### Alternative Payment Mechanisms

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<tr>
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<th>Stakeholder Recommendation</th>
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<th>Next Steps and Key Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td><strong>Texas Association for Home Care &amp; Hospice</strong></td>
<td><em>In progress</em></td>
<td></td>
<td><strong>HHSC will continue the internal workgroup focusing on coordination and streamlining efforts required by SB 200 (Sunset Bill).</strong> HHSC will also be looking at the need for value-based purchasing with providers. <strong>TAHC&amp;H is also interested in working with stakeholders and MCOs on facilitating innovative payment models.</strong> 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 an annual basis.**</td>
</tr>
<tr>
<td>23</td>
<td><strong>Quality Health Care Hospitals (QHCH)</strong></td>
<td><em>In progress</em></td>
<td></td>
<td><strong>HHSC is in the process of producing an initial summary document (issued within HHSC’s quality website) of currently funded payment models being used in managed care. In addition, the template used for the current contracting overview has been updated to capture additional information.</strong></td>
</tr>
<tr>
<td>30</td>
<td><strong>Texas Association for Behavioral Health</strong></td>
<td><em>In progress</em></td>
<td></td>
<td><strong>HHSC is working with the MCOs to encourage the use of value-based purchasing with providers. In doing so, HHSC will be coordinating with the MCOs on the development of LTSS measures, which will commence soon after the implementation of already developed measures.</strong></td>
</tr>
<tr>
<td>30</td>
<td><strong>Texas Association for Community Centers</strong></td>
<td><em>In progress</em></td>
<td></td>
<td><strong>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 has been the result when managed care seeks the lowest bidder. Rather than trimming the network in this way, TAHC&amp;H would like to see managed care companies contracting based on integrated purchasing initiatives, such as gain sharing, to reward physicians for improving Medicaid quality and reducing costs.</strong></td>
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<td>30</td>
<td><strong>Texas Council of Community Service Providers</strong></td>
<td><em>In progress</em></td>
<td></td>
<td><strong>HHSC is also interested in working with stakeholders and MCOs on facilitating innovative payment models.</strong> 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 an annual basis.**</td>
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**HHSC** is the abbreviation for the Texas Health and Human Services Commission.
Conduct data analysis to support incentive payments.

- Conduct an analysis to compare and compute:
  - Hospital outpatient out-of-network rates of contracted services:
  - Dollar impact of high utilization of outpatient and ER services; and
  - Development of potential incentive payments to MCOs that control outpatient rates of utilization.

This 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 the data to consider providing incentive payments to high performing MCOs. THHSC will consider expanding impact analyses to incorporate this feedback.

<table>
<thead>
<tr>
<th>Texas Hospital Association</th>
<th>Other</th>
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<td>Texas Medicaid should include coverage for services provided by Psychology predoctoral interns and postdoctoral fellows who are in the predoctoral or postdoctoral levels.</td>
<td>Texas Medicaid</td>
<td>Under Consideration</td>
<td>Implement policy language to implement the recommendation for stakeholder comment.</td>
<td>Timeline is dependent upon prioritization within the medical policy review process.</td>
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<td>Texas Medicaid</td>
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<td>Implement policy language to implement the recommendation for stakeholder comment.</td>
<td>Timeline is dependent upon prioritization within the medical policy review process.</td>
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**HHSC is drafting policy language to implement this recommendation for stakeholder comment.**

**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 committed to continuous improvement of the behavioral health services provided to Medicaid members. HHSC is drafting policy language to implement this provision for stakeholder comment.**

**HHSC has an existing process for reviewing Medicaid medical benefits. Stakeholders can submit a topic nomination form with evidence to support their recommendation. 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](http://www.hhsc.state.tx.us/medicaid/MPR/index.shtml).**

**Timeline is dependent upon prioritization within the medical policy review process.**
HHSC is required to assess members within the timeframes outlined in their contract. HHSC will review these timelines to ensure they are reasonable and adequate. Providers may request a change in the timeframe of the assessment by submitting a request to the HHSC Ombudsman (clients) or the HHSC Health Plan Management (providers). Stakeholders are requested to submit complaints and examples of untimely assessments to the HHSC Ombudsman (clients) or HHSC Health Plan Management (providers).

DME follow Medicaid policy, as well as federal and state laws. HHSC will consider the concerns identified here and is committed to strengthening the complaints process.

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 continue to monitor MCOs to ensure the assessments are happening in a timely manner.

HHSC is also reviewing the contractual timelines by which MCOs are required to assess members. The timeline is dependent upon prioritization within the medical policy review process. Once a topic nomination form is submitted, HHSC staff will do a policy scan and the policy nomination will be approved. The map will be published in the HHSC Health Plan Management (providers).

Removal of prior authorization for medical drug screens.

DME requests that are denied are reviewed and resolved by the HHSC DME Department. If the issue is not resolved to the satisfaction of the provider, the provider may appeal the decision. The appeal process is outlined in the HHSC DME policy and procedures. If the issue is not resolved by the HHSC DME Department, the provider may appeal to the HHSC Health Plan Management (providers).

HHSC is also reviewing the contractual timelines by which MCOs are required to assess members. The timeline is dependent upon prioritization within the medical policy review process. Once a topic nomination form is submitted, HHSC staff will do a policy scan and the policy nomination will be approved. The map will be published in the HHSC Health Plan Management (providers).

