Alternative Payment Mechanisms

#	Stakeholder Recommendation	Provided by	Status	HHSC Response	Next Steps and Key Milestones
22	**Promote adoption of innovative payment models.** The Behavioral Health Integration Advisory Committee (BHIAC) developed recommendations to encourage the use of innovative payment models for managed care providers. Traditional fee-for-service provider reimbursement is the most common form of payment in both the Texas fee-for-service and managed care models. This payment model reimburses for specific services. For behavioral health providers, these services generally include counseling sessions, mental health rehabilitative services, and targeted case management. Behavioral health professionals provide many services that are not reimbursed under the fee-for-service payment model, such as: provider-to-provider communication, phone conversations with members, services provided by multiple providers in the same group on the same day, and member navigation. These vital yet uncompensated services could be captured through alternative payment structures in a way that achieves meaningful health outcomes and cost efficiencies. The BHIAC recommendation is consistent with emerging federal policies. The Centers for Medicare and Medicaid Services (CMS) proposed managed care rule revisions (May 2015) and the Substance Abuse and Mental Health Services Administration (SAMSHA) grant for Certified Community Behavioral Health Clinics (CCBHCs) both encourage states to develop value-based, alternative payment models for managed care providers.	Texas Council of Community Centers	In progress	HHSC is exploring ways to more effectively recognize medical costs when setting MCO rates. This is an activity driven in part by CMS policy changes on what counts as administrative vs. medical costs. HHSC has established a Quality Improvement (QI) Cost Allocation workgroup, which is working on a two-year project with Medicaid-CHIP MCOs to integrate the new CMS guidance. This effort could support greater payment innovation by MCOs and healthcare providers. Additionally, HHSC has received funding through CMS/SAMSHA for a planning grant to establish a certification process for integrated care clinics (mental health, substance use disorder, limited primary care), and develop a prospective payment model (e.g. bundled payment) to support innovative and effective service provision. HHSC will also apply for a demonstration grant. HHSC is also interested in partnering with stakeholders and MCOs on facilitating innovative payment models. Sec 8.1.7.8.2 of the Texas Medicaid Uniform Managed Care Contract (UMCC) already encourages value-based contracting. Staff is considering ways to expand this option.	The templates for the Quality Improvement section of the Financial Statistical Reports (FSRs) will be designed and distributed to the MCOs by 6/1/16. MCOs will begin reporting Quality Improvement Costs to HHSC on their FSRs in the first Quarter of SFY 2017. The SAMSHA Grant project requires identification of special populations for different prospective payment system (PPS) rates. HHSC staff will begin working with the eight potential project sites to identify these populations. This will drive cost reporting and PPS development. The locations are a mix of rural, urban, and hybrid areas. HHSC is in the process of producing a de-identified summary document to post onto HHSC's quality website of current innovative payment models being used in managed care. In addition, the templates used for this provision are being reviewed for revision to capture additional information.
23	**Promote adoption of innovative Medicaid delivery models, such as physician-led accountable care organizations or patient-centered medical homes, as well as value based purchasing initiatives, such as gain sharing, to reward physicians for improving Medicaid quality and reducing costs.** At the recent Texas Medicaid Congress facilitated by TMA, several physicians noted they were interested in partnering with health plans to test new models of care, but either had no interest from the MCO(s) in their region or were unsure how to initiate the discussion. HHSC should facilitate efforts by physicians and MCOs to test new delivery system and payment models.	Texas Medical Association (TMA)/ Texas Pediatric Society	In progress	For the past three fiscal years, HHSC has incorporated contract provisions requiring MCOs to move down the path of value (quality) based contracting with providers. Each MCO submits to HHSC an annual inventory of their value (quality) 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 use the measures HHSC uses in its Pay-for-Quality Program as measures in their value-based contracting with providers.	HHSC is continuing to work with the MCOs to encourage the use of value-based purchasing with providers and is also considering changes to the managed care contract.
59	**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.	Texas Association for Home Care & Hospice	In progress	For the past three fiscal years, HHSC has incorporated contract provisions requiring MCOs to move down the path of value (quality) based contracting with providers. Each MCO submits to HHSC an annual inventory of their value (quality) 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 use the measures HHSC uses in its Pay-for-Quality Program as measures in their value-based contracting with providers.	HHSC is continuing to work with the MCOs to encourage the use of value-based purchasing with providers and is also considering changes to the managed care contract.
60	**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.	Texas Association for Home Care & Hospice	In progress	HHSC agrees that quality-related endeavors should be well coordinated and that administrative burdens should be kept to a minimum, and continues to keep that goal in the forefront as HHSC explores 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. HHSC welcomes TAHC&H feedback on development of LTSS measures, which will commence soon after the implementation of already developed measures.	HHSC will continue the internal workgroup focusing on coordination and streamlining efforts required by SB 200 (Sunset Bill).

103	**Conduct data analysis to support incentive payments.** Conduct an analysis to compare and compute: A. Hospital outpatient out-of-network rates of contracted services: B. Dollar impact of high utilization of outpatient and ER services; and C. Development of potential incentive payments to MCOs that control outpatient rates of utilization. The expanded analysis can be used to confirm or refute the correlations between high rates of outpatient utilization and high rates of non-contracted network providers. In addition, the agency can use the expanded analysis to measure the fiscal impact that high utilization rates have on managed care costs. The agency can use this data to consider providing incentive payments to high performing MCOs. THHSC can use this analysis to get a better understanding of the out-of-network activity. The current out-of-network rules tie the hands of providers and give a big advantage to Medicaid MCOs.	Texas Hospital Association	Under consideration	HHSC collects information vital to monitoring utilization rates in the program.	HHSC will consider expanding impact analyses to incorporate this feedback.

Benefits

#	Stakeholder Recommendation	Provided by	Status	HHSC Response	Next Steps and Key Milestones
26	**Texas Medicaid coverage of Health & Behavior (H&B) codes should be expanded to include services provided in the tertiary care environment.** Since April 1, 2014, health and behavior assessment and intervention (HBAI) 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.	CHAT (Children's Hospital Association of Texas)	Under consideration	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 do a policy scan 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.
27	**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.	CHAT (Children's Hospital Association of Texas)	In progress	HHSC is drafting policy language to implement this recommendation for stakeholder comment.	Once drafted, the policy will be posted on HHSC's Medical Policy Review webpage for stakeholder comments: http://www.hhsc.state.tx.us/medicaid/MPR/index.shtml Timeline is dependent upon prioritization within the medical policy review process.
28	**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.	CHAT (Children's Hospital Association of Texas)	In progress	HHSC has initiated a review of all Medicaid behavioral health services and will include coverage for services without patient present in this review. HHSC is drafting policy language to implement this provision for stakeholder comment.	Once drafted, the policy will be posted on HHSC's Medical Policy Review webpage for stakeholder comments: http://www.hhsc.state.tx.us/medicaid/MPR/index.shtml Timeline is dependent upon prioritization within the medical policy review process.
29	**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.	CHAT (Children's Hospital Association of Texas)	Under consideration	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 do a policy scan 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.

30	**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.	CHAT (Children's Hospital Association of Texas)	Under consideration	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 do a policy scan 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.
31 33 38	**Texas Medicaid coverage should include peer support services.** Improve access to mental health and substance use peer services provided by certified peer specialists. To accomplish this, HHSC should develop rules to define peer services, identify the requirements for certification, and specify supervision requirements. This needs to be done to ensure that quality services are available. We have accomplished a lot in this area already but the timing is right for refining and expanding. MCOs should be educated on the benefits of peer support services and encouraged to make these services available. Currently, peers are approved providers of mental health rehab services, but "peer support services" do not always align with rehab services. Additionally, LMHAs are currently the only providers of rehab services so until "peer support services" are validated as a reimbursable service, where these services can be provided will continue to be limited. Similar to peer support for individuals with mental illness, implement peer support services as a Medicaid paid benefit for people with developmental disabilities.	Disability Rights Texas/TMA/Texas Pediatric Society/Hogg Mental Health Foundation	Under consideration	HHSC staff are working with the Office of Mental Health Coordination and other stakeholders to determine the feasibility of adding peer support services to the Medicaid program. Depending on the findings of the group, legislation and/or an appropriation may be needed.	HHSC staff are working to develop cost assumptions and an exceptional item may be considered. Staff is also drafting policy language for input from the peer support services workgroup.
32 a-f 35 73	**Improve the provision of durable medical equipment to individuals receiving Medicaid services through a Managed Care Organization.** **1)** Require that assessments are done within a specified period of time. **2)** Require the delivery of DME within a specified period of time. **3)** Require the MCO contract with DME companies that can provide loaner or rental equipment to individuals while they transition from facility based care or while they are waiting on their equipment to be delivered. **4)** Require expedited appeals of DME denials. **5)** Allow for consumers to request and be granted single case agreements for DME when the company they have established a trusted relationship with is not within network. **6)** Coordinate a process to review and address system inconsistencies in how MCOs are providing and denying DME. Issues to be addressed include, but are not limited to: Not all MCOs are providing the same scope of DME as that available to fee-for-service clients. Not all MCOs are applying the medical necessity standard for DME established in Medicaid policy. Not all MCOs are informing beneficiaries of the opportunity to request an exceptional circumstances appeal for items of DME not otherwise listed in agency rule. Some MCOs are applying Medicare criteria instead of Texas Medicaid standards for certain DME requests. Some MCOs are denying DME requests based upon "bundling" and "coding" issues. These are not matters that a beneficiary can address in a fair hearing to challenge the denial. Some MCOs are advising the DME supplier to change the specific items requested in order to secure an approval. Some MCOs are requiring individuals to change DME providers even when their chosen provider is in network. Denial notices that are not legally sufficient, for example: Providing a list of medical necessity criteria without specifying which ones apply in a particular case. Simply informing the beneficiary that the requested DME item is "not part of your health plan." Denying an item of DME without identifying the rule or policy that supports the denial. Telling the beneficiary to contact his or her physician about the denial.	Disability Rights Texas/Every Child, Inc./Texas Council for Developmental Disabilities/The Arc of Texas	In progress	MCOs are required to assess members within the timeframes outlined in their contract. HHSC will review these timelines to ensure they are reasonable and will continue to monitor MCOs to ensure the assessments are happening in a timely manner. HHSC staff conduct desk reviews of standard operating policies and procedures, including prior authorization of DME. HHSC ensures that authorizations for DME follow Medicaid policy, as well as federal and state laws. HHSC will consider the concerns identified here and is committed to strengthening the oversight process in this area.	HHSC will review managed care DME-related complaints on a quarterly basis. This will enable trending and analysis regarding specific MCOs that receive the most complaints as well as the reasons for the complaints. Stakeholders are requested to submit complaints and examples of untimely assessments to the HHSC Ombudsman (clients) or HHSC Health Plan Management (providers): **HHSC Ombudsman** Phone: 1-877-787-8999 (Toll-Free) Online: https://www.hhsc.state.tx.us/ombudsman/complaint-process.shtml **HHSC Health Plan Management** Email: HPM_complaints@hhsc.state.tx.us or STAR.Health@hhsc.state.tx.us (for complaints specific to the STAR Health program) HHSC is also reviewing the contractual timelines by which MCOs are required to assess members, and will continue to ensure the assessments are happening in a timely manner. Additionally, HHSC is reviewing the recommendations that would also affect Medicaid fee-for-service policies.
36	**Collaborate with physicians and other stakeholders to develop an interconception care program for women at risk for low-birth weight babies or premature delivery.** Our organizations strongly support HHSC's plan to automatically enroll women into the women's health program when they lose pregnancy Medicaid coverage 60 days postpartum (the new process will begin in July 2016). Providing women timely access to family planning and preventive health screenings will help women to better time and space their pregnancies and to detect chronic conditions earlier. However, if a physician determines the patient needs ongoing chronic care management or treatment, few resources exist. Women with a prior premature delivery or a chronic illness, such as hypertension or diabetes, are at greater risk of poor birth outcomes, thus jeopardizing not only the health of the mother and baby but also increasing Medicaid birth-related costs. A healthy pregnancy begins well before conception. Establishing an interconception care program that provides treatment of chronic conditions will help achieve our mutual goals of improving the health of women and their babies.	Texas Medical Association (TMA)/Texas Pediatric Society (TPS)	In progress	HHSC's Better Birth Outcomes Workgroup is working to improve access to women's preventative, interconception, prenatal, and perinatal health care. Some of the initiatives related to interconception care include: - Automatic enrollment of eligible women into Healthy Texas Women program after pregnancy coverage expires will begin on July 1, 2016. - Healthy Texas Women Website - comprehensive website to educate women and providers about the array of family planning and primary care services available and how to navigate between the different programs. (https://www.healthytexaswomen.org/) - Someday Starts Now - DSHS program developed to help Texas communities decrease infant mortality using evidence-based interventions. The website features tools for providers in the healthcare and community settings, Life Planning and Birth Planning Tools, videos on the importance of breastfeeding, partner involvement, and preconception health as well as information for men and women of childbearing age for before, during and between pregnancies. (https://www.dshs.state.tx.us/healthytexasbabies/Someday-Starts-Now.doc) Additionally, the Women's Health Advisory Committee created by Senate Bill 200 of the 84th Legislature (Regular Session) will advise HHSC on women's health programs. This advisory committee began meeting in September 2015. (https://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/whac.shtml)	Automatic enrollment of eligible women into Healthy Texas Women program after pregnancy coverage expires will begin on July 1, 2016. HHSC is committed to improving access to interconception care and encourages continued stakeholder feedback through the Women's Health Advisory Committee.
37	**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.	Texas Medical Association (TMA)/Texas Pediatric Society (TPS)	Under consideration	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 will follow-up with TMA and TPS no later than May 1, 2016 to identify drug screens that are not being covered and circumstances where prior authorization may have been inappropriately applied.

