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

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

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

HHSC responses were shared directly with stakeholder groups in February 2016, updates were first posted to the website on April 11, 2016 and biannual updates on items in progress or under discussion will continue to be shared on the website. Items that are closed as of the last update will be provided in a separate file as there will be no further update. Items were closed either as complete, no action to be taken, or other (issue to be addressed through another existing process). In each quarterly update, changes to previous responses are noted with red strikethrough for language that is being removed in order to provide an update, and new language is provided in red.

Questions about this project can sent to MedicaidManagedCare@hhsc.state.tx.us.

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Table 1: Explanation of Response Fields

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

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	1c
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	PPAT				
HHSC Response:	Senate Bill (SB) 760 and rules issued by the Centers for Medicare & Medicaid Services (CMS) require HHSC to establish minimum access standards, including time and distance, for managed care organization (MCO) provider networks for certain provider types. As part of this analysis, HHSC staff completed the following activities: • compared HHSC existing provider access standards to other state Medicaid programs as well as Medicare standards established by CMS; • conducted literature reviews; • analyzed geo-maps, MCO network adequacy data and out-of-network utilization charts, and provider termination information; • requested HHSC external quality review organization (EQRO) conduct an analysis of best practices for developing provider access standards and monitoring MCO compliance with established standards; • reviewed annual survey results and "secret shopper" information collected by HHSC EQRO; • developed methodology for "secret shopper" and "provider referral" studies in the context of access requirements; • met with numerous stakeholder groups and reviewed stakeholder feedback provided at a public forum held on 11/30/2015; and • reviewed complaints related to network adequacy as well as survey results from the Consumer Assessment of Healthcare Providers and Systems that show member satisfaction with MCO provider networks. Using this information and data, HHSC staff developed a draft proposal for revising existing distance and appointment availability standards as well as creating new travel time standards. HHSC shared the draft proposal at the stakeholder forum on 6/6/2016. HHSC staff reviewed stakeholder input, analyzed the impact these new standards would have on existing MCO networks, comparing the proposed standards to standards for commercial insurance, and identifying all				

	contract provisions and rules that would need to be amended to implement the proposed access standards. HHSC made 3/1/2017 managed care contract changes and will revise rules after contract changes are effective. Any access standards not included in the 3/1/2017 contract amendment will be included in subsequent amendments. This will likely include access standards for urgent care and other acute care services. Network adequacy standards for LTSS will be included in 9/1/2018 managed care contracts. For additional information related to the revised network adequacy process, please contact MedicaidCHIP_Network_Adequacy@hhsc.state.tx.us
Date Last Updated:	10/26/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Develop provider access standards for MCO provider networks.	6/1/2016	Completed	
2	Conduct stakeholder forum to receive feedback on implementing SB 760.	6/6/2016	Completed	
3	Compile and summarize stakeholder feedback	7/12/2016	Completed	
4	Reassess and revise proposed provider access standards based on stakeholder feedback.	8/5/2016	Completed	
5	Amend managed care contracts as necessary to include initial access standards.	3/1/2017	Completed	
6	Amend managed care contracts as necessary to include long term services and supports and other network adequacy standards to meet requirements of CMS rules.	9/1/2018	On Target	
7	Amend agency rules as necessary to include revised access standards.	TBD	Ongoing	HHSC is currently in the process of amending agency rules.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**Number:**	1d
Recommendation:	Explore increasing single case agreements for persons with intellectual and developmental disabilities (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?]				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	PPAT				
HHSC Response:	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 on Rider 81 and Rider 82 were combined into one report and provide information on corrective actions taken against MCOs for not meeting network access standards and single case agreements. The Combined Report on Medicaid Managed Care Provider Network Adequacy, Monitoring, and Violations was available for the public February 2017. Here is the link to access the report: https://hhs.texas.gov/sites/default/files//Combined%20reports%20SB760%20and%20Riders%2081%20and%2082%20PDF.pdf HHSC requires MCOs to develop networks that can sufficiently serve their members, but also encourages MCOs to enter into single case agreements when absolutely necessary to ensure each member has access to necessary services. HHSC will continue monitoring efforts to ensure members access Medicaid benefits, including services for individuals with IDD and related conditions. HHSC and the Hogg Foundation hosted a Medicaid Brainstorming Session on September 29, 2016 to address service gaps and solutions for individuals dually diagnosed with IDD and behavioral health conditions. Part of the discussion addressed provider shortages and gaps in service provision that members with IDD experience.				