HHSC staff conduct desk reviews of standard operating policies and procedures, including prior authorization of DME. HHSC will review managed care DME-related complaints on a quarterly basis. This will enable trending and analysis reporting. HHSC staff will do a policy scan and the policy nomination will be approved. The map will be published in the HHSC Health Plan Management (providers).

HHSC staff conduct desk reviews of standard operating policies and procedures, including prior authorization of DME. HHSC will consider the concerns identified here and is committed to strengthening the complaints process.

HHSC staff conduct desk reviews of standard operating policies and procedures, including prior authorization of DME. HHSC will review managed care DME-related complaints on a quarterly basis. This will enable trending and analysis reporting. HHSC staff will do a policy scan and the policy nomination will be approved. The map will be published in the HHSC Health Plan Management (providers).

HHSC staff conduct desk reviews of standard operating policies and procedures, including prior authorization of DME. HHSC will consider the concerns identified here and is committed to strengthening the complaints process.
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 and substance use disorder benefits are the same as those for medical and surgical benefits. HHSC is working with MCOs to ensure this happens and is providing training to the MCO service coordinators to ensure they are able to accurately and more completely explain the COB option. Rates for support consultation would need to be established and will likely require legislative direction.

To improve the provider's understanding of the requirements to ensure MCOs comply with all elements of MHPAEA, HHSC continues to track and address parity complaints and requires that health plans demonstrate their compliance with all applicable elements of MHPAEA. HHSC awaits the final rules from CMS related to mental health parity and application within Medicaid managed care. HHSC will follow-up with TMA and TPS no later than May 1, 2016 to identify in-office lab services not covered.

The Texas dental community has been calling for policies to allow for venipuncture performed and analyzed in the physician’s in-office lab. Under the current Medicaid Manual, Texas Medicaid should include reimbursement to physicians for venipuncture performed and analyzed in the physician’s in-office lab.

HHSC currently requires that all MCOs comply with parity regulations. Additionally, HHSC continues to evaluate and modify current contractual limits (for example, covered services and benefit limits) for mental health or substance use disorder benefits are generally no more restrictive than requirements or limitations applied to medical and surgical benefits. Recent federal draft rules more clearly outline parity requirements specifically for mental health services. HHSC will follow-up with TMA and TPS no later than May 1, 2016 to identify in-office lab services not covered.

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 need for the treatment modality.

The issue of dental anesthesia administered in ambulatory surgical centers is connected to the review of the Medicaid Manual section 9.2.41.2 Laboratory Handling Fee. The Texas Health and Human Services Commission (HHSC) is requiring the MCOs to submit a new report on CDS utilization in managed care that uses claims data from FY 2016 through FY 2017, which will close the year of baseline measurement.

Texas Medicaid provides reimbursement for numerous evidence-based procedures and no numeric procedure codes.
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<tr>
<td>42</td>
<td>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 delays 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.</td>
<td>Children's Hospital Association of Texas</td>
<td>Under consideration</td>
<td>HHSC will work with CHAT and the MCOs to coordinate with the MCOs to address the specifics of the reported issue.</td>
<td>HHSC will reach out to CHAT by May 1, 2016 to schedule a meeting to further discuss potential solutions for the issue.</td>
</tr>
<tr>
<td>43</td>
<td>Expedite processing of new providers to facilitate claims processing. Timely processing of new providers for claim determination. Once we receive attestation from TMHP, some Managed Care Plans take up to 60 days to update their systems, which results in 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.</td>
<td>Children's Hospital Association of Texas</td>
<td>In progress</td>
<td>HHSC is convening a stakeholder forum on June 6, 2016 to discuss expedited credentialing as well as other SB 760 requirements.</td>
<td>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 to improve the Provider Credentialing process.</td>
</tr>
<tr>
<td>44</td>
<td>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.</td>
<td>CHAT (Children's Hospital Association of Texas)</td>
<td>Under consideration</td>
<td>HHSC will work with CHAT and the MCOs to coordinate with the MCOs to address the specifics of the reported issue.</td>
<td>HHSC will reach out to CHAT by May 1, 2016 to schedule a meeting to further discuss potential solutions for the issue.</td>
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<tr>
<td>45</td>
<td>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.</td>
<td>Texas Medical Association (TMA)/Texas Pediatric Society</td>
<td>Under consideration</td>
<td>Information should be made available by the adjudicator that specifies allowable modifiers for claims processing.</td>
<td>HHSC will work with TMA/TPS to ensure that May 1, 2016 is the deadline for provider training to be posted and acknowledged by the reported issue.</td>
</tr>
</tbody>
</table>
### Improvement in Eligibility Data Communication between TMHP and MCOs