39	**Ensure that Texas enforces mental health parity, allowing individuals receiving Medicaid managed care services to access needed mental health treatment.** Initial steps could include increased monitoring of MCO activity, educating plan members on mental health parity, and ensuring parity complaints receive priority attention. Millions of Texans currently have private health insurance either through their employer or self-funded plans. According to the Mental Health Parity and Addictions Equity Act of 2008 (MHPAEA), these individuals are guaranteed access to the mental health and substance use disorder benefits at the same level as medical and surgical benefits. However, many individuals find themselves facing barriers to treatment including caps on the quantity of treatment, high copays, or separate deductibles for people seeking mental health treatment. According to the Department of Labor, to date, the U.S. government has not taken a single public enforcement action against an insurer or employer for violating the laws established through MHPAEA.	Hogg Foundation for Mental Health	In progress	Mental Health Parity generally requires MCOs to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) for mental health or substance use disorder benefits are generally no more restrictive than requirements or limitations applied to medical and surgical benefits. HHSC currently requires that all MCOs comply with parity regulations. Additionally, HHSC continues to evaluate and modify current contractual requirements to ensure MCOs comply with all elements of MHPAEA. Recent federal draft rules more clearly outline parity requirements specifically for Medicaid members. These draft rules include information that would further strengthen and require states to demonstrate their compliance with mental health parity.	HHSC awaits the final rules from CMS related to mental health parity and application within Medicaid managed care. These rules may drastically change how HHSC monitors and evaluates mental health parity compliance. Further, this will impact how parity regulations are operationalized in managed care contracts, how HHSC solicits stakeholder feedback on parity regulations, and how plans are to make parity determinations. Until the final guidance is issued, HHSC continues to track and address parity complaints and requires that health plans comply with all applicable elements of MHPAEA.
53	**Establish measures for growth of consumer directed services 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 (FMSAs), yet there seems to be no mechanism for authorization, no billing code and no provider rates.	Coalition of Texans with Disabilities	In progress	HHSC is gathering information about CDS utilization in managed care. HHSC is analyzing the data to determine the most appropriate measures after a baseline is established. HHSC is working with MCOs to ensure individuals are well-informed about the CDS option. HHSC recently published training for MCO service coordinators to ensure they are able to accurately and more completely explain the CDS option. Rates for support consultation would need to be developed and will likely require legislative direction.	HHSC is requiring the MCOs to submit a new report on CDS utilization in managed care that uses claims data rather than authorization data. The first report (Q1 of State FY2016) is due in the third quarter of State FY 2016. The lag in the report allows adequate time for a claim to be processed. HHSC will analyze these data for 1 year to establish a baseline for each MCO, for which following years may be compared to establish a measurement of growth in members using the CDS option. Because the report is lagged for 2 quarters to allow adequate time for claims submission and adjudication, State FY 2016 reporting will be complete in Q3 of State FY 2017, which will close the year of baseline measurement.
68	**Closely monitor that the DMOs are only allowing clients to receive dental treatment at an ASC under general anesthesia when the situation clearly dictates the treatment modality.** Within Medicaid, there is an increase in the number of ambulatory surgical centers (ASCs) directly employing dentists and advertising to clients and main dentist providers encouraging them to schedule clients for dental care under general anesthesia. The advertising focuses on receiving dental care "while sleeping" and having all dental services completed in one visit. It is often unclear from the advertising whether the dental care is being delivered by a pediatric dentist at the ASC. Parents of pediatric patients are led to believe their child is receiving specialty care when in fact, a general dentist is performing the dental services.	Texas Dental Association	In progress	HHSC is developing a workgroup to further review this issue. The workgroup will look into ASC utilization practices with the collaboration of relevant stakeholders including IDD and provider groups.	The issue of dental anesthesia administered in ambulatory surgical centers is connected to the review of anesthesia policy that is currently underway. Actions of a proposed workgroup are dependent upon the timeline for anesthesia policy review. An update on these timelines will be provided on the next posting.
40	**Ensure full access to EPSDT services.** The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate ensures for the provision of screening, diagnosis, and treatment. While individual state Medicaid programs may place a limitation on the number of treatment sessions provided annually, they also include—for most part—exceptions processes to address those medically necessary services that require treatment beyond the stated limitation caps. HHSC should be sure to monitor such limits to ensure the children covered under Managed Care Organizations (MCOs) have full access to EPSDT mandated services as stipulated in the Texas Medicaid Manual.	Texas Speech-Language-Hearing Association	In progress	MCOs are required to provide EPSDT services (also known as THSteps) to all child members, including all services in the TMPPM (See UMCC 8.1.3.2).	HHSC will work with stakeholders to identify any inconsistencies among the plans and work to remedy them.
47	**Texas Medicaid should include reimbursement to physicians for venipuncture performed and analyzed in the physician's in-office lab.** Revise the payment policy to reimburse physicians for venipuncture performed and analyzed in the physician's in-office lab. The Medicaid manual (section 9.2.41.2 Laboratory Handling Charge) states that a physician may bill a laboratory handling charge for obtaining a specimen via venipuncture or catheterization and sent to an outside lab. Many physicians have in-office, moderately complex labs and run many tests in house. The current policy does not reimburse them for the staff costs or supplies of obtaining the specimen.	Texas Medical Association (TMA)/Texas Pediatric Society (TPS)	Under consideration	HHSC requires additional information from TMA/TPS to determine whether changes can be implemented to appropriately address this recommendation, as Medicaid currently provides reimbursement for numerous laboratory procedures and to numerous provider types.	HHSC will follow-up with TMA and TPS no later than May 1, 2016 to identify in-office lab services not covered.

Claims

#	Stakeholder Recommendation	Provided by	Status	HHSC Response	Next Steps and Key Milestones
42	**Require MCOs to use authentication factors including name, DOB, and sex as a determination of eligibility.** Demographic information for Claims processing becomes an issue when there is a middle name or suffix. Most Managed Care Plans will deny a claim if the name is not submitted exactly as it appears in their system. This causes delay in claims processing. Managed care plans should use an authentication factor that includes the name, DOB, and sex as a determination of eligibility opposed to denying a claim because the name is incorrect.	CHAT (Children's Hospital Association of Texas)	Under consideration	HHSC will coordinate with the MCOs to research whether changes can be implemented to appropriately address this recommendation; however, it is common for clients to provide HHSC and the MCOs with one version of their name and provide a different version of their name to a provider, limiting the ability of HHSC and the MCOs to effectively resolve this issue.	HHSC will reach out to CHAT and the MCOs no later than May 1, 2016 to schedule a meeting to further discuss potential solutions to this issue.
43	**Expedite processing of new providers to facilitate claims processing.** Timely processing of new providers for claim determination. Once we receive attestation from TMHP many Managed Care Plans take up to 60 days to update their system, which causes delays in payment to providers. It would be beneficial for TMHP and the Managed Care Organizations to work from the same attestation system to prevent delays in providers being added to the Managed Care Plans.	CHAT (Children's Hospital Association of Texas)	In progress	As part of SB 760, HHSC is reviewing expedited credentialing standards.	HHSC will continue with implementation of SB 760, internal projects that will improve the Provider Enrollment process, and coordination on external projects with the MCOs that will improve the Provider Credentialing process. HHSC is convening a stakeholder forum on June 6, 2016 to discuss expedited credentialing as well as other SB 760 requirements.
44	**Require consistency of claim denial reasons for both TMHP and MCOs.** We receive claim denials for the same reason, but we receive different Denial codes from the Managed Care Plans and TMHP. This is an administrative burden for the provider's staff when attempting to rectify denials for the same reason.	CHAT (Children's Hospital Association of Texas)	Under consideration	All adjudication entities are required to use HIPAA code values in communicating with providers. HHSC will coordinate with CHAT to address the specifics of the reported issue.	HHSC will reach out to CHAT no later than May 1, 2016 to schedule a meeting to further discuss potential solutions to this issue.
45	**Ensure Texas Medicaid recognizes all appropriate claims modifiers. If a modifier is not covered, the Medicaid fee-for-service or MCO provider manual should list any modifiers that are not recognized.** Reducing physician frustration and practice costs.	Texas Medical Association (TMA)/Texas Pediatric Society	Under consideration	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.	HHSC will reach out to TMA/TPS no later than May 1, 2016 to schedule a meeting to further discuss potential solutions to this issue.

61	**Improve accuracy of eligibility data communicated between TMHP and MCOs.** More up to date eligibility determination between TMHP and Managed Care Plans. We encounter issues where Managed Care plans have delays in uploading the State eligibility files, which cause erroneous denials related to eligibility. If Managed Care Plans were capturing eligibility timely it would prevent delays in payment. This may also cause issues if a patient has switched plans and the possibility of their treatment not being reported timely could cause delays in the family receiving other benefits, such as TANF, etc.	CHAT (Children's Hospital Association of Texas)	Under consideration	MCOs are contractually required to upload eligibility files in a timely manner. HHSC will work with CHAT to identify and enforce any specific MCO contract compliance issues.	HHSC will reach out to CHAT no later than May 1, 2016 to schedule a meeting to further discuss this issue and pursue a remedy if appropriate.