	HHSC reviewed the feedback provided during the brainstorming session, sent the brainstorming notes to all external stakeholders to ensure all information was collected accurately and completely, and identified next steps for the recommendations and the workgroup. The IDD System Redesign Advisory Committee (SRAC) will continue this discussion. Refer to the transition to managed care IDD SRAC subcommittee for future information.
Date Last Updated:	11/13/17

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Rider 81 and Rider 82 Reports were combined and are available to the public.	2/1/2017	Completed	
2	HHSC Medicaid Brainstorming Session to address service gaps and solutions for individuals dually diagnosed with IDD and behavioral health conditions.	9/29/2016	Completed	
3	Review feedback obtained during the brainstorming session, and send compiled notes to external stakeholders.	2/21/17	Completed	
4	Identify opportunities in the IDD System Redesign where MH-IDD recommendations discussed during the brainstorming session can be utilized.	9/1/2021	Ongoing	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	1f
Recommendation:	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.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with PPAT on 8/8/2016. PPAT provided feedback that retention is impacted by issues with billing, and provider challenges with submitting a claim that will be accepted without needing changes before processing (clean claim).				
Category:	Network Adequacy / Access to Care				
Provided By:	PPAT				
HHSC Response:	HHSC contractually requires Medicaid MCOs to notify HHSC of provider terminations in accordance with Uniform Managed Care Manual (UMCM) Chapter 5.4.1.1, "Provider Termination Report." Additionally, MCOs that do not meet the UMCM Chapter 5.14.8 State of Texas Access Reform (STAR) and STAR+PLUS Geo-Mapping Report standards—which monitor acute care provider types such as primary care physician (PCP), obstetrician/gynecologist, orthopedic surgeon, cardiologist, 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. In addition, HHSC staff are using data and reports to better understand provider terminations and feedback. Texas Medicaid and Healthcare Partnership (TMHP) conducts presentations at health-related institutions related to Medicaid State Programs (e.g., THSteps Medical and Dental, Children with Special Health Care Needs, Case Management for Children and Pregnant Women, etc.) to recruit new Medicaid providers. HHSC will explore additional options to work with the TMHP to recruit providers underrepresented in the Medicaid network. HHSC also meets with targeted stakeholder groups to discuss issues related to shortages of providers accepting certain populations, specifically individuals with IDD. Work on this issue is ongoing, and HHSC is continually seeking and collecting data related to this topic. If stakeholders have additional information or examples to share, please send that information to MedicaidManagedCare@hhsc.state.tx.us with the subject line: Data Regarding Recommendation 1f.				
Date Last Updated:	12/4/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Identify and review existing reports and sources of information to review for more information about provider terminations and feedback.	9/1/2017	Completed	
2	Discuss billing challenges with MCOs during the MCO one-on-one meetings to find out if they are seeing this issue, and steps they are taking to address the issue.	4/1/2018	On Target	
3	Identify next steps to improve provider recruitment including options to assess and address issues with billing and submitting a claim that will not need changes before processing.	6/1/2017	On Target	Next steps will be identified as appropriate after meetings with MCOs. Meetings are scheduled through June.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	3a
Recommendation:	Evaluate the expedited appeal, service authorization and prior authorization process for IDD clients.				
Additional Stakeholder Background:	Require plans to create an expedited appeal, service authorization and prior authorization process in order to resolve immediate issues that require resolution within timeframes more quickly than what is permissible in the Medicaid managed care manual, which is 30 days in most situations. For example, the 72 hour emergency medication provision is not sufficient in cases when the medication is dispensed on Friday, because if the IDD provider or family is unable to resolve the issue with the MCO on Monday, then the client goes without the medication for an indefinite period of time or the provider or family is forced to pay for the medication.				
Category:	Network Adequacy / Access to Care				
Provided By:	Providers Alliance for Community Services of Texas (PACSTX)				
HHSC Response:	The Uniform Managed Care Contract (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. The 72-hour emergency medication provision is intended to ensure members have access to needed medications even when a prescriber is not available by allowing the pharmacy to dispense and be reimbursed for a 72-hour supply of the medication. HHSC is actively working to make sure providers, members, and MCOs understand the process and have tools to utilize it. This topic was the focus of discussions of the IDD Managed Care Improvement Workgroup on 9/22/2015, 10/5/2015, 2/8/2016, and 5/2/2016, and is now being discussed in the IDD System Redesign Transition to Managed Care Subcommittee. HHSC will coordinate with the subcommittee to identify recommendations to improve the process and ensure individuals, providers, physicians, and pharmacies are aware of the process. The subcommittee worked with a representative from HHSC's Vendor Drug Program (VDP) to develop a prescription education information flyer for members and LTSS providers to use to assist in this process. At their October 2016 and December 2016 meetings, the subcommittee reviewed a draft and discussed recommendations for the flyer and provided feedback to the representative from VDP. The flyer was sent to HHSC Communications and Media Services to ensure the language and format is accessible for individuals with IDD. The subcommittee and full committee reviewed the final document during their October 2017 meeting and voted to finalize and publish the document.				
Date Last Updated:	11/13/17				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	IDD System Redesign Transition to Managed Care Subcommittee.	9/22/2015	Completed	
2	IDD System Redesign Transition to Managed Care Subcommittee.	10/5/2015	Completed	
3	IDD System Redesign Transition to Managed Care Subcommittee.	2/8/2016	Completed	
4	IDD System Redesign Transition to Managed Care Subcommittee.	5/2/2016	Completed	
5	IDD System Redesign Transition to Managed Care Subcommittee.	6/15/2016	Completed	
6	IDD System Redesign Transition to Managed Care Subcommittee to discuss recommended changes and review tools.	8/31/2016	Completed	
7	Full IDD SRAC Meeting. The subcommittee will present to the committee.	10/26/17	Completed	
8	IDD System Redesign Transition to Managed Care Subcommittee reviewed a draft tool and provided feedback.	10/3/2016	Completed	
9	IDD System Redesign Transition to Managed Care Subcommittee reviewed the updated tool and provided additional feedback.	12/13/16	Completed	
10	IDD System Redesign Transition to Managed Care Subcommittee will review the final tool.	10/03/17	Completed	Pharmacy brochure will be distributed to providers, MCOs, and published on the IDD SRAC webpage.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	3 b-d
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	PACSTX				
HHSC Response:	The IDD SRAC made recommendations on how to educate and reach out to individuals with IDD about managed care. HHSC requested feedback from the IDD SRAC on approaches to educating members on the complaint processes, including how to encourage individuals to formally submit complaints, which provides HHSC with more accurate complaint data and enables HHSC to address issues as they arise. HHSC will continue to coordinate with the IDD SRAC and the IDD Transition to Managed Care Subcommittee as issues arise to inform the MCOs about issues, to work through resolution of issues, and improve service delivery.				