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<tr>
<th>CHAT (Children’s Hospital Association of Texas)</th>
<th>Under consideration</th>
<th>HHSC will reach out to CHAT by no later than May 1, 2016 to schedule a meeting to further discuss this issue and pursue a remedy if appropriate.</th>
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- Improve accuracy of eligibility data communicated between TMHP and Managed Care Plans.
- Unenforced laws allow Managed Care Plans to delay or not communicate timely eligibility data to TMHP. This can lead to delays in processing claims and eligibility verification.
- HHSC will work with CHAT to identify and enforce any specific MCO contract compliance issues.
- CHAT will work with TMHP to ensure timely eligibility data communication.
- HHSC will reach out to CHAT by no later than May 1, 2016 to schedule a meeting to further discuss this issue and pursue a remedy if appropriate.
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<td>47</td>
<td>Require MCOs to directly communicate changes at least 60 days in advance of effective date.</td>
<td>Texas coalition of Texans with Disabilities/Coalition of Texans with Disabilities</td>
<td>HHSC will work to communicate this information in the timeliest manner possible and will work to ensure the information is actionable. HHSC will be proactive in communicating this information to providers. HHSC will also work to ensure that there is a clear timeline for communication regarding changes, where there are limits taken into consideration.</td>
<td>HHSC will examine a list of contracts for feedback that will provide valuable information to facilitate the communication of critical information to providers. Limitations in advance communication are ongoing.</td>
</tr>
<tr>
<td>48</td>
<td>HHSC should require DMOs to share their client outreach efforts with the dentist provider so that both can work together to help remove barriers to dental care.</td>
<td>Texas Dental Association</td>
<td>Providers have the ability to refer a patient who frequently misses appointments to the Texas Health Steps Outreach &amp; Informing Unit for follow-up. DMOs are required by contract to train providers about the availability of the Texas Health Steps Outreach &amp; Informing Unit. In addition, DMOs member handbooks emphasize the importance of keeping or properly rescheduling appointments. Finally, DMO member advocates identify members who miss appointments so they can help minimize barriers to care.</td>
<td>HHSC will work with the DMOs to identify possibilities for sharing information on outreach activities to reduce missed appointments.</td>
</tr>
<tr>
<td>49</td>
<td>Ensure that the &quot;authorized representative&quot; 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 dental office.</td>
<td>Texas Dental Association</td>
<td>HHSC will review the process of sharing names of authorized representatives to identify areas where changes can be made to improve the process.</td>
<td>HHSC is currently analyzing the legal implications of this change and will inform the Texas Dental Association of the outcome by June 1, 2016.</td>
</tr>
<tr>
<td>50</td>
<td>Provide all assessments for services to the consumer as they are completed and not only upon request.</td>
<td>Texas Coalition for Developmental Disabilities/The Arc of Texas</td>
<td>HHSC will take this request into consideration as we develop policy regarding assessments for these populations.</td>
<td>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.</td>
</tr>
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</table>

**Communications**

- **Improving Member and Provider Experience in Medicaid Managed Care**
- **Stakeholder Recommendation Provided by Status HHSC Response Next Steps and Key Milestones**
- **Communications**
  - **Improving Member and Provider Experience in Medicaid Managed Care**
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      - **Stakeholder Recommendation Provided by Status HHSC Response Next Steps and Key Milestones**

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Require MCOs to share meaningful and actionable data with network 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 opportunities for the MCO to be aware of network improvement by physicians and network that might not be otherwise available.

- 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.

Require MCOs to promptly notify physicians when the practice's assigned provider representative has changed.

- For frequently, ensure calls from physicians who have attempted to resolve complaints with a plan, but were ignored because their provider representative kept changing, often without notice. Require the practice to stand 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.

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 email.

- Beginning May 1, 2016, when HHSC becomes aware of drug shortages, it will notify applicable associations so they can notify their members.
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<td>Request that the DMOs submit the data in a new format with different data points.</td>
<td>DHSS</td>
<td>Under</td>
<td>Last Contact received the letter. This request must be reviewed to ensure that it aligns with the stakeholder recommendations.</td>
<td>HHSC will discuss ideas to better address this issue with the DMOs. This item will be discussed at the next DMOs meeting.</td>
</tr>
<tr>
<td>56</td>
<td>Recommend the baseline administrative and contract transactions for fee-for-service.</td>
<td>Texas Medicaid</td>
<td>Under</td>
<td>HHSC is still working with TDI and TAHP on this issue and will provide an update on the next posting.</td>
<td>HHSC will reach out Acadian Ambulance Service no later than May 1, 2016 to schedule a meeting to discuss potential solutions.</td>
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<td>57</td>
<td>Request for the DMO’s judicial performance standards not to change.</td>
<td>Texas Medicaid</td>
<td>Under</td>
<td>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.</td>
<td>TDI is still working with TIII and TII on this issue and an update will be provided on the next posting.</td>
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### Improving Member and Provider Experience in Medicaid Managed Care

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 their provider access and enrollment status. If the DMOs are not conducting verification with new providers and request enrollment under AIP, HHSC will request them to provide additional information in order to conduct a complete verification.

If the DMOs are not identifying the correct error codes, HHSC will conduct a verification with new providers and request the DMOs to provide additional information in order to conduct a complete verification.

Regardless of the errors, HHSC conducts verification with new providers and requests the DMOs to provide additional information in order to conduct a complete verification.

### Default Dental Home Assignment Methodology

Default dental home assignment methodology is also a topic currently under review as part of main dental home stakeholder working group.

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 their enrollment status.

If the DMOs are not conducting verification with new providers and request enrollment under AIP, HHSC will request them to provide additional information in order to conduct a complete verification.

Regardless of the errors, HHSC conducts verification with new providers and requests the DMOs to provide additional information in order to conduct a complete verification.

### Contract Provisions

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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 is 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 certificate, license and contract through DADS as of Sept. 1, 2013. Additionally, MCOs must enter into Network Provider Agreements with any willing hospital facility provider that includes commitments and those that have gone through a change in ownership after Sept. 1, 2013. STP status is extended for the first three operational years of a Medicaid MCO, with nursing facility status as STP ending 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.

