for Home Care & Hospice				
HHSC Response:	HHSC agrees that quality-related endeavors should be well coordinated and that administrative burdens should be kept to a minimum. HHSC continues to keep those goals in the forefront while exploring value-based contracting opportunities. HHSC agrees that the upcoming consolidation of quality areas from across the Enterprise required by SB 200 (Sunset Bill) presents an opportunity for this cooperation and streamlining. A number of Texas-specific measures have now been developed, but implementation of payment incentives for these measures is on hold due to the need for standardized, nationally recognized measures. LTSS will be included in the value-based payment program when such measures become available. HHSC will continue the internal workgroup focusing on coordination and streamlining efforts required by SB 200 (Sunset Bill). HHSC has incorporated contract provisions requiring MCOs to move down the path of value-based contracting with providers. Each MCO submits to HHSC an annual inventory of their value-based contracting initiatives with providers. This effort is further reinforced during quarterly one-on-one web-based meetings with MCOs where value-based payments are a standing agenda item. MCOs are also strongly encouraged to seek ways to evaluate and, if feasible, integrate high-value DSRIP projects into their networks. Based on the MCO deliverables and through HHSC discussions with MCOs, there are observable increases in the numbers of providers who are being paid via such value (quality) based				

	contracting arrangements. HHSC has observed MCOs often tend to adopt HHSC's Pay-for-Quality Program measures for their value-based contracting with providers. HHSC is continuing to work with the MCOs to encourage the use of value-based purchasing, and additional information will be reported in response to recommendation 23. The value based purchasing (VBP) summary document for 2015 will be posted on the VBP webpage http://www.hhsc.state.tx.us/hhsc_projects/ECI/Value-Based-Payments.shtml.
Date Last Updated:	7/1/2016

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	69
Recommendation:	Require DMOs to update their network rosters. The DMOs need to clean up their network rosters. This includes the "Find a Dentist" roster that is accessed by clients and the "Referring Dentist" roster that is accessed by main dentists needing to refer a client to a dental specialist. For each DMO, the rosters are a bloated confusing mess of dentist providers' contact information. Regarding the referring dentist roster, some provider dentists are listed upwards of 20 times at the same location/multiple locations while other dentists are listed only once at one location. Regarding the find a dentist roster, certain dentist providers are listed as a main dentist for locations in which it is logistically improbable for them to practice as a main dentist. Meaning, for example, that a dentist provider lives in Houston, but is shown in the roster as a main dentist for dental practices in Laredo, Mt Pleasant, El Paso, etc. The DMOs report that they have limited providers to four entries on the find a dentist roster, but that remains suspect. HHSC must require the DMOs to maintain accurate network rosters.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Dental Association				
HHSC Response:	HHSC conducts provider directory verification for the DMOs on a quarterly basis to identify inaccurate directory listings. HHSC may review DMO directory listings and request additional information from DMOs regarding credentialing practices and network adequacy as needed. HHSC is implementing additional standards for network adequacy as part of SB 760. The SB 760 workgroup is currently developing critical elements for the MCO online provider directories for inclusion in the UMCM. HHSC solicited stakeholder comments on Provider Directory Standards, including a Stakeholder Forum on 11/30/2015. These comments were incorporated into draft Provider Directory Standards released for additional comment in May 2016. The updated MCO Provider Directory standards will include new requirements for both print and online versions of MCO Provider D~~i~~rectories. Additional feedback was requested and received during the subsequent SB760 Stakeholder Forum held on 06/06/2016. HHSC will incorporate the additional comments into revised MCO Provider Directory standards. After the revisions have been added, the new draft of the Provider Directory standards will be provided to the S.B. 760 workgroup for agreement prior to submission through the HHSC UMCM amendment process. Stakeholders are requested to submit complaints and examples of inaccurate "Find a Dentist" or "Referring Dentist" rosters or dental plan provider directories to the HHSC Ombudsman (clients) or HHSC HPM (members and providers):				

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	HHSC Ombudsman Phone: 1-866-566-8989 Online: https://hhs.texas.gov/ombudsman HHSC HPM Email: HPM_complaints@hhsc.state.tx.us
Date Last Updated:	3/10/2017