	The IDD SRAC recommended that the MCOs, Local Intellectual and Developmental Disability Authorities (LIDDAs), and the LTSS HHSC 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 and 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 Office of the Ombudsman has held two meetings of the "Managed Care Support Network" that includes HHSC, DADS, the Department of Family and Protective Services, Aging and Disability Resource Centers, Area Agency on Aging, enrollment broker (MAXIMUS), and other representatives who interact regularly with consumers and families. The quality subcommittee of the IDD SRAC met regularly and made 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 included a more accessible webpage that includes pictures and fewer words to file a complaint, an appeal, or to obtain information, and for the MCOs to send out a magnet with a number to call to file a complaint. The quality subcommittee ended and the quality subcommittee projects transferred to the transition to managed care subcommittee. The Office of the Ombudsman, Program, and Communications staff are working together to finalize the webpage.
Date Last Updated:	11/13/17

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Quality subcommittee presents recommendations to Full IDD SRAC.	7/28/2016	Completed	
2	Quality subcommittee discussed recommendations with Communications staff.	10/12/2016	Completed	
3	HHSC Program, Communication, and Ombudsman staff met to discuss website options to meet the subcommittees' recommendations while maintaining HHSC branding standards.	12/2016	Completed	
4	HHSC IDD SRAC liaison and Quality subcommittee chair presented identified projects to address subcommittee members' recommendations during the Quality subcommittee meeting.	1/25/17	Completed	