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.

HHSC is under consideration
HHSC appreciates this feedback and will consider options to strengthen accountability measures.

Move non-emergency ambulance transportation out of the Managed Care System and under the oversight of HHSC

Due to the number of HMO’s in Texas, there are numerous ways that transportation is being managed. Some HMO’s 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

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.
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<tr>
<td>20</td>
<td>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.</td>
<td>The HHSC Ombudsman is currently looking at the roles of service coordinators and ways to strengthen the roles of the MCO provider relations teams especially when serving on a monthly basis, to determine the types, as well as the volume of complaints received related to nursing facility members.</td>
<td>New System</td>
<td>HHSC/DADS/Office of Ombudsman are coordinating and working with stakeholder groups to create available persons and contact information to Medicaid managed care consumers, as required by SB 760, 84th Legislature, Regular Session, 2015.</td>
<td>To report complaints directly to HHSC. <a href="https://www.hhsc.state.tx.us/ombudsman/">https://www.hhsc.state.tx.us/ombudsman/</a> or <a href="mailto:HPM_complaints@hhsc.state.tx.us">HPM_complaints@hhsc.state.tx.us</a></td>
</tr>
<tr>
<td>21</td>
<td>The HHS Ombudsman will host discussions with the State LTC Ombudsman and others about what is available to support and information services to Medicaid managed care consumers.</td>
<td>The HHSC/DADS Long-Term Care Ombudsman has requested nursing facility specific data from the MCOs, while HHSC receives complaints sent primarily by providers. Member and Provider manuals include detailed information on how to file a complaint and appeal.</td>
<td>In process</td>
<td>HHSC/DADS/Office of Ombudsman are coordinating and working with stakeholder groups to create available persons and contact information to Medicaid managed care consumers, as required by SB 760, 84th Legislature, Regular Session, 2015.</td>
<td>The HHSC/DADS Long-Term Care Ombudsman will provide information services to Medicaid managed care consumers.</td>
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<td>22</td>
<td>STAR+PLUS MCOs to notify a STAR+PLUS member in writing, within 5 days, if their service coordinator is no longer available or if there is a change in the service coordinator’s name or contact information.</td>
<td>HHSC also added requirements that an MCO notify members and providers up an on time for the first time, and then at least annually.</td>
<td>In process</td>
<td>HHSC/DADS/Office of Ombudsman are coordinating and working with stakeholder groups to create available persons and contact information to Medicaid managed care consumers, as required by SB 760, 84th Legislature, Regular Session, 2015.</td>
<td>The HHSC/DADS Long-Term Care Ombudsman will provide information services to Medicaid managed care consumers.</td>
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<td>23</td>
<td>HHSC includes improvements, through email or on websites, to include the star+plus member’s contact information, including contact name, address, phone number and email address, as well as notification of any changes to these.</td>
<td>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 on a monthly basis, to determine the types, as well as the volume of complaints received related to nursing facility members.</td>
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<td>HHSC/DADS/Office of Ombudsman are coordinating and working with stakeholder groups to create available persons and contact information to Medicaid managed care consumers, as required by SB 760, 84th Legislature, Regular Session, 2015.</td>
<td>The HHSC/DADS Long-Term Care Ombudsman will provide information services to Medicaid managed care consumers.</td>
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<td>24</td>
<td>HHSC is committed to ensuring clients receive the services they need and will certainly consider opportunities to leverage consolidation with DADS and the HHSC Ombudsman program, as well as other avenues to improve the HHSC Ombudsman program.</td>
<td>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 on a monthly basis, to determine the types, as well as the volume of complaints received related to nursing facility members.</td>
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<td>HHSC/DADS/Office of Ombudsman are coordinating and working with stakeholder groups to create available persons and contact information to Medicaid managed care consumers, as required by SB 760, 84th Legislature, Regular Session, 2015.</td>
<td>The HHSC/DADS Long-Term Care Ombudsman will provide information services to Medicaid managed care consumers.</td>
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The STAR+PLUS provider handbook includes guidelines on how to best utilize care coordination, as well as instructions on requesting care coordination for those individuals who are authorized to receive the benefit. Unfortunately, care coordinators do not change their name on the endorsement form before authorizing services for their members. This option will be available under STAR Kids through an integrated health home. HHSC will also assess the feasibility of subcontracting for acute care services, such as respiratory therapy, for members through an enhanced medical home model. The EHO must consider a vendor's health record that provides an easy to access, effective manner through which an enhanced medical home team can receive critical information about a person's change in condition. HHSC’s current contract standards and authorization processes will ensure that these concerns are addressed.

Service coordinators must meet with members when assessing LTSS prior to authorizing services. Prior authorizations are not required for emergency services, but may be used to ensure appropriate use of services. 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 their caregivers may request 
filing a claim with the provider's appeal process. A member may request 

HHSC does allow certain specialists to be PCPs and is willing to consider additional stakeholder feedback. Currently, members with special health care needs have access to the 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.

HHSC's role in STAR Kids is to provide information to members and family members about the services available to them. HHSC and its managed care contractors must ensure that individuals have the support needed to successfully plan and access services for individuals with complex medical, physical and developmental needs. Improving member and provider experience in Medicaid managed care is the focus of HHSC's current efforts. HHSC continues to provide training to MCOs around SC and requirements around care coordination and MCO standards will be operational effective 11/1/16. Everyone in STAR Kids will have access to service coordination. HHSC will detail case of stovepipe information systems, making sure members receive the transition planning and requirements regarding a person's change in condition. The STAR Kids contract is operational 11/1/16.