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HHSC held Stakeholder Forum at which input was received regarding new MCO Provider Directory standards.	11/30/2015	Completed	
2	HHSC held another Stakeholder Forum at which additional input was received regarding draft MCO Provider Directory standards.	6/6/2016	Completed	
3	Incorporate additional recommendations from June 2016 Stakeholder Forum into draft MCO Provider Directory standards.	8/15/2016	Completed	
4	Obtain SB 760 workgroup agreement on the draft provider directory standards prior to submitting the new critical elements through the UMCM amendment process.	9/1/2016	Completed	
5	Submit HHSC new critical elements for MCO Provider Directories through UMCM amendment process.	10/1/2016	Completed	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	72/75
Recommendation:	Medical decisions should be made by trained medical providers who actually treat the person rather than by reading a written record or having a record reviewed by person from an unrelated medical discipline. • Long term supports and services authorizations should be made by persons who know the person and his/her support needs rather than by reading a written record. • If the person and the managed care system disagree with a decision, ensure a timely process to accommodate emergencies. Parents of children with special health care needs and adults with complex, chronic medical needs should be allowed to use a willing specialist as a primary care provider. • Both an informal independent and a formal external process is available if the person and the managed care system disagree with a decision, with a timely process to accommodate emergencies. • Parents of children with special health care needs and adults with complex, chronic medical needs may decide to use a willing specialist as a primary care provider. • Reductions and denials in covered services by managed care companies, such as reductions in attendant service hours authorized, should be tracked and aggregated data should be available quarterly to HHSC and the public by health plan, by contract area and by type of service.				
Additional Stakeholder Background:					
Category:	Service Coordination / Member Assistance				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas/ Disability Rights Texas				
HHSC Response:	HHSC STAR+PLUS and STAR Kids contracts require service coordinators to meet with members when assessing LTSS needs, prior to authorizing services. Prior authorizations are not required for emergency services and, when a provider submits a prior authorization request for non-emergency services, the MCO must respond within 72 hours. If a member's services are reduced or denied, the member (or their provider) may appeal. HHSC tracks appeals, grievances, and assesses liquidated damages against MCOs that do not meet the state's requirements related to timeframes. HHSC reports appeals and grievances related to STAR+PLUS in regular stakeholder meetings. HHSC allows specialists to be PCPs so long as they agree to fulfill the requirements of a PCP, which include the Texas Health Steps exams for children and young adults. Currently, members with special health care needs may have specialists serve as their PCPs in accordance with UMCC Section 8.1.4.2, “Primary Care Providers." In STAR+PLUS and STAR Kids, all members are considered members with special healthcare needs.				
Date Last Updated:	6/22/2016				

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Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	74f
Recommendation:	Ensuring data regarding network adequacy is publicly disclosed and requiring MCOs to report publicly on the impact of their provider networks on access to care.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas				
HHSC Response:	SB 760 requires HHSC to submit to the Legislature and make public a biennial report containing information on Medicaid members' access to healthcare services in managed care.				
Date Last Updated:	3/13/2017				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Internal completion of report; begin routing through internal processes.	9/15/2016	Completed	
2	Complete and publish report on MCO compliance with established network adequacy requirements.	12/1/2016	Completed	

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Agency/Division:	HHSC FSD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X This recommendation is addressed through an existing process. See details below.	**Number:**	74h
Recommendation:	Medicaid reimbursement rates for providers need to be appropriate to pay for services provided to people with disabilities.				
Additional Stakeholder Background:	Some people with disabilities may require more resources and longer visits to provide quality care and providers need to be reimbursed to reflect the additional time and resources needed.				
Category:	Rates				
Provided By:	EveryChild, Inc. / Texas Council for Developmental Disabilities / The Arc of Texas				
HHSC Response:	Rate increases are contingent on legislative appropriations. HHSC regularly requests increased funding to address rates where it deems increases are necessary. HHS agencies are currently preparing legislative appropriations requests for the FY18-19 biennium including exceptional items. Stakeholders will have an opportunity to provide input and recommendations through that process.				
Date Last Updated:	4/11/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	N/A			