5	HHSC Program, Communication, and Ombudsman staff will meet and develop a timeline to create an accessible webpage for individuals and will present the timeline to the subcommittee.	4/4/17	Completed	
6	HHSC SRAC liaison will provide updates each meeting and work with the subcommittee to obtain feedback during the webpage design		Ongoing	
7	HHSC will survey STAR+PLUS MCOs to obtain more information on how they currently address complaints and if they currently send magnets.	4/4/17	Completed	
8	Accessible webpage design will be tested by individuals with IDD to ensure it is user friendly.	5/1/2018	Delayed	The webpage design is not yet complete to begin testing and feedback.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	3c
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	PACSTX				
HHSC Response:	HHSC currently does not analyze the requested data for the IDD population specifically. HHSC is continuing to 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 recognizes that the first step towards improving member satisfaction is obtaining member feedback on the current service delivery system. HHSC, through its EQRO, conducts routine Consumer Assessment of Healthcare Providers & Systems (CAHPS) surveys of Medicaid and Children's Health Insurance Program (CHIP) managed care members to obtain feedback on healthcare. See recommendation 95 for progress on assessing the applicability of this survey to the IDD population. HHSC reviewed and assessed data, including complaint data, and complaints related to network adequacy and prior authorizations, for inclusion in the House Bill 3523 Legislative Report submitted to the legislature in November 2016. The report can be viewed here: https://hhs.texas.gov/sites/hhs/files//system-redesign-for-indiv-with-idd.pdf. HHSC also added questions related to members with IDD to the PCP Referral Study. This study surveys primary care providers about their experiences in referring members for specialist care. HHSC asked providers about whether they see patients with IDD and to describe their experiences in referring members with IDD for specialist care, including behavioral health care. HHSC is also conducting a focus study to look at consumer experiences of care pre and post STAR Kids implementation. This study will select samples and stratify results using the following eligibility categories: Medically Dependent Children Program, DADS IDD Waivers, Supplemental Security Income (SSI) fee-for-service (FFS), and SSI STAR+PLUS. This should allow HHSC to analyze results specific to members with IDD.				
Date Last Updated:	11/17/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Research to determine if the EQRO data collection process could specify experiences of individuals with intellectual and developmental disabilities.	Spring 2017	Complete	HHSC is working with the EQRO to develop cost estimates regarding different options (e.g., surveys, focus groups, etc.). As a result of IDD SRAC input in October 2017, EQRO is running HEDIS results specifically for individuals with IDD. The results are slated to be shared with the committee in December. Ongoing work on this topic will be facilitated through IDD SRAC.
2	Submit House Bill 3523/ Senate Bill 7 IDD Legislative Report.	11/1/2016	Complete	The House Bill 3523/ Senate Bill 7 IDD Legislative Report was submitted in November 2016. The report can be viewed here: https://hhs.texas.gov/sites/hhs/files//system-redesign-for-indiv-with-idd.pdf.
3	PCP Referral Study final report.	5/31/2018	On Target	Data collection for Phase 2 was delayed until August 2017 due to initial low response rate of less than 12 percent. Data collection will be complete in November with a final report slated for spring 2018. The completed report will be shared with IDD SRAC at this time. Ongoing work on this topic will be facilitated through IDD SRAC.
4	STAR Kids focus study final report.	5/31/2019	On Target	Preliminary results from the pre-implementation study were presented to the STAR Kids Advisory Committee at their public meeting on March 1, 2017. The final pre-implementation report was shared with the committee in summer 2017. The final summary report which will include post-implementation measure results will be shared with the advisory committee in summer 2019. Ongoing work on this topic will be obtained through the committee.

Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	4 / 34d / 51 / 6
Recommendation:	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 Affordable Care Act (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.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/9/2016. These organizations provided feedback that it is important for HHSC to ensure MCOs know their role with home and community based services (HCBS) settings standards and person-setting planning.				
Category:	Network Adequacy / Access to Care				
Provided By:	Disability Rights Texas/EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas				
HHSC Response:	HHSC contractually requires Medicaid MCOs to comply with state and federal anti-discrimination laws. **Section 7.05** ***Compliance with state and federal anti-discrimination laws.*** (a) MCO agrees to comply with state and federal anti-discrimination laws, including without limitation: (1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*); (2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); (3) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq.*); (4) Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107); (5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688); (6) Food Stamp Act of 1977 (7 U.S.C. §200 *et seq.*); and (7) The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement. MCO agrees to comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued pursuant to these laws. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in				

	or denied any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to discrimination. (b) MCO agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15, prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its programs, benefits, or activities on the basis of national origin. Applicable state and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. MCO agrees to ensure that its policies do not have the effect of excluding or limiting the participation of persons in its programs, benefits, and activities on the basis of national origin. MCO also agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities. New federal Medicaid managed care rules include additional clarification regarding non-discrimination related to members and providers in Medicaid Managed Care. HHSC has analyzed the final rule to determine which additional changes to Managed care contracts or policies are necessary. With regard to network adequacy, some standards were proposed based on the requirements of SB 760, 84th Legislature, and were effective in March 2017. These updates included new time and distance standards, based on county designation, and requiring MCOs to ensure members have access to two age-appropriate PCPs within specific travel time and mileage thresholds. As part of this revision, HHSC will use data developed by Data Analytics to analyze compliance. While these revisions do not apply to all provider types covered in the new CMS managed care rules, HHSC is currently working to revise network access standards for additional provider types, including LTSS, to ensure full compliance by the September 2018 effective date for the CMS network adequacy regulation. As required by the new managed care rules, HHSC is updating contracts to explicitly provide that a member may choose his or her network provider to the extent possible and appropriate, effective September 2017. There are additional CMS requirements with which HHSC must comply by September 2018, including having a process for exceptions to the provider-specific (non-LTSS) network standards. While HHSC currently has an exception process in place for network adequacy standards, the agency will also need to start monitoring any exceptions and include findings in the 1115 annual report. The regulations also require states to publish online network adequacy standards and make the information available in alternate formats to members with disabilities at no cost upon request. HHSC is working towards posting these standards online. In addition, HHSC will continue to meet with stakeholder groups to discuss issues related to shortages of providers accepting certain populations, specifically individuals with IDD, and will coordinate with MCOs to ensure compliance with federal HCBS settings rules.
Date Last Updated:	11/17/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Finish analysis of new CMS managed care rules effective 2016 and 2017, and determine impact to this issue.	7/31/2017	Completed	Staff have completed analysis of federal regulations related to discrimination and have determined that UMCC Section 7.05 requires MCO compliance with all state and federal discrimination laws, including without limitation: • Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*); • Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); • Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq.*); • Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107); • Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688 regarding education programs and activities; • Food and Nutrition Act of 2008 (7 U.S.C. §2011 *et. Seq.)*; and • The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable.
2	Contract changes proposed related to member choice of provider.	3/1/2017	Completed	
3	Contract changes effective.	9/1/2018	On Target	HHSC staff have determined that managed care contracts require MCOs to ensure member choice of providers as required by federal law. HHSC will make additional contract amendments as needed to further clarify MCO requirements regarding provider choice.
4	HHSC will ensure MCOs understand their role in regards to compliance with the federal HCBS settings rule.	3/1/2022 and Ongoing	On Target	HHSC is continuing to work with stakeholders concerned with programs serving individuals with IDD as well as MLTSS HCBS services to ensure Texas is in compliance with the federal HCBS rule by March 2022. This work will be ongoing over the next several years as HHSC works with