HHSC’s role in STAR Kids is to ensure that appropriate care is provided, that the person is treated with respect, and that they are able to take advantage of this service. Every child in STAR Kids who needs service coordination will have a service coordinator. This includes activities that assist members to find adult providers and preparing members for transitioning to STAR+PLUS when appropriate.
<table>
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<tr>
<th>#</th>
<th>Stakeholder Recommendation</th>
<th>Provided by</th>
<th>Status</th>
<th>HHSC Response</th>
<th>Next Steps and Key Milestones</th>
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<tbody>
<tr>
<td>25</td>
<td>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.</td>
<td>Coalition of Texans with Disabilities/EverYchild, Inc./Texas Council for Developmental Disabilities/The Arc of Texas/Disability Rights Texas</td>
<td>In progress</td>
<td>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 ventilator services as defined in Medicaid rules. The workgroup will collaboratively address key barriers to transitioning ventilator-dependent members as well as to the community. Finding community providers who are trained and available to deliver these services in community-based models, 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.</td>
<td>A meeting with MCO service coordination managers will be scheduled to discuss how to facilitate the transfer of members from NF to community and the transfer of ongoing information related to these activities.</td>
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<td>1a-b</td>
<td>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 CMS providers and families to submit reimbursement for these services from either MCOs or HHSC. The workgroup addressed this recommendation and developed the following recommendation: Our current fee-forservice payment structure includes a Medicaid provider (MLPA) option. This has been successful in minimizing the number of disputes among providers and families. However, there are areas where additional information is needed to appropriately address this recommendation.</td>
<td>Private Providers Association of Texas (PPAT)</td>
<td>Under consideration</td>
<td>HHSC requires additional information from PPAT on a process that 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.</td>
<td>PPAT feedback indicates that PPAT and CMS plan to develop an interim process. PPAT will continue to work with CMS regarding services for which MCOs are not paying. PPAT will continue to work with CMS regarding services for which MCOs are not paying.</td>
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<td>1c</td>
<td>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 have to travel outside of their local community to obtain medical care, what challenges do they experience as a result of such travel, etc.? 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.</td>
<td>Private Providers Association of Texas (PPAT)</td>
<td>Under consideration</td>
<td>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.</td>
<td>HHSC will continue working on implementation of SB 760, including the required biennial report.</td>
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<td>74f</td>
<td>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.</td>
<td>EveryChild, Inc./Texas Council for Developmental Disabilities/The Arc of Texas</td>
<td>In progress</td>
<td>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.</td>
<td>HHSC will continue working on implementation of SB 760, including the required biennial report.</td>
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Last Updated: April 11, 2016
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<tr>
<th>Improvement</th>
<th>Description</th>
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<tr>
<td>Medicaid managed care</td>
<td>Improve member and provider experience</td>
<td>In progress</td>
</tr>
<tr>
<td>Provider directories</td>
<td>Improving accuracy and completeness</td>
<td>In progress</td>
</tr>
<tr>
<td>Network adequacy</td>
<td>Evaluate utilization of out-of-network providers</td>
<td>Complete</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>Improve quality and access</td>
<td>Complete</td>
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<tr>
<td>Special populations</td>
<td>Ensure access and quality for dual eligibles</td>
<td>Complete</td>
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<tr>
<td>Single case agreements</td>
<td>Increase utilization of out-of-network providers</td>
<td>Complete</td>
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<tr>
<td>Outreach and education</td>
<td>Increase awareness and participation</td>
<td>Complete</td>
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<tr>
<td>Hearing services</td>
<td>Improve member and provider experience</td>
<td>Complete</td>
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**Recommended Improvements:**

- HHSC contractually requires Medicaid MCOs 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 reviewing data on network adequacy as part of the establishment of acute care access standards for each Medicaid MCO and will share results with stakeholders. HHSC will report updated network adequacy standards at the Medicaid MCO annual meeting on September 1, 2016.

- SB 760 requires HHSC to publish network adequacy standards and stakeholders will be notified of its publication on the website. HHSC assesses liquidated damages when an MCO fails to provide a covered service. Additionally, HHSC is currently reviewing data on network adequacy as part of the establishment of acute care access standards for each Medicaid MCO and will share results with stakeholders. HHSC will report updated network adequacy standards at the Medicaid MCO annual meeting on September 1, 2016.

- HHSC is considering additional improvements to the Medicaid MCO online provider directories for inclusion in the UMCM. Additional recommendations will be implemented following identification of improvements, including a request to improve the Medicaid MCO online provider directories for inclusion in the UMCM. Additional recommendations will be implemented following identification of improvements, including a request to improve the Medicaid MCO online provider directories for inclusion in the UMCM.
Providers Alliance for HHSC contractually requires Medicaid MCOs to comply with state and federal anti-discrimination laws. HHSC will review the effectiveness of previous 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 available. The MCO must reimburse the pharmacy for the temporary supply. Additionally, if the prescriber's office is closed, the MCO must provide a PA approval or denial immediately. Providers Alliance for HHSC is a group of individuals involved in efforts to improve the quality and accessibility of health care for people with intellectual and developmental disabilities. The Alliance is composed of advocates, providers of services, and individuals and families they serve.