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	74l
Recommendation:	Allow for members to access out-of-network providers without prior authorization if there is not a provider within 30 minutes or 10 miles from their home and/or if a request from a service coordinator does not get a response within 24 hours.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas				
HHSC Response:	SB 760 and new federal regulations require HHSC to establish minimum access standards, including time and distance, for MCO provider networks for certain provider types. CMS new federal regulations regarding Medicaid and CHIP managed care requirements were finalized in May 2016. The rules did not provide any specific time distance standards, but rather left it up to states to develop standards for certain categories. HHSC is reviewing mileage standards as part of the SB 760 workgroup, but does not have any plans to require out-of-network access without prior authorization. Today, if MCOs cannot provide medically necessary covered services through network providers, the MCO must, upon the request of a network provider, allow a referral to a non-network physician or provider. The MCO may require a prior authorization for the service.				
Date Last Updated:	6/20/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	77
Recommendation:	Payment that is equal to the published state benefit for all MCOs.				
Additional Stakeholder Background:					
Category:	Rates				
Provided By:	Outpatient Independent Rehabilitation Association				
HHSC Response:	HHSC currently does not set rates for services reimbursed by MCOs. MCOs are delegated the responsibility of managing a provider network and setting rates.				
Date Last Updated:	4/11/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	N/A			

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	78
Recommendation:	When Star Kids is effective 9/1/2016, what will be the procedure for allowing providers to enroll in the contracted network?				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Outpatient Independent Rehabilitation Association				
HHSC Response:	When STAR Kids is implemented on 11/1/2016, the program will follow all procedures as other carve-ins. HHSC will require MCOs to recruit and offer contracts to significant traditional providers (STPs) who have been delivering benefits to individuals who will be served in STAR Kids. As in previous managed care expansions, STAR Kids MCOs are required to offer contracts to STPs who have been actively serving children and young adults eligible for the STAR Kids program.				
Date Last Updated:	4/11/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division:	HHSC-MCD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	82
Recommendation:	Change the timeframe when a member can switch plans from 30 to 90 days. Timeframe around member ability to switch plans: Currently members can change MMC plans every 30 days; we are asking to expand that timeframe to every 90 days. When a change occurs, providers must go through the process of obtaining new orders/documentation and a new PA. Members are not aware of the potential consequences of the change and how it impacts their current and future benefit.				
Additional Stakeholder Background:	During the December 8, 2016 stakeholder meeting with Executive Commissioner Traylor, Mr. Jeremy Crabb, Texas Rehab Providers Council, provided the following additional information: Mr. Jeremy Crabb stated that after discussing this in the previous meeting, his organization went back and researched the patient population to identify where the switches occurred. In the last 90 days, 3 percent switched back to MCOs, 30 percent of whom switched two or more times. Half of that population is eligible for STAR Kids.				
Category:	Continuity of Care				
Provided By:	Texas Rehab Providers Council				
HHSC Response:	HHSC must follow federal regulations and state law with respect to Medicaid members' ability to change plans. Federal regulation requires HHSC to let members change plans at any time for specific reasons. Review of data has shown that the majority of members who change plans are doing so for reasons allowed by federal regulation.				
Date Last Updated:	4/11/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division:	HHSC Financial Services	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X This recommendation is addressed through an existing process. See details below.	**Number:**	84 / 86
Recommendation:	Ensure that provider payments, including direct service professionals/attendants, are sufficient to support service delivery transformations, such as expansion of managed care.				
Additional Stakeholder Background:	Payments to support managed care goals - Ensure that provider payments, including direct service professionals/attendants, are sufficient to support service delivery transformations, such as expansion of managed care. HHSC should analyze and publicize rates and the impact of rates on timeliness of assessments, access to needed health/medical services and recruitment and retention of attendant/direct support professionals. This report should include information about potentially preventable events such as hospital or long term care facility admissions, readmissions; conditions that could have been prevented; trends and quality improvements needed. This report should note any inequities regarding wages and/or benefits across settings within Medicaid managed care and in traditional Medicaid. The analysis should include recommendations to improve rates when gaps in access to health care or in-home supports and services inequities across settings are identified. Service coordinators should be qualified and compensated to meet the needs of individuals with complex behavior and medical needs, both inside the MCO and elsewhere versus being the lowest paid workers. Medicaid reimbursement rates for providers need to be appropriate to pay for services provided to people with disabilities. Some people with disabilities may require more resources and longer visits to provide quality care and providers need to be reimbursed to reflect the additional time and resources needed.				
Category:	Rates				
Provided By:	Disability Rights Texas / EveryChild, Inc. / Texas Council for Developmental Disabilities / The Arc of Texas				
HHSC Response:	Rate increases are contingent on legislative appropriations. HHSC regularly requests increased funding to address rates where it deems increases are necessary. HHS agencies are currently preparing legislative appropriations requests for the FY18-19 biennium including exceptional items. Stakeholders will have an opportunity to provide input and recommendations through that process.				
Date Last Updated:	4/11/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	N/A			