				stakeholders to develop a remediation plan, obtain CMS approval of that plan, and implement the plan by the deadline.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	5
Recommendation:	Analyze outpatient and emergency room services use. Perform a comprehensive analysis of Medicaid outpatient clinic and Emergency Room use by Service Delivery Area by MCO. Compare the actual utilization of Medicaid outpatient and ER services to Healthcare Effectiveness Data and Information Set (HEDIS) standard use rates by age group to identify which MCOs in which markets have high rates of outpatient and emergency room 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.				
Additional Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Hospital Association (THA)				
HHSC Response:	HHSC currently is analyzing outpatient services and emergency department visits by plans and service areas; however, this data is not being compared with the HEDIS standard. HHSC will meet with THA to discuss this recommendation, and obtain additional information about the scope of the analysis and benefit of this review. This meeting will be scheduled following the legislative session.				
Date Last Updated:	11/17/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Meet with THA, and determine next steps.	2/1/2018	Delayed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	6c
Recommendation:	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 UMCM, Chapter 15); however, these protocols are currently under review. Any changes to the utilization management protocols should be fully-vetted with the Behavioral Health Integration Advisory Committee (BHIAC) and other interested stakeholders, and should promote streamlined and consistent application.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Council of Community Centers				
HHSC Response:	HHSC reviewed the Mental Health Rehabilitation and Mental Health Targeted Case Management benefit, including any potential changes to the utilization management guidelines as part of the rules development process and the medical benefit policy. HHSC has not made any modification to the utilization management protocols. HHSC has published the medical benefit policy for mental health rehabilitative services and mental health targeted case management in the Texas Medicaid Provider Procedure Manual. The draft rules for the managed care section of the HHSC Texas Administrative Code to address these benefits also do not make any modifications to the existing utilization management protocols.				
Date Last Updated:	11/17/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Post medical benefit policies for public comment.	Summer 2016	Completed	
2	Update the Frequently Asked Questions document that serves as guidance to MCOs and providers on the administration of these two benefits.	Summer 2017	Ongoing	HHSC staff are reviewing comments provided by the Texas Council and will continue to work with the council until the FAQs are updated.
3	Adopt Texas Administrative Code rules.	August 2018	On Target	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	7 / 18-19 / 21
Recommendation:	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 durable medical equipment (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 primary care physician (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, Texas Speech-Language-Hearing Association (TSHA) supports the establishment of care standards for Medicaid beneficiaries transitioning from one delivery system to another.				
Additional Stakeholder Background:	HHSC met with TSHA in the summer of 2016 and received additional information clarifying that some of the items listed in this recommendation continue to be issues, especially as it relates to prior authorization requirements and MCOs.				
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Rehab Providers Council/Outpatient Independent Rehabilitation Association/TSHA				