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 denied access to or the benefit of Medicaid expansion. We offer the following analysis and considerations, consistent with recent ACA proposed guidelines to insurers regarding non-discrimination.

Regularly scheduled meetings of LTSS IDD providers, MCOs, and LIDDAs should be held at the local level. The IDD SRAC recommended that the MCOs, LIDDAs and the LTSS DADS waiver providers meet routinely through regional healthcare collaborations to address operational issues/challenges as the MCOs, LIDDAs and providers have an opportunity to work through specific cases. The IDD SRAC also recommended that the MCOs, LIDDAs and the LTSS DADS waiver providers meet routinely through regional healthcare collaborations to address operational issues/challenges as the MCOs, LIDDAs and providers have an opportunity to work through specific cases. 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/challenges as the MCOs, LIDDAs and providers have an opportunity to work through specific cases. 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/challenges as the MCOs, LIDDAs and providers have an opportunity to work through specific cases. 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/challenges as the MCOs, LIDDAs and providers have an opportunity to work through specific cases.

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 eligibility criteria, and lack of prior authorization. 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 eligibility criteria, and lack of prior authorization. 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 eligibility criteria, and lack of prior authorization.

HHSC should consider whether there is a need to develop data requirements for the MCOs to report data on the number of individuals in the IDD population served by the MCO and the services they require on an annual basis. HHSC should consider whether there is a need to develop data requirements for the MCOs to report data on the number of individuals in the IDD population served by the MCO and the services they require on an annual basis. HHSC should consider whether there is a need to develop data requirements for the MCOs to report data on the number of individuals in the IDD population served by the MCO and the services they require on an annual basis.

HHSC should develop and implement a plan to publish quarterly reports to the public on the performance of MCOs in providing services to individuals with intellectual and developmental disabilities. HHSC should develop and implement a plan to publish quarterly reports to the public on the performance of MCOs in providing services to individuals with intellectual and developmental disabilities. HHSC should develop and implement a plan to publish quarterly reports to the public on the performance of MCOs in providing services to individuals with intellectual and developmental disabilities.
Improving Member and Provider Experience in Medicaid Managed Care

The Behavioral Health Integration Advisory Committee (BHIAC) developed recommendations to address some of the administrative challenges providers often experience in a managed care environment. The recommendations include streamlining prior authorization processes, requiring prompt prior authorization decisions, and requiring MCOs to follow standardized authorization guidelines for targeted case management and mental health reimbursement services.

Streamline MCO prior authorization processes and standardize authorization guidelines for targeted case management and mental health reimbursement 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 service plan, Texas Administrative Code, and other applicable reference material. Should any changes to the utilization management guidelines be made, stakeholders will be informed of the changes prior to implementation. HHSC monitors infractions of this policy and addresses them as necessary.
- Authorization process should originate on the therapy provider. We are getting push-back from the physicians. Several MCOs have instituted policy making the PCP responsible for authorizing all service plans. This would align with TMHP's processes. 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 has caused delays in delivery of services.
- 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 they authorize. 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 is critical to ensure uniformity and consistency in how guidelines are adopted and how requirements are applied for PA determination.
- 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 Prior Authorization Request Form. Additionally, HHSC has submitted a concept paper to Centers for Medicare and Medicaid Services (CMS) for a uniform managed care service request form for targeted case management and mental health rehabilitation services. CMS approved the concept for Texas to develop and implement a single registration form to all MCOs that will be used for targeted case management and mental health rehabilitation services (MH TCM and Rehab). HHSC has leveraged Texas Department of Insurance (TDI) Standard Prior Authorization Request Form and detailed elements of the Texas Authorization Request Form (TARF) as the foundation for the standardized form. The TARF provides a standard registration form for 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 guidelines should be made under the following considerations:
  - HHSC will continue to explore other opportunities to help providers navigate the differences, and are working toward standardizing how they manage cost containment.
  - HHSC continues to work with CMS and stakeholders to develop the concept of an improved way of

HHSC will continue to examine opportunities for targeted case management and mental health rehabilitation services.

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- Streamline MCO prior authorization processes and standardize authorization guidelines for targeted case management and mental health reimbursement services.
- Improving access to hospital level of care.
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HHSC is still exploring this recommendation and will provide a stakeholder update as soon as possible.

HHSC-VDP has added tools on its website to simplify the process for a provider or patient to learn what prior authorization (PA) criteria have been identified HHSC uses a very broad formulary to allow prescribers to choose the appropriate treatment for their patient. The members of the advisory committees that identify 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.

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 that edit.

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 that edit.

Further, MCOs should be required to honor the TMHP effective date regardless of whether the MCO has completed the credentialing process and pay claims retroactive to that date once the physician is credentialed by TMHP. Currently, physicians must submit a Medicaid enrollment application then await receipt of a TPI number(s) before beginning the HMO credentialing process while awaiting a physician’s TPI number, but this is not standard practice because some MCOs interpret the HHSC-HMO rules to preclude establishing a parallel process. Once TMHP finalizes a physician’s Medicaid enrollment, the information should be immediately transmitted to the MCO so the plan can complete their credentialing.

Require Medicaid MCOs to simultaneously process physician credentialing applications when 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 while awaiting a physician’s TPI number, but this is not standard practice because some MCOs interpret the HHSC-HMO rules to preclude establishing a parallel process. Once TMHP finalizes a physician’s Medicaid enrollment, the information should be immediately transmitted to the MCO so the plan can complete their credentialing.