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Agency/Division:	HHSC Financial Services	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	87
Recommendation:	Increase payments to cover costs of physicians acquiring long-acting reversible contraceptives (LARCs), such as IUDs, to promote greater use of the devices and to help reduce Texas' rate of unplanned pregnancies.				
Additional Stakeholder Background:					
Category:	Rates				
Provided By:	TMA / TPS				
HHSC Response:	Currently FFS LARC reimbursement rates are reviewed every two years. Rates could be reviewed more often in order to keep rates more closely aligned with provider costs. Practitioners also have the option to order LARCs from a pharmacy and have the LARC shipped to the practitioner's office; this option eliminates any cost to the provider relating to the actual LARC. HHSC has reviewed this issue, and will now review LARC rates every year. The review of LARCs will be presented annually in the November public rate hearing with an effective date of January 1, starting with November 2016.				
Date Last Updated:	6/24/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	94
Recommendation:	Continue seeking input from individuals, families and LTSS providers regarding processes they deem are burdensome and delay access to services, streamlining such as appropriate via a combination of ongoing workgroups and at least annual feedback from stakeholders.				
Additional Stakeholder Background:					
Category:	Stakeholder engagement and feedback				
Provided By:	PPAT				
HHSC Response:	HHSC appreciates the ongoing commitment of our stakeholders to provide meaningful feedback on the Medicaid program. We will continue to look for ways to strengthen our communication with members, advocates, providers, and MCOs. HHSC has initiated a new Medicaid and CHIP stakeholder forum as an opportunity to learn about changes to policy that impact the many individuals served by Medicaid and CHIP. The first of these all-inclusive stakeholder meetings will be held on July 26, 2016, 1:00 - 5:00 p.m. Through our advisory committees, individuals with disabilities are given opportunities to serve and express their concerns regarding the quality of care received. Several advisory committees are in the process of identifying members as a result of the Executive Commissioner's decisions to reestablish the Texas Council on Consumer Direction and the State Medicaid Managed Care Advisory Committee. These committees—in addition to the Intellectual and Developmental Disabilities (IDD) System Redesign Advisory Committee (SRAC), the BHIAC, Medical Care Advisory Committee, and the STAR Kids Advisory Committee—provide a forum for stakeholder input on policies impacting the delivery of Medicaid managed care services. Using the forums described above, HHSC will continue to consider feedback from families, individuals with disabilities receiving services, and LTSS providers on a number of policies, including ways to alleviate burdensome processes. HHSC will actively seek feedback by adding topics to current appropriate stakeholder forum agendas.				
Date Last Updated:	6/24/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	96
Recommendation:	Regularly scheduled meetings of LTSS IDD providers, MCOs, and Local Intellectual and Developmental Disability Authorities (LIDDAs) should be held at the local level.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	PPAT				
HHSC Response:	The IDD SRAC recommended MCOs, LIDDAs, and the LTSS Department of Aging and Disability Services (DADS) waiver providers meet routinely through regional healthcare collaborations to address operational issues and specific case issues. Regional healthcare collaboration meetings may assist in resolving day-to-day operational challenges as the MCOs, LIDDAs, and providers have an opportunity to work through specific cases. One LIDDA, Texana, has used a regional collaborative to problem-solve issues around implementation of Community First Choice .The collaborative was so successful they intend to continue to meet to problem solve other issues. HHSC encourages problem solving and collaboration at a local level.				
Date Last Updated:	June 22, 2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