HHSC Response:	At this time, HHSC cannot mandate to MCOs which benefits require prior authorization or that MCOs follow the same processes for prior authorization. HHSC will continue to explore other opportunities to help providers better understand MCO processes. HHSC is exploring how best to address the issue related to MCOs not accepting a faxed PA request based on letterhead or fax cover page. Currently, there is no law, rule, or contract requirement to prevent MCOs from implementing this type of policy to help control therapy utilization. HHSC currently requires MCOs to ensure continuity of care when an individual transitions from FFS or another managed care program into their plan. See Section 8.2.1 of the UMCC. Each MCO has medical director and other clinical staff that can discuss specific cases or processes with therapy providers. These staff can be accessed using each MCO's provider relations hotline. HHSC requests therapy providers send requests to HPM_Complaints@hhsc.state.tx.us with an indication of whether a member's access to care is of concern due to a PA request response, or lack thereof. MCOs are required to respond timely to access to care complaints when HHSC makes them aware of such complaints. Effective 3/1/2017, MCO websites must allow providers to submit PA requests and include online processes to permit the following: submission of electronic claims and any related documentation requested by the MCO; submission of claims appeals and reconsiderations, and submission of clinical data. The website also must include email addresses for receipt of provider complaints.
Date Last Updated:	12/8/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Meet with TSHA	8/16/2016	Completed	
2	Research examples of MCO-specific issues	8/31/2016	Completed	
3	Follow up with TSHA about possible solutions for PA fax/letterhead concern	4/1/2018	Delayed	HHSC continues to work with TSHA to develop a possible solution to the concerns.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	10 a-b
Recommendation:	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 Texas Provider Identifier (TPI) number(s) before beginning the (health maintenance organization (HMO) credentialing process. TMA and Texas Pediatric Society (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.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	HHSC is committed to improving the enrollment and credentialing systems and processes, and is currently taking action to streamline this process. Physicians will notice some of the up-front changes immediately. Most of them will expedite reenrollment by reducing the need for printing and mailing documents, like proof of licensure. Among the changes: •System updates that make the portal compatible with more recent Internet browsers; •The ability to immediately upload supporting documentation; •An e-sign feature that allows physicians to sign the enrollment agreement electronically; •Instructions on how to upload documents and submit the application using an e-signature; and •Guidance and more accurate error messages to avoid application mistakes before submission. In addition to the above steps, on February 17, 2017 HHSC posted a request for proposals for the procurement of a Provider Management and Enrollment System to further streamline the enrollment process.				

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	On March 23, 2017, the Texas Association of Health Plans (TAHP) in collaboration with the Texas Medical Association (TMA) announced a joint effort to reduce red tape and administrative burdens for physicians and health care providers seeking to participate in the Texas Medicaid program. TAHP and TMA have selected Aperture, LLC, for a statewide Credentialing Verification Organization (CVO) contract used by all 20 Medicaid health plans in Texas to streamline the provider credentialing process. Implementing the recommendation to combine the enrollment and credentialing processes would require rule and system changes. HHSC currently provides the MCOs with a Medicaid Provider file every Tuesday that contains a listing of providers enrolled in the Medicaid program. MCOs are currently allowed to begin the credentialing process while providers are in the process of enrolling if they wish to shorten the timeframe. The state is not statutorily allowed to retroactively pay claims for a time period that the provider was not fully enrolled and credentialed. However, HHSC efforts to streamline enrollment through a centralized portal, and TAHP's efforts to streamline credentialing, is expected to significantly shorten the amount of time it takes a provider to become fully enrolled and credentialed. Remaining activities are related to the RFP that is also reported on in item 12, so future updates to these action items will be reported in item 12.
Date Last Updated:	12/4/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HHSC and TAHP finalize approach and credentialing vendor's data requirements. HHSC will work with vendor to identify all data that should be transmitted from TMHP to the credentialing vendor.	To be determined (TBD)		
2	Complete operational and technical changes to operationalize data exchange between TMHP and credentialing vendor	TBD		
3	Provider Management and Enrollment System Request for Proposal Released (RFP)	2/17/2017	Completed	
4	(RFP) Vendor Conference	3/1/2017	Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	11a
Recommendation:	Simplify and streamline method for physicians and prescribers to access prior authorization requirements in VDP. Simplify and streamline the Medicaid VDP, 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.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	After further discussion with TMA/TPS VDP envisions the following: • Phase I includes the creation and ongoing maintenance of the "Pharmacy Clinical Prior Authorization Assistance Chart". HHSC will modify the UMCM to add MCO reporting requirements to identify their implemented clinical criteria to support an ongoing, updated chart. • Phase II includes the addition of clinical PA information to the PDL. Any single drug on the PDF that has clinical criteria would have a link to the criteria/requirements. HHSC will contact its PDL vendor to request a change that adds Clinical PA information. This will include an estimate of any potential costs and a timeline for implementation.				
Date Last Updated:	10/31/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Submit proposed UMCM changes for quarterly reports from MCOs.	6/30/2016	Completed	
2	Develop "Pharmacy Clinical Prior Authorization Assistance Chart" sample, and share with TMA and TPS for feedback.	9/1/2016	Completed	
3	Meet with TMA and TPS to obtain feedback on responses.	9/1/2016	Completed	TMA and TPS did not have changes, and there was agreement that this was useful as a first step in this process.
4	Add Pharmacy Clinical Prior Authorization Assistance chart to VDP website.	9/1/2016	Completed	
5	Develop processes to consolidate quarterly MCO reports into a single document.	9/15/2016	Completed	
6	Review options to update or replace the existing "Texas Medicaid Pharmacy Prior Authorization" video to include better clinical prior authorization information.	9/30/2016	Completed	
7	Review and correct MCO first quarterly report.	10/10/2016	Completed	
8	Compile and post first MCO quarterly report.	10/15/2016	Completed	
9	Obtain examples from other states of PDL document.	11/1/2016	Completed	
10	Obtain feedback from TMA and TPS on the examples from other states.	11/15/2016	Completed	
11	Research into options of working with an existing vendor to implement changes.	11/15/2016	Completed	
12	Meet with TMA and TPS to discuss timelines.	11/15/2016	Completed	
13	Work with PDL contractor to develop timeline for site revisions.	11/30/2016	Completed	
14	Begin quarterly MCO Clinical PA reporting process.	11/30/2016	Completed	
15	Replace "Texas Medicaid Pharmacy Prior Authorization" video on the vendor drug website with one-page document explaining the process as an interim step until video can be updated.	12/15/2016	Completed	
16	Incorporate Clinical PA links into PDL document.	2/1/2017	Completed	