While allowing physicians and other acute care providers to simultaneously pursue Medicaid enrollment and HMO credentialing, the state will expedite physician enrollment into HMO networks.

HHSC is committed to improving the enrollment and credentialing systems and processes. We will strongly consider this recommendation when developing 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 is exploring online options for referrals. Currently providers have the ability to fax referrals for specialist services, but an online option could speed up the process.

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HHSC-VDP has added tools on its website to simplify the process for a provider or patient to learn what prior authorization (PA) criteria have been identified.
Provide rationale for changing a drug status from preferred to non-preferred.

Texas Medical Association (TMA)/Texas Pediatric Society

In progress

The high frequency of changes to the Preferred Drug List (PDL) requires that the rationale for the change be posted in the PDL. To address provider concerns, the committee has developed a new tiered methodology for communicating rationale for changes.

HHSC will work with its Preferred Drug List vendor to ensure the rationale for changes is clearly communicated without divulging confidential information.

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, HHSC will work with its Prospective Drug Utilization Review vendor to enhance the published rationale without divulging confidential information.

Revise requirements managing drug benefit to the package insert instead of indication.

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.

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.

Eliminate use of Texas Provider Identifier and only use the NPI number.

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.
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| Eliminate recoupments when a patient is erroneously enrolled in a plan. | Complete | HHSC has established a Provider Recoupment Workgroup to research recoupment issues and identify potential solutions to reduce the number of recoupments. The workgroup is partnering with MCOs to reduce recoupments and is working to ensure that recoupments occur only when the payer believes that the patient was erroneously enrolled in the plan.  
  *HHSC has drafted a high-level estimate to determine system change costs and will notify stakeholders of the feasibility once the estimate is complete.* |
| Implement a provider type and specialty code for urgent care. | 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.* |
| 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). | 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.* |
| Encourage MCOs to "gold star" provider practices that can show a history of proper utilization of medical services and waive certain prior authorization requirements. | 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.* |
| Eliminate pre-authorization for simple procedures in the office. | Under consideration | HHSC is considering ways to alleviate this concern. MCOs might consider waiving pre-authorization for certain procedures or providing a lower level of pre-authorization.  
  *Update to be provided on future posting.* |

*Last Update: April 11, 2016*

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HHSC conducts provider directory verification for the DMOs on a quarterly basis to identify inaccurate directory listings. HHSC may review DMO directory
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
must resolve it within 2 days.
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
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
• 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
• 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.
• Plans must monitor the number of network providers not accepting new Medicaid patients as a way to ensure sufficient in-network providers are available.
• Ensuring the state’s network adequacy standards, assessment procedures and data documenting compliance is clear and transparent to public.
• 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
HHSC should adopt additional standards regarding network adequacy, including:
• 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.
Require DMOs to update their network rosters.
HHSC is interested in improving the information we use to ensure informed decision making. While
HHSC is always interested in improving the information we use to ensure informed decision making. While
If a member makes a request of their service coordinator for help with things like finding a provider or getting more information about their plan, they should expect a response 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.

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, 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 affect out-of-network access for members. HHSC is also working with the External Quality Review Organization (EQRO) to develop recommendations for network adequacy standards. The EQRO Report is expected in May 2016.

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 mental health services for this population, 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. MCOs and DMOs that do not meet network adequacy requirements are subject to potential sanctions including, but not limited to, liquidated damages, and must maintain an adequate provider network as a condition of contract renewal and renewal.

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.

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.
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.

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 patients 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.

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 MCOs in which markets have high rates of utilization. Evaluate HEDIS standards and consider whether any changes to the standards be made. The analysis will identify whether rates are high or low, and further investigation is warranted to better understand the reasons for the variance. This analysis can be completed by measuring the actual number of visits per 1,000 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 standards. An update will be provided on the next posting.
## Continuity of Care