Executive Commissioner's Commitment to
Improving Member and Provider Experience in Medicaid Managed Care

Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	99
Recommendation:	Hold stakeholder meetings with HHSC and MCOs to specifically discuss issues with MCOs on a quarterly basis to increase the transparency of MCO operations.				
Additional Stakeholder Background:					
Category:	Stakeholder engagement and feedback				
Provided By:	Outpatient Independent Rehabilitation Association				
HHSC Response:	Though some of the MCOs conduct their own forums with stakeholders on a regular basis, the suggestion for a more inclusive forum that includes HHSC staff as well as MCO representatives is appreciated and will be taken under consideration. HHSC will continue to make efforts to work closely with the MCOs and various stakeholder groups to address concerns through the newly formed State Medicaid Managed Care Advisory Committee (SMMAC) that the Executive Commissioner reinstituted after the passage of SB 200, 84th Legislature. HHSC plans to use the SMMAC to work with stakeholders and MCOs. In addition to the SMMAC, HHSC will continue to hold the IDD Managed Care Workgroup meetings on a quarterly basis. HHSC will host regular STAR Kids stakeholder meetings. These meetings include stakeholders, MCOs, and HHSC and DADS staff. In addition, HHSC has initiated a new Medicaid and CHIP stakeholder forum as an opportunity to learn about changes to policy that impact the many individuals served by Medicaid and CHIP. The first of these all-inclusive stakeholder meetings will be held on July 26, 2016, 1:00 - 5:00 p.m.				
Date Last Updated:	6/24/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

Executive Commissioner's Commitment to
Improving Member and Provider Experience in Medicaid Managed Care

Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	102
Recommendation:	Move non-emergency ambulance transportation out of the Managed Care System and under the oversight of HHSC. Due to the number of MCOs in Texas, there are numerous ways that transportation is being managed. Some MCOs are managing internally and some are outsourcing it to numerous transportation brokers. Large regional providers and local ambulance providers that provide non-emergency transportation are experiencing an enormous administrative burden regarding plan eligibility, plan requirements and claim submission requirements.				
Additional Stakeholder Background:					
Category:	Contract Provisions				
Provided By:	Acadian Ambulance Service of Texas				
HHSC Response:	HHSC does not plan to carve-out ambulance services from Medicaid managed care. However, HHSC is currently exploring options to streamline non-emergency ambulance transportation and will continue to work with stakeholders.				
Date Last Updated:	7/1/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	NA			

Executive Commissioner's Commitment to
Improving Member and Provider Experience in Medicaid Managed Care

Agency/Division:	HHSC Financial Services	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X This recommendation is addressed through an existing process. See details below.	**Number:**	105
Recommendation:	Raise the current base HCBS rate for community attendants.				
Additional Stakeholder Background:	The current base HCBS rate for Community Attendants is $7.86. On September 1, 2015 the base rate will increase $.14 to $8.00. Advocacy groups over the last 18 months had engaged in a $10 Campaign that pushed for $10 as the base rate for Community Attendants during the 84th Legislative Session. The outcome of only a $.14 increase to $8 for workers in HCBS programs was disappointing.				
Category:	Rates				
Provided By:	ADAPT Texas				
HHSC Response:	Rate increases are contingent on legislative appropriations. HHSC regularly requests increased funding to address rates where it deems increases are necessary. HHS agencies are currently preparing legislative appropriations requests for the FY18-19 biennium including exceptional items. Stakeholders will have an opportunity to provide input and recommendations through that process.				
Date Last Updated:	4/11/2016				

Major Milestones with Status Updates: (Add additional lines as needed to detail each major milestone. Milestones do not need to be completed sequentially.)

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	N/A			