17	Work with TMA and TPS to obtain feedback from providers and administrators to test the revised tutorial (to replace the previous video).	3/1/2017	Completed	
18	Work with TMA and TPS to identify providers and administrators to test the revised PDL document prior to full launch.	3/17/2017	Completed	
19	Work with THSteps to update and revise tutorial to include clinical prior authorizations in the explanation of the drug authorization process.	3/15/2017	Completed	
20	Share draft document with TMA/TPS for feedback from the associations and a sampling of providers. This will be the draft revision of the PDL document incorporating links to clinical prior authorization criteria.	5/17/2017	Completed	
21	Fully launch revised PDL document incorporating links to clinical prior authorization criteria.	8/1/2017	Completed	Clinically-enhanced PDL posted to VDP website.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	12
Recommendation:	Eliminate use of TPI 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.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	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 TPI and the DADS Contract Identifiers. HHSC does require the MCOs and Providers conducting business with the MCOs to utilize either a NPI or Atypical Provider Identifier (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 take time to implement in a manner that supports both the Fee for Service and Managed Care service delivery models. Initial work has been done to identify changes needed and the impact to future procurements. This will take place across multiple programming and contractual changes over the course of 5-10 years. Information related to impacted procurements will be released through the procurement process when appropriate, and reported here after release.				
Date Last Updated:	12/4/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Draft and publish request for proposal (RFP) for Provider Management and Enrollment system.	2/17/2017	Complete	
2	(RFP) Vendor Conference	3/1/2017	Complete	
3	(RFP) Proposal Response Phase	5/24/2017	Complete	
4	(RFP) Evaluation Phase	10/27/2017	Complete	
5	(RFP) Field of Competition Approved	11/10/2017	Complete	
6	(RFP) Recommended Vendor Approved	3/8/2018	On Target	
7	(RFP) Contract Awarded	12/31/2018	On Target	
8	Vendor Transition	1/17/2019	On Target	
9	Stakeholder evaluation of vendor deliverables		On Target	
10	PMES Testing	9/1/2019	On Target	
11	PMES Implementation (TPI no longer used - system live)	1/31/2020	On Target	
12	Vendor Operations of PMES	2/1/2020	On Target	

Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	13 / 41
Recommendation:	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 FFS 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.				
Additional Stakeholder Background:	In further discussions with TMA, it was noted that this issue is also related to homeowner and auto insurance claims.				
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS /Coalition of Texans with Disabilities				
HHSC Response:	In April 2017, HHSC implemented additional information on the 834 Enrollment File and associated Capitation files to inform the MCOs of gaining and losing members and also reflecting the gaining and losing MCO. In Spring 2017, HHSC moved this item to the Eligibility and Enrollment Workgroup with the MCOs to continue to evaluate cases to determine if a systemic issue still exists. Program Enrollment and Support, Medicaid CHIP Services has been working with Access and Eligibility Services over the past few months to identify agency issues that contribute to provider recoupments and are identifying possible HHSC system solutions to address agency concerns. At this time we				

	don’t have specific examples to extend the scope to include Third Party Liability division to help analyze related recoupments associated with home owner and auto insurance claims.
Date Last Updated:	11/02/17

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Provider Recoupment ongoing agenda item added to the Eligibility and Enrollment Workgroup	6/2018	Ongoing	The Eligibility and Enrollment Workgroup will coordinate with HHSC Access and Eligibility Services and the MCOs to evaluate member examples to determine the validity of the recoupment.
2	Add values to current interfaces to provide additional member information to MCOs.	4/2017	Complete	Work continues to update current interfaces with additional member information. Timelines as of March 20, 2017 estimate this work will be completed by April 2017. The delay is due to additional HHSC technology requirements to implement STAR Kids on November 1, 2016.