Communications

#	Stakeholder Recommendation	Provided by	Status	HHSC Response	Next Steps and Key Milestones
47	**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.	Coalition of Texans with Disabilities	In progress	HHSC will work to communicate this information in the timeliest manner possible and will work to share this information in additional forums such as MCO leadership meetings and through weekly notices. MCO rate communications to providers depend on when HHSC releases the information. While HHSC strives to be proactive in communications regarding rates, there are times when this is not possible.	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.
48	**HHSC should require 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.	Texas Dental Association	Under consideration	Providers have the ability to refer a patient who frequently misses appointments to the Texas Health Steps Outreach & Informing Unit for follow-up. DMOs are required by contract to train providers about the availability of the Texas Health Steps Outreach & Informing Unit's services. In addition, DMO member handbooks emphasize the importance of keeping or properly rescheduling appointments. Finally, 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 discuss ideas to address this issue with the DMOs in the upcoming quarterly HHSC/DMO meeting tentatively scheduled for April 2016 and determine what actions are possible.
49	**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.	Texas Dental Association	Under consideration	HHSC will review the process of sharing names of authorized representatives to identify areas where changes can be made to improve the process.	HHSC is currently analyzing the legal implications of this change and will inform the Texas Dental Association of the outcome by June 1, 2016.
50	**Provide all assessments for services to the consumer as they are completed and not only upon request.** Ensure transparency and continuity for consumers by requiring that all assessments for determining eligibility for waiver services, personal assistance services, habilitation, Community First Choice, Private Duty Nursing, Personal Care Services, durable medical equipment and therapy services as well as the Individual Service Plan are uniformly provided to the individual when completed and not just upon request.	Every Child, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas	Under consideration	HHSC will take this request into consideration as we develop policy regarding assessments for these populations. MCOs report a significant expense to print assessments to share them with members. For example, the CFC Assessment (H6516) is 20+ pages.	HHSC is still taking this suggestion under consideration and will continue to work with the MCOs on ways to share information with individuals receiving services about their assessments and service plan.

52 a	**Require MCOs to share meaningful and actionable data with physicians.** Require MCOs to share meaningful and actionable data with network physicians, such as notification of patient emergency department usage and prescription data, as well as providing confidential comparative data on their practice's utilization and costs. Further, some health plans indicate they meet at least quarterly with network physicians to review performance data and practice issues. This promotes dialogue between the physicians and MCOs as well as opportunities for the MCO to be aware of hassles experienced by physicians and patients that might not otherwise be elevated.	Texas Medical Association (TMA)/Texas Pediatric Society	In progress	HHSC will survey plans to find out how frequently they share data with physicians and will consider implementing a contract requirement if appropriate.	HHSC will work with the Texas Association of Health Plans to gather information from the MCOs regarding the frequency they share information with physicians and acute care providers and may consider future contract amendments.
52 b	**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.	Texas Medical Association (TMA)/Texas Pediatric Society	In progress	HHSC will survey plans to find out what their processes are to share this information with physicians and will consider implementing a contract requirement if appropriate.	HHSC will work with the Texas Association of Health Plans to gather information from the MCOs regarding a process to share this information with physicians and may consider future contract amendments.
11 e	**Implement expedited communications to notify MCOs and physicians of drug shortages.**	Texas Medical Association (TMA)/Texas Pediatric Society	In progress	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.	Beginning May 1, 2016, when HHSC becomes aware of drug shortages, it will notify applicable associations so they can notify their members.

Contract Provisions

#	Stakeholder Recommendation	Provided by	Status	HHSC Response	Next Steps and Key Milestones
54	**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).	Acadian Ambulance Service of Texas	Under consideration	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.	HHSC will reach out Acadian Ambulance Service no later than May 1, 2016 to schedule a meeting to discuss potential solutions.
55	**Require that the DMOs adhere to the main dentist model as defined in rule and in contract.** Despite the clear definition and contract expectations for main dentists, the dental managed care organizations (DMOs) are allowing dentist providers to be credentialed an unlimited number of dental office locations thereby showing certain dentists credentialed at locations in which they have never stepped foot in the office. This out-of-control credentialing not only highly misleads clients searching for a main dentist, but corrupts the automated dental home assignment process used by the DMOs in situations where the client has not self-selected a main dentist. Certain dental practices receive an unfair advantage in the assignment process because it appears they have dentists practicing at locations in which those dentists are not really practicing.	Texas Dental Association	In progress	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. Additionally, both DMOs regularly monitor network rosters for accuracy, contact providers to validate provider network rosters, and monitor claims activity to identify inactive providers. Default dental home assignment methodology is also a topic currently under review as part of main dental home stakeholder workgroup.	HHSC will discuss ideas to better address this issue with the DMOs. This item will be discussed at the quarterly HHSC/DMO meeting tentatively scheduled for April 2016.
56	**Amend Section 8.1.4.2 of the Texas Medicaid Uniform Managed Care Contract to give Medicaid and CHIP managed care organizations (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).	Texas Nurse Practitioners	Under consideration	HHSC is currently working with the Texas Department of Insurance (TDI) and Texas Association of Health Plans and evaluating its ability to make this change. 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, 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/issue 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 is still working with TDI and TAHP on this issue and an update will be provided on the next posting.
57	**Require that the 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.	Texas Dental Association	No action to be taken	DMOs must offer Medicaid benefits to the same amount, duration, and scope as the fee-for-service 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.	N/A

58	**Establish credentialing and minimum performance standards for nursing facility providers seeking to participate in the STAR + PLUS Medicaid managed care program that are consistent with adopted federal and state standards.** HHSC has not implemented other current law (Senate Bill 7, 2013) regarding the Commission's responsibility to – "….establish credentialing and minimum performance standards for nursing facility providers seeking to participate in the STAR + PLUS Medicaid managed care program that are consistent with adopted federal and state standards. A managed care organization may refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards established by the commission under this section"	AARP	In progress	HHSC is considering options to strengthen this process. Currently the contract includes standard STP provisions statewide for nursing facilities in STAR+PLUS. The MCO must treat a NF as an STP if it holds a valid certification, license and contract through DADS as of Sept. 1, 2013, Additionally, MCOs must enter into Network Provider Agreement with any willing nursing facility provider that includes new providers and those that have gone through a change in ownership after Sept. 1, 2013. STP status is extended for the 1st three operational years of a Medicaid MCO, with nursing facility status as STP expiring on February 28, 2018.	A meeting was held with associations, MCOs and NF providers on 3/15/16 requesting their input on MCO credentialing standards for NFs. A meeting will be scheduled with AARP once feedback is received from this meeting.
104	**Implement accountability measures linked to reimbursement** It is important that HMO's have accountability measures so advocates can monitor what they are doing. These accountability measures should be in the contract linked to reimbursement so the HMO's have an economic incentive to perform in a way that benefits the people receiving services. ADAPT of Texas has drafted what we are calling Community Integration Performance Indicators. Community Integration Performance Indicators: 1. # of people out of nursing facilities/institutions; 2. # of people going into nursing facilities/institutions; 3. # of people getting face to face service coordination; 4. # of people getting phone service coordination; 5. # of people offered consumer directed services; 6. # of people selecting consumer directed services; 7. # of people living in their own home or apartment; 8. # of people living in assisted living; 9. # of people in adult foster care; 10. # of people living in group homes; 11. Availability/use of architectural barrier modifications; 12. Length of time receiving services; 13. Length of time keeping an attendant; 14. System of back up for attendants; 15. Pay wages $8.00 to $9.00; 16. Pay wages $9.00 to $10.00; 17. Pay wages above $10.00; 18. Access to durable medical equipment; 19. Access to Assistive Technology such as communication devices; 20. Nurse delegation of health maintenance task to unlicensed Direct Care Attendants; 21. Advisory Committee made up of at least 50% of people using the services and supports.	ADAPT Texas	Under consideration	HHSC appreciates this feedback and will consider options to strengthen accountability measures.	HHSC will consider options to strengthen accountability measures.
102	**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.	Acadian Ambulance Service of Texas	Under consideration	HHSC is currently exploring options to streamline non-emergency ambulance transportation.	HHSC will reach out to Acadian Ambulance Service no later than May 1, 2016 to schedule a meeting to discuss potential options.

Service Coordination/Member Assistance

#	Stakeholder Recommendation	Provided by	Status	Current Status	Next Steps and Key Milestones
24	**Improve consumer protections, assistance and ombudsman services.** SB760 includes improvements, though short of what was originally envisioned, including more in-person services. Consider opportunities to leverage consolidation with DADS and the DADS Ombudsman program. Funding by MCOs—could be Medicaid reimbursable expenses?	Coalition of Texans with Disabilities	In progress	HHSC is committed to ensuring clients receive the services they need and will certainly consider opportunities to leverage consolidation with DADS and the DADS Ombudsman program, as well as other options to serve this population. The HHS Ombudsman Managed Care Assistance Team is available to assist all clients enrolled in managed care that may be experiencing barriers to care. The State Long-Term Care Ombudsman is available for all clients residing in nursing homes and assisted living facilities. The Health and Human Services (HHS) Transition Plan submitted to the Legislature indicates the State Long-Term Care Ombudsman will be administratively attached to the HHS Office of the Ombudsman. SB 760, 84th Legislature, Regular Session, 2015, directs the HHS Office of the Ombudsman to coordinate a network of entities to provide support and information services to Medicaid managed care consumers.	The HHS Ombudsman will host discussions with the State Long-Term Care Ombudsman and other entities that could be part of the SB 760 network to support Medicaid managed care consumers to determine ways they can improve consumer protections and ombudsman services. HHSC will develop a plan for the SB 760 network and seek input/feedback from the network of entities.
62 a-c 63 64	**Require (or strongly encourage) MCOs, LTSS providers and other persons/entities/organizations which interface with individuals (or their LAR, families, etc.) receiving care/services via the Medicaid managed care program to share and review the process for submitting a complaint with individuals, LARs and families and, perhaps on an annual basis, require MCOs to remind their members of the process.** Although HHSC and DADS recently disseminated the process for submitting a complaint to those who receive DADS and HHSC communications, many stakeholders still do not subscribe to these communications or even know they can. Many also still have no access to a computer, and many do not feel comfortable asking the MCO how to submit a complaint or even filing one if they do know how to submit a complaint for fear of some form of retaliation. Clarify the differences between filing a complaint via the HPM Complaint email box, the Ombudsman or on-line form for reporting to the Ombudsman and sending an email to contact@hhsc.state.tx.us (an option noted when one clicks on the link to the ombudsman form) and inform stakeholders. Note: Some stakeholders have been told any of the 3 options can be used to submit a complaint about the Medicaid managed care program. Consider consolidating the 3 options if no distinct differences exist. Consider offering persons who access the HHSC complaint email box the option to either send their complaint via email or use a form similar to the Ombudsman on-line form. The form should be revised to include a question as to whether the issue pertains to an MCO, and if so, which one, as well as a question that asks the person to identify if the issue pertains to a person in a nursing facility, a person with IDD, etc.	Private Providers Association of Texas (PPAT)	In progress	HHSC realizes the importance of the services being provided to customers and is committed to providing as many options as possible to file complaints/inquiries regarding Medicaid Managed Care. HHSC and the Office of the Ombudsman work closely to resolve all reported issues. Both areas receive inquiries from Medicaid members and contracted providers, however, the Office of the Ombudsman mainly receives member initiated complaints, while HHSC receives complaints sent primarily by providers. Member and Provider manuals include detailed information on how to file a complaint and appeal. Clients and providers can submit their complaints through all available avenues and should feel confident that their issue will be routed to the appropriate responder in a confidential and secure manner. Current processes include a tracking number, receive dates, due dates, resolved dates, trending and analysis for global and isolated issues and collaboration with program staff. Complaint data is reported daily and analyzed quarterly unless otherwise specified by leadership or due to a project need. The HHS Ombudsman Managed Care Assistance Team coordinates resolution of managed care inquiries and complaints and will coordinate a network of entities to provide support and information services to Medicaid managed care consumers, as required by SB 760, 84th Legislature, Regular Session, 2015. MCOs who retaliate against members are in violation of their contract and HHSC can place the MCO on Corrective Action Plans, as well as administer monetary sanctions for any violation of the contract. To report complaints directly to HHSC. https://www.hhsc.state.tx.us/ombudsman/ or HPM_complaints@hhsc.state.tx.us	The HHSC/DADS Long-Term Care Ombudsman has requested nursing facility specific data from the MCOs, on a monthly basis, to determine the types, as well as the volume of complaints received related to nursing facility members. HHSC/DADS/Office of Ombudsman are coordinating and working with stakeholder groups to create flyers/magnets for clients that include a simple explanation of the complaint process and list the most critical numbers to call for health and emergencies. HHSC staff also participate in monthly coordination meetings with the Office of the Ombudsman to ensure member needs are met. HHSC will determine the feasibility of implementing an electronic form for complaints submission.
65 66	**Ensure independent ombudsmen are available for people experiencing barriers to accessing managed care services** The complaint system should be improved to ensure consumer complaints are documented and addressed timely and appropriately. Consumers and representatives have many ongoing burdens which preclude them from repeatedly seeking responses to complaints. The complaint system should funnel complaints to a proper channel so consumers and representatives do not have to repeatedly seek help for specific issues.	Disability Rights Texas/ EveryChild, Inc./Texas Council for Developmental Disabilities/The Arc of Texas	Under consideration	The HHS Ombudsman Managed Care Assistance Team is available to assist all clients enrolled in managed care that may be experiencing barriers to care. The State Long-Term Care Ombudsman is available for all clients residing in nursing homes and assisted living facilities. The HHS Transition Plan submitted to the Legislature indicates the State Long-Term Care Ombudsman will be administratively attached to the HHS Office of the Ombudsman. Any trends or global issues identified through complaints initiate a deeper HHSC review of the MCO or provider and their processes either by a desk review, onsite review, or secret shopper call. HHSC is currently looking at the roles of service coordinators and ways to strengthen the roles of the MCO provider relations teams especially when serving IDD populations. Stakeholders will be invited to participate in HHSC's service coordination workgroup which will ensure specific client needs are being met. SB 760, 84th Legislature, Regular Session, 2015, directs the HHS Office of the Ombudsman to coordinate a network of entities to provide support and information services to Medicaid managed care consumers.	The HHSC/DADS Long-Term Care Ombudsman has requested nursing facility specific data from the MCOs, on a monthly basis, to determine the types, as well as the volume of complaints received related to nursing facility members. HHSC/DADS/Office of Ombudsman are coordinating and working with stakeholder groups to create flyers/magnets for clients that include a simple explanation of the complaint process and list the most critical numbers to call for health and emergencies. HHSC is also working to facilitate a service coordination workshop for the MCOs and agency staff to discuss issues discovered through complaint trends and communication with stakeholders, as well as the roles and responsibilities of service coordinators. The HHS Ombudsman will host discussions with the State LTC Ombudsman and other entities that could be part of the SB 760 managed care consumer support network, to determine ways they can improve consumer protections and ombudsman services.
88 89	**Establish caseload limits for service coordinators and improve consumer access.** Establish adequacy standards for service coordinators, including caseload limits. Many consumers report not knowing their service coordinator or how to contact her. Service coordinators seem overloaded and challenged to provide timely assistance.	Coalition of Texans with Disabilities/ Providers Alliance for Community Services of Texas (PACSTX)	In progress	HHSC recently published a resource document explaining how to find an assigned service coordinator from the five STAR+PLUS MCOs and will share this document with providers and associations. Also, HHSC continues to review stakeholder feedback regarding network adequacy changes as part of its implementation of SB 760.	HHSC has added a requirement to the managed care contracts, effective 9/1/16, which will require the STAR+PLUS MCOs to notify a STAR+PLUS member in writing, within 5 days, if their service coordinator changes and provide updated contact information. HHSC also added requirements that an MCO notify members in writing with: name of service coordinator, phone number, minimum contacts, and type of contacts, also effective 9/1/2016.