<table>
<thead>
<tr>
<th>#</th>
<th>Stakeholder Recommendation</th>
<th>Provided by</th>
<th>Status</th>
<th>HHSC Response</th>
<th>Next Steps and Key Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>Change time frame when a member can switch plans from 30 to 90 days.</td>
<td>Texas Rehab Providers Council</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Timeframe around member ability to switch plans. Currently members can change plans every 30 days. We are asking Texas Health and Human Services Commission to change this timeframe to every 90 days. Time frames are important as members are not aware of the potential consequences of the change and how it impacts their control and future benefit.</td>
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<tr>
<td>83</td>
<td>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.</td>
<td>Texas Rehab Providers Council</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td></td>
<td>PA &amp; 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 the 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 orders to be accepted as “good” as long as the physician signature date is within 180 days of service date.</td>
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<tr>
<td>74</td>
<td>Medicaid reimbursement rates for providers need to be appropriate to pay for services provided to people with disabilities.</td>
<td>EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas</td>
<td>Priority Follow-up Required</td>
<td>HHSC regularly requests increased funding to address rates where it deems increases are necessary.</td>
<td>Stakeholders will have an opportunity to provide input and recommendations through the process.</td>
</tr>
<tr>
<td>84</td>
<td>Ensure that provider payments, including direct service professionals/attendants, are sufficient to support service delivery transformations, such as expansion of managed care.</td>
<td>Disability Rights Texas/EveryChild, Inc./Texas Council for Developmental Disabilities/The Arc of Texas</td>
<td>Priority Follow-up Required</td>
<td>HHSC regularly requests increased funding to address rates where it deems increases are necessary.</td>
<td>Stakeholders will have an opportunity to provide input and recommendations through the process.</td>
</tr>
<tr>
<td>86</td>
<td>Raise the current base HCBS rate for community attendants.</td>
<td>ADAPT Texas</td>
<td>Statutory Change Required</td>
<td>HHSC currently does not set rates for services reimbursed by MCOs. MCOs are delegated the responsibility of managing a provider network and setting rates.</td>
<td>Stakeholders will have an opportunity to provide input and recommendations through the process.</td>
</tr>
<tr>
<td>105</td>
<td>Payment that is equal to the published state benefit for all MCOs.</td>
<td>Outpatient Independent Rehabilitation Association</td>
<td>No action to be taken</td>
<td>HHSC currently does not set rates for services reimbursed by MCOs. MCOs are delegated the responsibility of managing a provider network and setting rates.</td>
<td>N/A</td>
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<td>77</td>
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<tr>
<td>Issue</td>
<td>Description</td>
<td>Status</td>
<td>Details</td>
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<td>85</td>
<td>More adequately support people with complex medical and physical support needs to achieve community integration in the least restrictive setting to meet their needs.</td>
<td>In progress</td>
<td>HHSC and DADS have developed a high medical needs add-on for the Intermediate Care Facilities for Persons with Intellectual and/or Developmental Disabilities and are 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.</td>
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<tr>
<td>86</td>
<td>Increase payments to cover costs of physicians acquiring long-acting reversible contraceptives (LARCs), such as IUDs, to promote greater use of these devices and to help reduce Texas’ rate of unintended pregnancies.</td>
<td>In progress</td>
<td>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 this annual LARC. HHSC will review LARC rates every year. The review schedule will be shared with stakeholders once it is determined.</td>
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</table>
## Stakeholder Engagement and Feedback

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<tr>
<td>93</td>
<td>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.</td>
<td>Texas Private Provider Association of Texas (PPAT)</td>
<td>Under consideration</td>
<td>HHSC Goal: to engage stakeholders and gather input from individuals and entities which interface regularly with HHSC.</td>
<td>HHSC will discuss the feedback, seeking input from our IDD System Redesign Advisory Committee (SRAC) and the MCOs. This item will be added to the July 28, 2016 SRAC Meeting agenda and HHSC will discuss the feasibility of this survey with MCOs.</td>
</tr>
<tr>
<td>94</td>
<td>Continue seeking input from individuals, families and LTSS providers regarding processes they deem as burdensome and delay access to services, streamlining such as appropriate via a combination of ongoing workgroups and at least annual feedback from stakeholders.</td>
<td>Texas Private Provider Association of Texas (PPAT)</td>
<td>In progress</td>
<td>HHSC Goal: to engage stakeholders and gather input from individuals and entities which interface regularly with HHSC.</td>
<td>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.</td>
</tr>
<tr>
<td>95</td>
<td>Conduct satisfaction surveys from individuals with IDD who have had their acute care services transitioned to managed care. The recommendation includes development of a questionnaire that is 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 with questionnaires 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 contained in the introductory information prior to the 9/1/14 transition was not relevant to assist persons in making an informed MCO selection for a host of reasons. For instance, many of the items to be rated were not items of most importance to persons with IDD.</td>
<td>Texas Private Provider Association of Texas (PPAT)</td>
<td>Under consideration</td>
<td>HHSC Goal: to engage stakeholders and gather input from individuals and entities which interface regularly with HHSC.</td>
<td>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.</td>
</tr>
<tr>
<td>97</td>
<td>Meaningfully inform and include people with DD on councils, workgroups, and committees concerning their health and human services.</td>
<td>Disability Rights Texas/EveryChild, Inc./Texas Council for Developmental Disabilities/The Arc of Texas</td>
<td>In progress</td>
<td>HHSC Goal: to engage stakeholders and gather input from individuals and entities which interface regularly with HHSC.</td>
<td>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.</td>
</tr>
</tbody>
</table>

Last Updated: April 11, 2016
Hold stakeholder meetings with HHSC and MCOs to specifically discuss issues with MCOs on a quarterly basis to increase the transparency of MCO operations.

| Stakeholder Meetings | Consideration
|----------------------|------------------
| HHSC and MCOs        | Periodic

Outpatient

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 SCID representation 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.

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
- TMA and other organizations provide training to acute care providers regarding their respective responsibilities

This includes ensuring that providers understand their respective responsibilities in providing medical and other health-related care and services under the Texas Medicaid Managed Care program.

- TMA and other organizations work with HHSC to provide training and support to acute care providers regarding their respective responsibilities.

This includes ensuring that providers understand their respective responsibilities.

Note: The Texas Medicaid Managed Care program includes all services provided to individuals with IDD, including

- Managed care services
- Medicaid services
- Other services provided by MCOs to individuals with IDD

Also conduct additional training for all affected stakeholders (MCOs, MCO SCs, LTSS IDD providers, and individuals with IDD receiving 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
- Communication of changes to processes to affected stakeholders

Note: Use of complaint data related to IDD services related issues might be helpful in identifying topics that would be beneficial to include in any training as well as issues related to other agency workgroup meetings in which IDD-related issues are discussed.

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).

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).