92	**Improve understanding and effectiveness of care coordination within the Medicaid managed care model.** a) Increase provider education on (1) populations that receive automatic care coordination, (2) how to best utilize this automatic care coordination and (3) how to request care coordination on behalf of a patient that does not automatically receive it. b) Include a patient's care coordinator name and phone number on the patient's Medicaid card and in the patient's electronic portal c) Care coordinators should be held responsible for helping a transition age youth find adult providers d) Billable care coordination by both the physician and a social worker/nurse coordinator in the provider setting should be streamlined and MCOs should clearly outline for all medical homes how to take advantage of this service e) Educate providers on the unique care coordination model STAR Kids MCOs will be responsible for implementing f) Encourage MCOs to provide a capitated care coordination PMPM to practices able to demonstrate high quality outcomes with internal care coordination efforts.	Texas Medical Association (TMA)/Texas Pediatric Society	In progress	The STAR+PLUS provider handbook includes guidelines on how to best utilize care coordination, as well as instructions on requesting care coordination for those who do not automatically receive this benefit. Unfortunately, care coordinators do change over time, so it is not practical to include their name on the member ID card. Everyone in STAR Kids will have access to service coordination (SC). HHSC staff completed one round of statewide information sessions for both providers and families to provide them information regarding STAR Kids, including information on how to access SC and transition planning in the Winter/Spring of 2015/16. Another round of information sessions will occur toward the end of the Summer 2016. HHSC continues to provide training to MCOs around SC and transition planning in preparation for November 1st implementation of STAR Kids. MCOs will be able to allow a member to receive SC through an integrated health home if it meets STAR Kids program requirements. The MCO must reimburse a health home that provides SC to its members through an enhanced rate structure, a per-member-per month fee, or other reasonable methodology agreed to between the MCO and health home. Like STAR+PLUS, STAR Kids has a service coordinator hotline number that will be on a STAR Kids member ID card, which will be an easy way for families or providers to reach a service coordinator. In addition, MCOs must provide a named service coordinator to any member who requests one, even if they are not in the groups that get one automatically (levels 1 and 2). Everyone in STAR Kids will also have access to transition planning beginning at age 15. A transition specialist at the MCO, working closely with the service coordinator, will help the family with transition planning. This includes activities like assisting members to find adult providers and preparing members for transitioning to STAR+PLUS when appropriate.	HHSC has added a requirement to the managed care contracts, effective 9/1/16, which will require the STAR+PLUS MCOs to notify a STAR+PLUS member in writing, within 5 days, if their service coordinator changes and provide updated contact information. In addition, each MCO has a service coordination hotline providers can call to receive the contact information for a member's care coordinator. STAR Kids definitions and requirements around care coordination and MCO standards will be operational effective 11/1/16.
72 75	**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.	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas/ Disability Rights Texas	In progress	Service coordinators must meet with members when assessing LTSS prior to authorizing services. Prior authorizations are not required for emergency services. A member may file an appeal with the health plan. Instructions on how to file an appeal can be found in the plan's member handbook. A member may request a fair hearing from the state at the same time they file an appeal with the health plan. If members get a notice of agency action, instructions for requesting an appeal are included on the notice. If members do not get a notice, they may contact 2-1-1 or their service coordinator. HHSC does allow certain specialists to be PCPs and is willing to consider additional stakeholder feedback. Currently, members with special health care needs may have specialists serve as their primary care providers in accordance with UMCC Section 8.1.4.2, "Primary Care Providers."	HHSC will review current contract standards and authorization processes and ensure that these concerns are addressed.
34 a 67	**Improve access to services in the community and MCO transition planning.** HHSC and its managed care contractors must ensure individuals have the support needed to successfully plan and access services for individuals with complex medical, physical and psychiatric needs in the community. Early selection of an MCO and MCO involvement in service/discharge planning will ensure timely and successful transitions/diversions for those in or at risk of institutional placement and improve MCO enrollment of individuals with complex needs from the community interest lists. MEPD involvement and MCO enrollment and service planning will ensure that switching from institutional to community Medicaid and into managed care can be accomplished without delay or complexity.	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas/ Disability Rights Texas	In progress	HHSC is working to clarify and strengthen requirements of service coordinators, particularly in the transition to community. HHSC is updating the managed care requirements and improving language in the STAR+PLUS Handbook about the role and responsibilities of a service coordinator. All members enrolled in the STAR Kids managed care program will have access to service coordination. The STAR Kids service coordinator will be expected to assist the individual in locating and coordinating all Medicaid acute care and long term services and supports, which includes coordination to facilitate a smooth transition from an institutional setting to the community. The STAR Kids program will also include extensive requirements regarding transition planning for children aging out of STAR Kids into STAR+PLUS.	The STAR+PLUS handbook changes regarding expectations for members in a nursing facility and other programs (e.g. IDD waivers, 1919(j)) will be effective early summer 2016. STAR+PLUS contract changes effective 9/1/16 will include additional required service coordination training and assessment requirements regarding a person's change in condition. The STAR Kids contract is operational 11/1/16.
91	**Allow for a community-based, outside party, like a local authority, to contract with an MCO to provide acute care service coordination.**	EveryChild, Inc., Texas Council for Developmental Disabilities, The Arc of Texas	In progress	This option will be available under STAR Kids through an integrated health home. HHSC will also assess the feasibility of subcontracting for acute care service coordination services in STAR+PLUS as part of the service coordination workgroup.	Update to be provided on future posting.
34 e 67	**Enhance service coordination.** Enhanced service coordination; enhanced medical/nurse coordination and supervision; and coordination and communication between acute and community care providers including transparency regarding assessments and authorization/denial of services. Identify, if needed, a complex care unit/swat (statewide or regional) team to best facilitate transitions between settings; between MCOs/MCO contract areas, or to address unusual chronic needs and prevent health care or other crises.	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas/ Disability Rights Texas	Under consideration	HHSC will consider this recommendation in the SB 760 workgroup discussions around service coordination.	Update to be provided on future posting.

Network Adequacy/Access to Care

#	Stakeholder Recommendation	Provided by	Status	HHSC Response	Next Steps and Key Milestones
25 34 c 67	**Expand home-based care for ventilator-dependent consumers.** People with ventilators are at elevated risk for institutionalization. A potential pilot—designed by a person with vent assistance—can improve cost-effective independent living.	Coalition of Texans with Disabilities/ EveryChild, Inc./Texas Council for Developmental Disabilities/Arc of Texas/Disability Rights Texas	In progress	HHSC is committed to ensuring individuals with ventilators are able to successfully remain in the community, or are able to transition to the community if in a nursing facility. On February 23, 2016, HHSC convened a Ventilator-dependent Workgroup of stakeholders and MCOs to explore options for addressing the needs of individuals with ventilators receiving Medicaid services, including individuals who are at an elevated risk of institutionalization. The workgroup will collaboratively address barriers to transitioning institutionalized members on vents to the community, finding community providers who are trained and available to deliver these services to community based members, and educating these providers along with MCO Service Coordinators on this specialized service. On March 21, 2016, HHSC and DADS staff met internally to discuss/review materials submitted by community advocates after the 2/23/16 meeting with stakeholders.	A meeting with MCO service coordination managers will be scheduled to discuss their role in activities related to transitions from NF to community and the transfer of ongoing information related to these activities.
1 a-b	**Ensure LTSS providers and families obtain reimbursement for services not covered by MCOs.** Consider an interim option for individuals to receive care when the services are not available through the MCO. Not doing so has the potential to result in unintended, adverse consequences for persons receiving services. This includes developing a process for LTSS providers and families to obtain reimbursement for these services from either MCOs or HHSC. [MCOs are paid to assure access to and improved coordination of care. In cases, however, when families or providers cannot obtain needed care or assistance from the MCO, thus pay for the service out-of-pocket, an MCO's fee remains unchanged.]	Private Providers Association of Texas (PPAT)	Under consideration	HHSC requires additional information from PPAT to determine whether changes can be implemented to appropriately address this recommendation.	HHSC will follow-up with PPAT no later than May 1, 2016 to identify services that are not being covered and ensure health plans are providing all Medicaid covered services.
1 c	**Evaluate current network access standards related to distance clients must travel to receive care.** Collect data on the impact of current network access standards related to distance from one's home to the acute care provider on individuals, families and providers. In other words, how many persons currently now have to travel outside of their local communities to obtain medical care; what challenges do they experience as a result of such; etc.) Note: Many families work and cannot take time off to travel extended distances (as an example, from Corpus to San Antonio) to take their loved one to the doctor. More importantly, many individuals are not able to tolerate lengthy trips.	Private Providers Association of Texas (PPAT)	Under consideration	HHSC currently collects member information through Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Due to resource constraints, the surveys alternate every other year between programs and age groups.	This item is still under consideration. HHSC will determine whether changes can be implemented to appropriately address this recommendation and will provide an update on the next posting.
74 f	**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.**	EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas	In progress	SB 760 requires HHSC to submit to the Legislature and make public a biennial report containing information and statistics about recipient access to providers through the provider networks of the managed care organizations and managed care organization compliance with contractual obligations related to provider access standards.	HHSC will continue working on implementation of SB 760, including the required biennial report.

1 d	**Explore increasing single case agreements for persons with IDD.** Explore options for increasing the number of 'single case' agreements MCOs reportedly have in an effort to ensure persons with IDD have at least the same access to care they had prior to the 9/1/14 transition. [When will the reports called for in Rider 81 related to Medicaid Managed Care Organization Network Adequacy Action Report and, more importantly, Rider 82 related to Assessment of Single Case Agreements be available?]	Private Providers Association of Texas (PPAT)	In progress	All Medicaid MCOs are contractually required to provide members with access to covered services and service management/coordination, including assistance in finding a provider. HHSC assesses liquidated damages when an MCO fails to provide a covered service. Additionally, HHSC is currently collecting data on single case agreements as part of the last transition of acute care for people with IDD and will share the analysis with stakeholders. HHSC reports required by Rider 81 and Rider 82 will provide information on disciplinary actions taken against MCOs for not meeting network access standards and single case agreements and will be publicly available on September 1, 2016.	HHSC will continue monitoring efforts to ensure members access Medicaid benefits, including services for individuals with IDD and related conditions. HHSC is hosting a summit in the coming months (mid-2016) to address service gaps and solutions for individuals dually diagnosed with IDD and behavioral health conditions. Part of the summit discussion will include provider shortages and gaps in service provision that members with IDD experience. HHSC continues work on Rider 81 and Rider 82 reports which will be completed and publically available September 1, 2016.
1 e	**Increase utilization of out-of-network providers where gaps in networks exist.** Evaluate utilization of out-of-network providers and if not widely used determine why and, as appropriate, identify ways to increase access to such, particularly in cases when an MCO is experiencing challenges in attracting healthcare providers to their networks.	Private Providers Association of Texas (PPAT)	In progress	SB 760 requires HHSC to publish network adequacy standards and stakeholders will be notified of its publication on the website. HHSC will also work to incorporate stakeholder recommendations to improve network adequacy. MCOs are contractually penalized for OON use above certain thresholds and single case agreements can be used when providers are not in-network.	Implementation of SB 760 is ongoing.
1 f	**Improve provider recruitment and retention.** Collect data on why acute care providers will not contract with MCOs or do, then drop out within months, followed by making, as appropriate, needed changes to enhance acute care provider recruitment and retention across the MCO networks.	Private Providers Association of Texas (PPAT)	In Progress	HHSC contractually requires Medicaid MCOs to notify HHSC of provider terminations in accordance with UMCM Chapter 5.4.1.1, "Provider Termination Report." Additionally, MCOs that do not meet the UMCM Chapter 5.14.8 STAR and STAR+PLUS Geo-Mapping Report standards—which monitor acute care provider types such as PCP, OB/GYN, Orthopedic Surgeon, Cardiovascular Disease, General Surgeon, Urologist, Ophthalmologist, Outpatient Behavioral Health Provider, Acute Care Hospital, and Nursing Facility—typically submit UMCM 5.15 Special Exception Request for variance of mileage. HHSC acknowledges this issue and appreciates continued stakeholder feedback. HHSC coordinates with provider associations and collects feedback on strengths and challenges within the Medicaid managed care program with the ultimate goal of improving the program and increasing the number of providers that are willing to participate.	Work on this issue is ongoing.
2 a	**Continue to explore ways to improve the MCO on-line directories, including how to improve access to and ease in use of the on-line 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.	Private Providers Association of Texas (PPAT)	In progress	The SB 760 Workgroup is currently developing critical elements for the MCO online provider directories for inclusion in the UMCM. 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 11/30/15. These comments are being incorporated into draft Provider Directory Standards that will be released in May 2016 for additional stakeholder feedback. The draft standards will include both print and online directories.
2 b	**Require MCOs to find doctors for LTSS clients.**	Private Providers Association of Texas (PPAT)	Complete	HHSC contractually requires Medicaid MCOs to provide service management/coordination to members, including assistance in finding a provider. Additional improvements will be implemented including identification of members to call for support and increased efforts to ensure MCOs are providing necessary services.	HHSC is considering additional improvements.

3 a	**Evaluate the expedited appeal, service authorization and prior authorization process for IDD clients.**	Providers Alliance for Community Services of Texas (PACSTX)	In progress	UMCC Section 8.1.21.2, "Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies," permits a pharmacy to fill consecutive 72-hour supplies if the prescriber's office remains unavailable. The MCO must reimburse the pharmacy for the temporary supply. Additionally, if the prescriber's office calls the MCO's prior authorization (PA) call center, the MCO must provide a PA approval or denial immediately.	This topic continues to be a focus of the IDD Managed Care Improvement Workgroup and HHSC will coordinate with the workgroup to identify recommendations to improve the process and ensure that individuals, providers, physicians and pharmacies are aware of the process.
3 b 3 d	**Educate IDD clients and providers about the appeal process and improve the timeliness of MCO responses to IDD providers and families.** Educate IDD clients and providers about the role of the appeal process to resolve certain types of issues with the MCO, the role of the complaint process to resolve certain types of issues with the MCO, when a complaint should be filed with HHSC, and the rights and responsibilities of clients and providers in those processes. IDD providers and families have systemic issues with obtaining services for individuals in a timely manner. The emphasis on the HHSC website is to work through MCOs and their processes prior to sending a complaint to HHSC. However, providers for individuals with IDD have had a difficult time understanding how to navigate the internal workings of the MCOs. When an issue arises, providers first attempt to get a hold of a MCO service coordinator. If and when a service coordinator returns a phone call, the response is usually not timely. For example, if the client needs to see a psychiatrist in order to have a change in medications because of an emerging condition, IDD providers and families have reported getting bumped from one person to the next in attempts to resolve issues, delaying the delivery of care for many individuals. The lack of timely response from the MCO often leads to providers and/or families paying out of pocket for services that should have been paid for by the MCO. These incidents are rarely reported as a complaint to HHSC since they end up being resolved by the family or provider. However, the time involved to resolve an issue by IDD provider staff and families is extensive and may have led to negative outcomes for the individuals involved. In this way, complaint data can be misleading because families and providers rarely file a formal appeal or complaint with the MCO (attempting to work out issues with the service coordinator) and even less frequently get to the step of reporting issues to HHSC unless the issue is longstanding.	Providers Alliance for Community Services of Texas (PACSTX)	In progress	The IDD System Redesign Advisory Committee (SRAC) recently made recommendations on how to educate and outreach to individuals with IDD about managed care. HHSC will also seek feedback from the IDD SRAC on approaches to educating members on the complaint processes, including how to encourage individuals to formally submit complaints, which will provide HHSC with more accurate complaint data and enable HHSC to address issues as they arise. HHSC will continue to coordinate with the IDD SRAC and the IDD Managed Care Improvement Workgroup as issues arise to inform the MCOs about issues, to work through resolution of issues, and improve service delivery. Additionally, the IDD SRAC recommended that the MCOs, LIDDAs and the LTSS 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 issues/challenges as the MCOs, LIDDAs and providers have an opportunity to work through specific cases. SB 760, 84th Legislature, Regular Session, 2015, directs the HHS Office of the Ombudsman to coordinate a network of entities to provide support and information services to Medicaid managed care consumers.	The quality subcommittee of the IDD SRAC meets monthly and plans to look at the complaint process during their April 2016 meeting and make recommendations on a more user friendly guide for individuals and families, including key differences between the complaint and appeal processes. The quality subcommittee's recommendations will be presented to the full IDD SRAC in July 2016 for additional feedback. In August 2016, the IDD SRAC will present the final recommendations to HHSC executive leadership for approval. HHSC is also exploring the possibility of meetings at the local level.
96	**Regularly scheduled meetings of LTSS IDD providers, MCOs, and LIDDAs should be held at the local level.**	Private Providers Association of Texas (PPAT)	In progress	The IDD SRAC recommended that the MCOs, LIDDAs and the LTSS 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 issues/challenges as the MCOs, LIDDAs and providers have an opportunity to work through specific cases.	HHSC is exploring the possibility of meetings at the local level.
3 c	**HHSC should publish data about IDD consumer experience.** HHSC should publish data about IDD consumer experience related to delays or denials of care from lack of network adequacy, not meeting medical necessity criteria, not meeting internal guidelines or benchmarks for use of medications, and lack of prior authorization.	Providers Alliance for Community Services of Texas (PACSTX)	Under consideration	HHSC currently does not analyze the requested data for the IDD population specifically. HHSC will research whether changes can be implemented to obtain and publish the requested data information in the future, as well as explore ways to leverage the EQRO reports for inclusion of the requested data.	HHSC is looking at what data we readily have available and can include self-reported data from the MCOs in the next SB 7 legislative report that is due to the legislature in September 2016.
4 34 d 51 67	**Increase provider network non-discrimination standards.** Certain individuals, based on their disability or complex needs, are struggling to locate and access health care in a timely manner and without having to travel farther than they did prior to Medicaid managed care expansion. We offer the following analysis and considerations, consistent with recent ACA proposed guidelines to insurers regarding non-discrimination. HHSC should adopt, increase awareness and enforce clear standards in contracts and rules that an individual shall not, on the basis of race, color, national origin, sex, age, or disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity.	Disability Rights Texas/EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas	In progress	HHSC contractually requires Medicaid MCOs to comply with state and federal anti-discrimination laws. HHSC will review the effectiveness of previous trainings for providers wishing to serve people with IDD conducted by MCOs and explore opportunities to expand this training to other areas.	New federal Medicaid managed care rules include additional clarification regarding non-discrimination of members and providers in Medicaid Managed Care. The rules are expected to be final in May or June 2016. HHSC will analyze the final rule to determine if additional changes to Managed care contracts or policies are necessary.

34 b 67	**Improve access to hospital level of care.**	EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas/Disability Rights Texas	Under consideration	At this time, the MCO assesses for hospital level of care, but TMHP provides authorization. Additionally, HHSC has submitted a concept paper to Centers for Medicare and Medicaid Services with a proposal for serving medically fragile adults through the 1115 waiver. This concept paper is slated for discussion with CMS in February 2016 and HHSC will keep stakeholders informed of the progress as the concept is further evaluated.	HHSC will continue to work with CMS and stakeholders to develop the concept of an improved way of delivering services to individuals who are medically fragile. Contingent on CMS and legislative/leadership feedback, HHSC will amend the 1115 waiver and develop an assessment tool and process for this benefit.
6 a	**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.	Texas Council of Community Centers	Complete	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 (MH TCM and Rehab). 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 MH TCM and Rehab. 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.
6 b	**Challenges with different MCO processes.** With the recent STAR Kids program awards, HHSC now contracts with 20 managed care organizations (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.	Texas Council of Community Centers	In progress	In order to offer choices to our clients in their managed care plan, HHSC does have a large number of MCO contracts. 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 will continue work on internal projects that will improve the Provider Enrollment process and coordination on external projects with the MCOs that will improve the Provider Credentialing process. HHSC will continue to explore other opportunities to help providers better understand MCO processes.
6 c	**Seek feedback from stakeholders on utilization management protocols.** The state has made significant strides towards a streamlined credentialing process, and now requires all MCOs to accept prior authorization requests on the standardized Texas Department of Insurance form. HHSC's managed care contracts also require MCOs to follow established utilization management protocols when reviewing targeted case management and mental health rehabilitation service requests (see HHSC's Uniform Managed Care Manual, Chapter 15); however, these protocols are currently under review. Any changes to the utilization management protocols should be fully-vetted with the BHIAC and other interested stakeholders, and should promote streamlined and consistent application.	Texas Council of Community Centers	In progress	HHSC is currently conducting a review of the Mental Health Rehabilitation and Mental Health Targeted Case Management benefit, including any potential changes to the utilization management guidelines. As part of this review process, there will be opportunities for stakeholders to provide feedback on any proposed changes.	HHSC continues to refine the medical benefit policy for mental health rehabilitative services and mental health targeted case management. This includes a review of relevant governance documents (including the state plan, Texas Administrative Code, and other applicable reference material). Should any changes to the utilization review process for these services be made, it will be included as part of the medical benefit policy for the services and stakeholders will be given an opportunity to provide feedback. This policy review is expected to be completed in 2016.
7 18-19 21	**Streamline MCO prior authorization requirements.** - Standardization of elements of a "good" physician order" & uniformity in how guidelines are adopted and how requirements are applied for PA. We ask all MCO's follow CMS guidelines for what they will accept as a "good order" based on CMS elements of an order. Also, we ask all of our MCO's follow TMHP guidelines in how PA requirement are applied to PA guidelines. For example, Some require auth for a service while others do not require auth for that same service. Standardization of review amongst MMC plans for PA determination on pediatric –rendered DME services, such as oral supplementation requirements would be very beneficial to the patient. - Authorization requirements that are consistent and align with TMHP requirements. This should not only include the parameters by which they authorize, but also the manner in which it occurs. MCOs are not using the Universal Authorization form with the exception of CHC. They will accept the form, but continue to require their own forms as well. This also applies to TMHP. To further increase consistency of the authorization process providers should be allowed to submit all necessary documents to the MCO directly once the PCP has ordered and approved services, by signing the plan of care and or the initiation of services by signing the initial order. This would align with TMHP's processes. - Authorization process should originate on the therapy provider. We are getting push-back from the physicians. Several MCO s have instituted policy making the PCP responsible for submitting all authorization paperwork . This has caused delays in delivery of services. - Existing prior authorization procedures vary substantially between MCOs. Prior authorization procedures and documentation requirements should align with those outlined in the Texas Medicaid Manual. Additionally, providers should have the authority to submit prior authorization requests directly to the MCO provided the ordering physician has reviewed the plan or care and signed all required documents. When continuation of services is needed for an additional period of time requiring reauthorization, it is imperative that the process be completed without an interruption of service provision. Additionally, TSHA supports the establishment of care standards for Medicaid beneficiaries transitioning from one delivery system to another.	Texas Rehab Providers Council/Outpatient Independent Rehabilitation Association/Texas Speech-Language-Hearing Association	No action to be taken	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.	N/A

8	**Require acceptance of online referrals.** Currently providers have the ability to fax referrals for specialist services, but an online option could speed up the process.	CHAT (Children's Hospital Association of Texas)	Under consideration	HHSC is exploring online options for referrals.	HHSC is still exploring this recommendation and will provide a stakeholder update as soon as possible.
9	**Ensure that formulary requirements agree with standard of care and does continuously change. Additionally, when it does change, ensure pharmacists are aware of the change in time to update their systems.**	CHAT (Children's Hospital Association of Texas)	In progress	HHSC uses a very broad formulary to allow prescribers to choose the appropriate treatment for their patient. The members of the advisory committees that recommend prior authorization criteria are practicing physicians and pharmacists who, together with state staff, attempt to ensure that the standard of care remains available with minimum limitations. As HHSC implements a new Drug Utilization Review Board, additional attention can be given to this recommendation.	HHSC will work with its Preferred Drug List vendor and Drug Utilization Review Board to ensure that drugs designated as 'Preferred' include clinically-accepted, standard first-line treatments. HHSC posts changes on its website after DUR Board recommendations are made and again prior to their implementation. Stakeholders are notified of changes via e-mail. HHSC will review additional methods of communication. HHSC will convene the new DUR Board on April 29, 2016. New communications, if identified, will be applied prior to the July 2016 implementation of the revised PDL.
10 a-b	**Shorten timeline for physician enrollment and credentialing in Medicaid.** Require Medicaid MCOs to simultaneously process physician credentialing applications while the physician pursues Medicaid enrollment via TMHP. Currently, physicians must submit a Medicaid enrollment application then await receipt of a TPI number(s) before beginning the HMO credentialing process. TMA and TPS frequently receive complaints from physicians that the entire process takes 6 months or more to become enrolled in Medicaid, credentialed by the HMOs, and then begin seeing HMO patients. Some plans indicate they will initiate the credentialing process while awaiting a physician's TPI number, but this is not standard practice because some HMOs interpret the HHSC-HMO rules to preclude establishing a parallel process. Once TMHP finalizes a physician's Medicaid enrollment, the information should be expeditiously transmitted to the HMO to allow the plan to complete credentialing. Further, HMOs should be required to honor the TMHP effective date regardless of whether the HMO has completed the credentialing process and pay claims retroactive to that date so that physicians can begin seeing patients more quickly. By allowing physicians and other acute care providers to simultaneously pursue Medicaid enrollment and HMO credentials, the state will expedite physician enrollment into HMO networks.	Texas Medical Association (TMA)/Texas Pediatric Society	Under consideration	HHSC is committed to improving the enrollment and credentialing systems and processes. We will strongly consider this recommendation when developing the SB 200 requirement for the new streamlined enrollment and credentialing systems and will seek input from provider associations, the Texas Association of Health Plans, and all other impacted stakeholders during the development of these systems.	HHSC currently provides the MCOs with a Medicaid Provider file every Tuesday that contains a listing of the Providers that are enrolled in the Medicaid program. The MCOs are working on a collaborative project that will improve the MCO Credentialing process for all of the MCOs participating in Texas Medicaid Managed Care programs.
11 a	**Simplify and streamline method for physicians and prescribers to access prior authorization requirements in the Vendor Drug Program.** Simplify and streamline the Medicaid Vendor Drug program, which is inordinately complex given that the management of the prescription drug benefit is split between HHSC and the MCOs. It is much too cumbersome for prescribers to determine which drugs or drug classes are subject to additional clinical edits and if there is an edit, which plans also have adopted it. Physicians should have a single location to look up this information rather having to go to each PBMs website to figure it out. Within each drug class on the PDL, include a hotlink so that when a physician views the PDL he/she can immediately determine if there are any associated clinical edit(s) for the entire class of drugs or a particular drug within the class. The link should take the physician to each clinical edit and also name each individual HMO that also has opted to implement the identical HHSC edit or a less stringent version. Currently, physicians must search each individual HMO website to determine which plans have adopted particular clinical edits.	Texas Medical Association (TMA)/Texas Pediatric Society	In progress	HHSC-VDP has added tools on its web site to simplify the process for a provider or patient to learn what prior authorization (PA) criteria have been implemented by each MCO.	HHSC will contact its PDL vendor to request a change to the published PDL to add Clinical PA information; and estimate the potential cost, if any, and timeline for implementation. HHSC will modify the UMCM to add MCO reporting requirements to identify their implemented Clinical PA to support an updated web tool. UMCM changes will be submitted by June 30, 2016 for a Fall 2016 implementation.
11 b	**Limit changing drugs from preferred to non-preferred status on the PDL to annual revisions.**	Texas Medical Association (TMA)/Texas Pediatric Society	Statutory Change Required	With few exceptions, individual drug classes are only reviewed and changed once per year. Semi-annual updates to the Preferred Drug List (PDL) only affect half the drugs. State law requires quarterly reviews of drugs for the PDL.	N/A

11 c	**Provide rationale for changing a drug status from preferred to non-preferred.**	Texas Medical Association (TMA)/Texas Pediatric Society	In progress	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 Preferred Drug List vendor and Drug Utilization Review Board to explore options for enhancing the published rationale without divulging confidential information.
11 d	**Improve access to clinical edits in Epocrates.**	Texas Medical Association (TMA)/Texas Pediatric Society	In progress	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 will work with its Prospective Drug Utilization Review vendor that manages the Texas Medicaid Epocrates contract. The best, feasible option for improved communication of Clinical PA criteria will be identified and an implementation plan will be developed.
11 f	**Revise requirements managing drug benefit to the package insert instead of indication.** Legacy 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.	Texas Medical Association (TMA)/Texas Pediatric Society	No action to be taken	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.	N/A
11 g	**When the Drug Utilization Review Board considers a clinical edit, publicize the justification for the proposal and the entity that recommended it.**	Texas Medical Association (TMA)/Texas Pediatric Society	In progress	At Drug Utilization Review (DUR) Board meetings, the objective of the proposed clinical prior authorization (PA) requirement is presented and discussed. HHSC and/or its MCOs are the entities that recommend clinical PA requirements.	HHSC will work with its Prospective Drug Utilization Review (DUR) vendor to enhance the explanation of the objective in the Clinical Prior Authorization document. This recommendation will be applied to PA criteria approved by the DUR Board after September 2016.
12	**Eliminate use of Texas Provider Identifier and only use the NPI number.** The legacy enrollment process is inefficient and confusing. Many physicians have multiple TPI numbers because they have multiple office locations or participate in multiple Medicaid programs, such as acute care Medicaid and Texas Health Steps. Relying on the physician's NPI number for enrollment and claims submission rather than multiple Medicaid TPI numbers will streamline both processes for physicians and the state.	Texas Medical Association (TMA)/Texas Pediatric Society	In progress	Due to the legacy systems supporting Fee for Service processing in both Acute and Long Term Services and Supports, HHSC cannot immediately discontinue the use of State Identifiers for providers such as the Texas Provider Identifier (TPI), and the DADS Contract Identifiers. HHSC does require the MCOs and Providers conducting business with the MCOs to utilize either a NPI or API for the submission of claims. The TPI is a value utilized for establishing enrollment with HHSC for the Medicaid program but is not utilized for claims processing.	It is the intent of HHSC to implement changes that will continue to expand the use of NPI and API values while diminishing the use of TPI and Contract IDs. These actions will however take time to implement in a manner to support both the Fee for Service and Managed Care service delivery models.

13 41	**Eliminate recoupments when a patient is erroneously enrolled in a plan.** Abide by Texas insurance requirements establishing that coordination of benefits is an insurance function, thus eliminating the need for costly Medicaid recoupments from providers when a Medicaid health plan discovers a patient was erroneously enrolled in the plan. Medicaid MCOs frequently recoup payments from providers as much as two years after a service was provided. The recoupments are triggered by various reasons, such as after the MCO is informed the patient was retroactively enrolled in Medicaid fee-for-service or was mistakenly enrolled in two MCOs simultaneously. While the provider can subsequently bill Medicaid fee for service or the correct MCO for services, this process is time consuming and expensive for the practice. Since the patient did not lose Medicaid eligibility, the recoupment should be managed among the payers, which is how commercial carriers manage these types of recoupments. Additionally, we have received an increase in calls from providers reporting Medicaid is recouping payments when it identifies another insurer as the responsible party, such as an auto or home insurer. The recoupments often occur months to years after the service was provided and the family no longer carries insurance with that carrier, thus making it difficult for the physician to file a claim. These types of recoupments also should be handled between Medicaid and the insurer when a provider has provided the service in good faith and made reasonable attempt to determine if a party besides Medicaid was liable.	Texas Medical Association (TMA)/Texas Pediatric Society/Coalition of Texans with Disabilities	In progress	HHSC has established a Provider Recoupment Workgroup to research recoupment issues and identify potential systems changes with the goal of reducing the number of recoupments. The workgroup is partnering with MCOs to identify reasons for recoupments. The workgroup identified staff error as the cause of some recoupments and training is being conducted with the goal of reducing the number of recoupments. The workgroup also reviewed interfaces with the federal government and other circumstances that resulted in duplicate recoupment cases. HHSC aims to reduce and minimize as many recoupments as possible and will research all options, including recoupment from fee-for-service or private insurance, rather than the provider, as appropriate.	Work of the HHSC Provider Recoupment Workgroup is ongoing.
14	**Implement a provider type and specialty code for urgent care.** Many primary care physicians cover urgent care centers in addition to operating their own practices. Without a separate provider type, it wreaks havoc with PCP assignments and makes it difficult to differentiate physician after-hours clinics from other facilities.	Texas Medical Association (TMA)/Texas Pediatric Society	Under consideration	HHSC is considering ways to alleviate this concern. MCOs might consider using an add-on code rather than a different provider type.	Update to be provided on future posting.
15	**Add a feature to the TMHP and MCO fee schedules or policy manuals to determine any place of service or diagnosis restrictions (e.g., whether procedure can only be performed on an in-patient).** Having a single place to look up such information will make it easier for physicians to abide by Medicaid utilization restrictions, which often vary from other payers.	Texas Medical Association (TMA)/Texas Pediatric Society	Under consideration	HHSC will consider ways to implement this request.	HHSC has drafted a high-level estimate to determine system change costs and will notify stakeholders of the feasibility once the estimate is complete.
16	**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.**	Texas Medical Association (TMA)/Texas Pediatric Society	Complete	Health plans currently are able to utilize this practice.	N/A
17	**Eliminate pre-authorization for simple procedures in the office.**	Texas Medical Association (TMA)/Texas Pediatric Society	No action to be taken	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.	N/A

20	**Increase data collection and screening efforts to improve the accuracy and completeness of the data reported by Medicaid MCOs.** THA recommends increasing efforts to screen the information reported in the Medicaid encounter database. Years ago, the agency implemented policy changes to screen Medicaid inpatient fee-for-service data and created the Medicaid Blue Ribbon file. The Blue Ribbon information has been used numerous times over the years to measure the impact of proposed and post-implementation policy changes. The same data collection and screening procedures should be applied to inpatient and outpatient data provided by the Medicaid MCOs.	Texas Hospital Association	Under consideration	HHSC has implemented a version of the Fee for Service Blue Ribbon file in the Managed Care model and is in the process of revising both the requirements that are stipulated by the MCOs to Providers for claims submission, and also enhancing the editing of the encounters by the MCOs to HHSC.	HHSC is always interested in improving the information we use to ensure informed decision making. While HHSC regularly collects and examines data, we will explore the feasibility of applying the standards of the Blue Ribbon File to other data sets.
69	**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.	Texas Dental Association	In progress	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. In addition, HHSC is implementing additional standards for network adequacy as part of SB 760.	This is part of the regular contract monitoring function conducted by HHSC Health Plan Management. SB 760 implementation is currently in progress.
70	**Outreach to physicians/office managers/specialists for additional stakeholder input on barriers that discourage or prevent them from enrolling as a Medicaid managed care provider and conduct ongoing outreach to medical and other professional schools.** a) Outreach to physicians/office managers/specialists for additional stakeholder input on barriers that discourage or prevent them from enrolling as a Medicaid managed care provider from their perspective. b) On-going outreach to medical schools and other professional schools such as psychiatry, dental, nursing, occupational therapy, physical therapy. Work with professional schools to provide curriculum on community-based services, special needs populations and Medicaid. c) Work with health-related institutions and allied health professional schools with on-site clinics that might not currently accept Medicaid to begin accepting Medicaid patients.	Providers Alliance for Community Services of Texas (PACSTX)	In progress	HHSC currently does not collect input on barriers to managed care enrollment and additional resources will be required to address this issue. However, HHSC does coordinate with provider associations and collects feedback on strengths and challenges within the Medicaid program.	HHSC will continue to coordinate and work with provider associations and advocates and collect feedback on strengths, challenges, and possible solutions to challenges within the Medicaid program.
71 74 a-e 74 g 74 j 74 l-m	**HHSC should adopt additional standards regarding network adequacy, including:** • Requiring MCOs to ensure availability and access to all medical assistance benefits to meet the health care needs individuals with disabilities. • Requiring MCOs to ensure continuity of providers by allowing the ability to maintain relationships with specialists after an individual is enrolled into a managed care plan. Continuity of care for individuals with long-term disabilities greatly contributes to preventing complications and promotes long-term stability, which in turn reduces the incidence of higher acute care costs. • Regularly assessing networks to identify gaps in access to care, accompanied by a plan to remedy those gaps and monitor access to care in those areas. • Ensuring the state's network adequacy standards, assessment procedures and data documenting compliance is clear and transparent to public. • Strong legal protections are needed to ensure that enrollees have access to high quality, medically necessary services. • Plans must monitor the number of network providers not accepting new Medicaid patients as a way to ensure sufficient in-network providers are available. • Plans should timely report if there has been any "significant change" in health status to LTSS providers and with permission and as requested by the member. • MCO members' should have access to services within time frames that account for differences in urban and rural areas: a) Hospital services and emergency care with a 30 minute drive of or 15 miles from home or workplace. b) Urgent care where no pre-authorization is required: within 24 hours of request. c) Urgent care where prior authorization is required: within 48 hours of request. d) All other requests: within 10 days, but no later than 15 days. e) Allow for enrollees to access out-of-network providers without prior authorization if there is not a provider within timeframes or 10 miles from their home and/or if a request from a service coordinator does not get a response within 24 business hours. f) If a grievance is reported, plans should resolve this grievance within 10 days, unless the grievance concerns potential loss of life or limb, severe pain, or imminent and serious threat to health, the plan must resolve it within 2 days.	Disability Rights Texas/Every Child, Inc./Texas Council for Developmental Disabilities/The Arc of Texas	In progress	SB 760 requires HHSC to publish network adequacy standards. SB 760 also requires HHSC to implement different mileage standards for urban and rural areas if feasible. HHSC is in the process of reviewing mileage and other network adequacy standards. Currently, HHSC contractually requires MCOs to comply with various network adequacy metrics including but not limited to: wait times for appointments, mileage standards, and out of network utilization. MCOs that are not in compliance are required to develop a corrective action plan to improve access. MCOs currently are not required to monitor providers with closed panels with the exception of PCPs. HHSC will research whether changes can be implemented to appropriately address this recommendation. HHSC contractually requires MCOs to provide medically necessary services to all individuals in accordance with UMCC Section 8.1.2, "Covered Services." Additionally, MCOs are contractually required to provide continuity in the care of newly enrolled members in accordance with UMCC Section 8.2.1, "Continuity of Care and Out-of-Network Providers." However, this is only required for a limited period of time. When a provider is not in an MCO's network, the MCO must follow out-of-network utilization and reimbursement requirements. MCOs may also use single case agreements to allow a provider to serve only one or a few members and not be listed in the directory as a network provider. Many MCOs put this into place for members with IDD. Requiring MCOs to allow members to continue care with an out-of-network provider indefinitely may require legislative direction. Additionally, HHSC anticipates new federal regulations will impact Medicaid network adequacy standards. MCOs are already required to resolve complaints within a ten day timeframe and issues requiring immediate attention are escalated.	HHSC expects the Centers for Medicare and Medicaid Services' (CMS) new federal regulations regarding Medicaid and CHIP managed care requirements to be final in May or June 2016. These regulations will inform how this suggestion is implemented. HHSC is also working with the External Quality Review Organization (EQRO) to develop recommendations for revised network access standards. The EQRO Report is expected in May 2016.
74 i	**Plans should strive to make primary care services available within 30 minutes or 10 miles of an enrollee's residence.**	EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas	In progress	SB 760 and new federal regulations require time and distance considerations.	HHSC expects the Centers for Medicare and Medicaid Services' (CMS) new federal regulations regarding Medicaid and CHIP managed care requirements to be final in May or June 2016. These regulations will inform how this suggestion is implemented. HHSC is also working with the External Quality Review Organization (EQRO) to develop recommendations for revised network access standards. The EQRO Report is expected in May 2016.

74 k	**If a member makes a request of their service coordinator for help with things like finding a provider or getting them information about their plan, they should respond within 24 hours.**	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas	Under consideration	While not a specific requirement of SB 760, HHSC will consider this recommendation in the SB 760 service coordination workgroup.	HHSC is still working on the best approach to implementing this recommendation. Timeline is in development.
74 l	**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.**	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas	In progress	SB 760 and new federal regulations require time and distance considerations.	HHSC expects the Centers for Medicare and Medicaid Services' (CMS) new federal regulations regarding Medicaid and CHIP managed care requirements to be final in May or June 2016. These regulations will inform how this suggestion is implemented. HHSC is also working with the External Quality Review Organization (EQRO) to develop recommendations for revised network access standards. The EQRO Report is expected in May 2016.
76	**Ensure that the MCOs are ready, willing and able to provide mental health services to individuals with intellectual and other developmental disabilities (IDD). Develop trauma-informed systems of care for individuals with IDD.** Network adequacy for this population in general can be challenging – network adequacy for mental health services for this population can be even more difficult. Comprehensive assessments in the managed care programs should include mental health screening and evaluations for individuals with IDD.	Hogg Foundation for Mental Health	Under consideration	HHSC acknowledges this issue and appreciates continued stakeholder feedback. Texas is a large state that includes rural counties where there are few primary care, specialty, or behavioral health providers. Also, Texas and the nation are experiencing a shortage of mental health providers and the extent of the mental health shortage is expected to worsen as the workforce continues to age (Hogg Foundation for Mental Health, 2011). To ensure access to Medicaid providers, HHSC expects its contracted Medicaid MCOs and DMOs to ensure access to primary care, specialty, and behavioral health providers within a certain distance of an individual's home, as defined by the state. However, MCOs and DMOs can only meet this standard when the provider base exists and the providers are also contracted with the state Medicaid program. MCOs and DMOs that do not meet these standards are subject to remedies, including liquidated damages, and must maintain an adequate provider network as a condition of contract retention and renewal.	HHSC will explore the feasibility of developing trauma informed systems of care for individuals with IDD as well as comprehensive assessments in managed care that include mental health screening and evaluations.
78	**When Star Kids is effective 9/1/2016, what will be the procedure for allowing providers to enroll in the contracted network?**	Outpatient Independent Rehabilitation Association	Complete	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.
79	**Share the implementation timeline for SB 760.**	AARP	In progress	HHSC is developing an implementation plan for SB 760. The SB 760 workgroup will amend certain rules related to network adequacy requirements. In addition, the workgroup will review comments submitted during the November 30th Public Forum, and determine how to incorporate feedback into Medicaid managed care contracts and Uniform Managed Care Manual.	An SB 760 stakeholder forum has been scheduled for June 6th, 2016. HHSC anticipates initial rule and contract changes will be completed in September 2016. Additional rule and contract changes deemed necessary will be completed in early 2017.

80	**Identify accurate and comprehensive methods for tracking and proving network adequacy, particularly for pediatric services and LTSS.** Network Adequacy – As you know, this has been an ongoing concern for our organization and other stakeholders, particularly when it comes to establishing network adequacy for specialty services and long term services and supports (LTSS). Because home care agencies are by nature mobile, the current geo tracking system is inadequate for establishing network adequacy for home and community based services. We would like to work closely with your staff on the implementation of SB 760 and identify accurate and comprehensive methods for tracking and proving network adequacy, particularly for pediatric services and LTSS. We have provided recommendations to your staff in the past, such as measuring start-of-care timeframes, and would appreciate the opportunity to refresh those conversations.	Texas Association for Home Care & Hospice	In progress	HHSC is developing an implementation plan for SB 760. The SB 760 workgroup will amend certain rules related to network adequacy requirements. In addition, the workgroup will review comments submitted during the November 30th Public Forum, and determine how to incorporate feedback into Medicaid managed care contracts and Uniform Managed Care Manual.	HHSC is currently working with EQRO to develop recommendations for revised network access standards. The EQRO report is expected in May 2016.
81	**Ensure access to providers of pediatric and adult services.** While an MCO might employ or contract with a specific number of providers based on the number of beneficiaries in their network, the providers may be trained or limited in the ages of the people they treat. Ensuring access to providers of pediatric and adult services, as appropriate, would address this concern while strengthening provider networks and promoting beneficiary access. Additionally, fee schedules should be set in accordance with the current Medicaid fee schedule so that providers are not discouraged from accepting patients enrolled through MCOs.	Texas Speech-Language-Hearing Association	In progress	HHSC is continuing its work on SB 760 implementation. HHSC worked with our External Quality Review Organization (EQRO) to perform an appointment availability study to validate provider directory information and appointment wait times for select provider types. This study looks at appointment availability separately for children and adults for primary care providers and behavioral health providers and also appointment availability for OB/GYN services and children's vision care. HHSC does not set rates for services reimbursed by MCOs. MCOs are delegated the responsibility of managing a network and setting rates.	HHSC and EQRO are working to finalize the appointment availability study. Once results have been finalized, HHSC will determine actionable next steps.
5	**Analyze outpatient and emergency room services use.** Perform a comprehensive analysis of Medicaid outpatient clinic and Emergency Room use by Service Delivery Area by Managed Care Organization. Compare the actual utilization of Medicaid outpatient and ER services to HEDIS standard use rates by age group to identify which MCOs in which markets have high rates of outpatient and ER care. The analysis must be performed by age group because the HEDIS standard for utilization of service varies dramatically for clients of different ages. While 100% compliance with HEDIS standards may not be feasible for the Texas Medicaid population, the standards serve as a widely-used, widely-credible standard for managed care delivery nationwide. The analysis can be completed by measuring the actual number of visits per 1,000 by age group.	Texas Hospital Association	In progress	HHSC currently is analyzing outpatient services and emergency department visits by plans and service areas. HHSC plans to have this data available for internal HHSC review in mid-February 2016; however, this data will not be compared with the HEDIS standard.	An update will be provided on the next posting.

	Continuity of Care				
#	**Stakeholder Recommendation**	**Provided by**	**Status**	**HHSC Response**	**Next Steps and Key Milestones**
82	**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.	Texas Rehab Providers Council	No action to be taken	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.	N/A
83	**When a member does make a MMC plan change, we are asking for a transfer of the existing PA for service needs to "carry over" to the new plan, for the remainder of the PA date span.** PA & physician order continuity upon MMC change: When a member does make a MMC plan change, we are asking for a transfer of the existing PA for service needs to "carry over" to the new plan, for the remainder of the PA date span. Most times, when this switch occurs providers must obtain new orders and PA's delaying service to an already current member with an active PA (previous MCO). Included in this, we would like for current physician order to be accepted as "good" as long as physician signature date is within 180 days of service date.	Texas Rehab Providers Council	No action to be taken	HHSC contractually requires MCOs to provide continuity in the care of newly enrolled members in accordance with UMCC Section 8.2.1, "Continuity of Care and Out-of-Network Providers." However, this requirement is contingent upon the member's provider notifying the MCO of the existence of a prior authorization. The order is valid for the shortest period of one of the following: (1) 90 calendar days after the transition to a new MCO or 180 calendar days for LTSS services for STAR+PLUS members; (2) until the end of the current authorization period; or (3) until the MCO has evaluated and assessed the member and issued or denied a new authorization.	N/A

	Rates				
#	**Stakeholder Recommendation**	**Provided by**	**Status**	**HHSC Response**	**Next Steps and Key Milestones**
74 h	**Medicaid reimbursement rates for providers need to be appropriate to pay for services provided to people with disabilities.**	EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas	Statutory Change Required	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.
84 86	**Ensure that provider payments, including direct service professionals/attendants, are sufficient to support service delivery transformations, such as expansion of managed care.**	Disability Rights Texas/EveryChild, Inc./Texas Council for Developmental Disabilities/The Arc of Texas	Statutory Change Required	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.
105	**Raise the current base HCBS rate for community attendants.**	ADAPT Texas	Statutory Change Required	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.
77	**Payment that is equal to the published state benefit for all MCOs.**	Outpatient Independent Rehabilitation Association	No action to be taken	HHSC currently does not set rates for services reimbursed by MCOs. MCOs are delegated the responsibility of managing a provider network and setting rates.	N/A

85	**More adequately support people with complex medical and physical support needs to achieve community integration in the least restrictive setting to meet their needs.**	EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas	In progress	HHSC and DADS have developed a high-medical needs add-on for its Intermediate Care Facilities for Persons with Intellectual and/or Developmental Disabilities and is currently working on developing such an add-on for the Home and Community-based Services (HCS) Program.	Proposed rules for HCS high medical needs add-on should be published in the Texas Register for comment on September 23, 2016. Final rule should be adopted effective December 19, 2016. Rate for HCS high medical needs add-on should be effective by January 1, 2017.
87	**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.**	Texas Medical Association (TMA)/Texas Pediatric Society	In progress	Currently fee-for-service 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 will review LARC rates every year. The review schedule will be shared with stakeholders once it is determined.

Stakeholder Engagement and Feedback

#	Stakeholder Recommendation	Provided by	Status	HHSC Response	Next Steps and Key Milestones
93	**Seek stakeholder input about access to care issues from stakeholders beyond from just those individuals and entities which interface regularly with HHSC. Although not inclusive, such could be accomplished by conducting stakeholder forums across the state (similar to the 'Listening Sessions' HHSC held) and/or via a survey.** Notes: Regardless of the method selected (and if the feedback to be obtained will cross various populations), it is strongly recommended HHSC ensures the feedback/data it collects is identified and analyzed by population. Coupled with the above, the following is recommended: - Any survey conducted should be relatively short and simple and ask questions pertinent to the population from which information is being collected. - Input from stakeholders in the development of the survey should be obtained. - Regardless of which method or methods HHSC decides to use to obtain feedback, the recommendations received and HHSC's response to the feedback (actions it will initiate to address) should be timely and made available to all interested persons. - HHSC include any recommendations offered in the various 2015 SB 7 Advisory Committee Reports and which are not duplicative of recommendations stakeholders submit through this process for review and consideration at the November 9, 2015 meeting.	Private Providers Association of Texas (PPAT)	Under consideration	HHSC strives to engage stakeholders and appreciates suggestions for improving this process. HHSC will explore ways to better engage a broad base of stakeholders.	HHSC held a stakeholder forum and completed a stakeholder survey on implementation of SB760. HHSC is currently compiling and reviewing stakeholder responses for consideration in ongoing efforts to improve network adequacy. HHSC will also consider options for seeking stakeholder input on an ongoing basis.
94	**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.**	Private Providers Association of Texas (PPAT)	In progress	HHSC appreciates the on-going 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 will continue to consider feedback from families and LTSS providers on ways to alleviate burdensome processes. HHSC will actively seek feedback by adding this topic to current appropriate stakeholder forum agendas.
95	**Conduct satisfaction surveys from individuals with IDD who have had their acute care services transitioned to managed care.** The recommendation includes development of a questions that are relevant to persons with IDD, hence sent separately from any questionnaire sent to others enrolled in the Texas Medicaid managed care program. Note: The introductory information sent to persons with IDD prior to the 9/1/14 transition contained STAR+PLUS Health Plan Report Cards. The purpose of such was to offer individuals and families information about the MCOs as reported or rated by others using the MCOs. The information was not relevant to assist persons in making an informed MCO selection for a host of reasons. One reason is that persons enrolled in an IDD waiver whose acute care services were transitioned to managed care in the Medicaid Rural Service Areas in 2012 were not sent the questionnaire that served as the basis for the Health Plan Report cards sent to individuals and families prior to the 9/1/14 transition. Even if the questionnaire had been sent to the 2012 IDD MRSA transition group, many of the items to be rated were not items of most importance to persons with IDD.	Private Providers Association of Texas (PPAT)	Under consideration	HHSC will discuss the feasibility of a satisfaction survey for this population, seeking input from our IDD System Redesign Advisory Committee as well as the MCOs.	This item will be added to the July 28, 2016 IDD System Redesign Advisory Committee (SRAC) Meeting agenda and HHSC will discuss the feasibility of this survey with MCOs.
97 98	**Meaningfully inform and include people with DD on councils, workgroups, and committees concerning their health and human services.**	Disability Rights Texas/EveryChild, Inc./Texas Council for Developmental Disabilities/The Arc of Texas	In progress	While HHSC makes every effort to inform and include individuals with developmental disabilities on committees, councils and workgroups, we are always interested in ways we might enhance outreach and participation. HHSC is currently examining our committee memberships and other opportunities for public comment to look for areas of improvement.	HHSC will continue to consider individuals with DD for council, workgroups and committees. HHSC currently engages the HHSC civil rights agency staff in council and committee membership decisions to ensure adequate and diverse representation on the councils and committees.

99	**Hold stakeholder meetings with HHSC and MCOs to specifically discuss issues with MCOs on a quarterly basis to increase the transparency of MCO operations.**	Outpatient Independent Rehabilitation Association	Under consideration	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. HHSC will continue to hold the IDD Managed Care Workgroup and STAR+PLUS stakeholder meetings on a quarterly basis. HHSC will continue to host regular STAR Kids stakeholder meetings. HHSC will continue to work with stakeholders and MCOs as the need arises for additional meetings and collaboration. The above mentioned meetings, include stakeholders, MCOs, and HHSC and DADS staff.
34 d 100 101	**Efforts to educate TMA and other organizations representing acute care providers regarding the transition of IDD services into the Texas Medicaid managed care system need to be initiated or, if already initiated, intensified.** This includes ensuring: - Those organizations educate their respective members about the IDD population, - Acute care providers understand their respective responsibilities in providing medical and other health-related care and services under the Texas Medicaid Managed Care program, and - HHSC responds to acute care providers' concerns about the Texas Medicaid managed care system which many cite as their reasons for either refusing or terminating their 'relationships' with MCOs (concerns such as increased administrative requirements not experienced under 'traditional' Medicaid and reported billing and payment issues). Also conduct additional training for all affected stakeholders (MCOs, MCO SCs, LTSS IDD providers, and individuals with IDD receiving services (either acute care only or other services, specifically CFC) through STAR+PLUS and their LARs or families, Local IDD Authorities) to include: Further training related to the roles and responsibilities of the MCOs, LIDDAs and LTSS under managed care, and Communication of changes to processes to affected stakeholders. Note: Use of complaint data related to IDD service-related issues might be helpful in identifying topics that would be beneficial to include in any training as well as issues raised in various agency workgroup meetings in which IDD-related issues are discussed.	Private Providers Association of Texas (PPAT)/ EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas	In progress	While HHSC makes every effort to inform and include organizations and providers on forums, councils and workgroups, we are always interested in ways we might enhance outreach and education.	HHSC will request feedback from the IDD System Redesign Advisory Committee (SRAC) regarding the best way to engage and educate TMA and other organizations. This topic will be added to the next Transition to Managed Care SRAC Subcommittee meeting tentatively scheduled for 4/25/16 (this may be moved to May).