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Agency/Division/Department:	HHSC FSD / MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X This recommendation is addressed through an existing process. See details below.	**Number:**	14
Recommendation:	Implement a provider type and specialty code for urgent care. Many PCPs 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.				
Additional Stakeholder Background:					
Category:	Network adequacy / access to care				
Provided By:	TMA / TPS				
HHSC Response:	The Legislative Budget Board published a staff report on increasing access to urgent care providers and HHSC monitored to see if there would be legislative direction around this item. There was not legislative direction to add this new benefit. HHSC has an existing process for reviewing proposals for new or changes to existing 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: https://hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/medicaid-medical-dental-policies Once a topic nomination form is submitted, HHSC staff will research the request and present to a governance committee for review. The governance committee determines whether the proposal should be further reviewed to determine if it will become a Medicaid benefit. A fiscal estimate will need to be completed before a decision can be made to incorporate the proposal as a Medicaid benefit. If the fiscal estimate exceeds $500,000, the Legislative Budget Board will have to approve the funding associated with the policy proposal. Timeline is dependent upon prioritization within the medical policy review process.				
Date Last Updated:	12/12/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Review issue and determine next steps.	3/1/2018	Completed	Legislative Budget Board published the staff report on increasing access to urgent care providers in Medicaid. There was no legislative direction around this item. It was determined that this suggestion would need to be submitted through the Medicaid medical benefits process to be considered.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	15
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	HHSC researched options to provide the public with a more streamlined method for looking up FFS and MCO benefits and claims submissions. MCOs are required to disclose payment methodologies and fee schedules with contracted providers. Because MCOs may negotiate different rates with providers there is no standard fee schedule for each MCO. MCOs are required to post provider handbooks on their websites. For fee-for-service, providers can review the Texas Medicaid Provider Procedures Manual (TMPPM) for additional information on covered benefit. The FFS schedule is also available online at http://public.tmhp.com/FeeSchedules/.				
Date Last Updated:	12/12/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Research options.	9/30/2016	Completed	
2	Determine feasibility.	11/15/2016	Completed	
3	Discuss options with TAHP and TMHP.	9/1/2017	Completed	It was determined that this recommendation would not be feasible.
4	Notify stakeholders of feasibility.	12/1/2017	Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	23
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Alternative Payment Mechanisms				
Provided By:	TMA / TPS				
HHSC Response:	For the past three fiscal years HHSC has incorporated contract provisions requiring MCOs to move down the path of value-based contracting with providers. Each MCO submits to HHSC an annual inventory of their value-based contracting initiatives with providers. This effort is further reinforced during quarterly one-on-one web-based meetings with MCOs where value-based payments are a standing agenda item. MCOs are also strongly encouraged to seek ways to evaluate and, if feasible, integrate high-value DSRIP projects into their networks. Based on the MCO deliverables, and through HHSC discussions with MCOs, there are observable increases in the numbers of providers who are being paid via such value-based contracting arrangements. HHSC has observed MCOs often tend to adopt HHSC's Pay-for-Quality Program measures for their value-based contracting with providers. HHSC is continuing to work with the MCOs to encourage the use of value-based purchasing with providers and has changed the MCO contracts for 9/1/17. These contract changes are described in response to item 22. The deliverable associated with the contract provision (MCO submitted tracking tool and narrative description of their payment models) has been modified to help ensure accurate data collection. This will further enable HHSC to track MCO progress in this area. The value based purchasing (VBP) summary document for 2015 is posted on the VBP webpage: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement/value-based-payments.				

	HHSC met with representatives from TMA and other providers regarding their interest in entering into value-based contracting relationships with MCOs for Medicaid and CHIP services. To help ensure that value-based contracting is occurring where feasible, HHSC will create and send out a broadcast communication to stakeholders regarding HHSC's support and direction of value-based contracting. This communication will include a dedicated email for inquiries from stakeholders. If inquiries related to unresponsiveness come in through the email, HHSC will reach out to the appropriate parties to help connect individual MCOs with interested providers. HHSC is also exploring data that could be added to the "data and reports" subpage of the quality website (https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement/data-and-reports) to assist providers in understanding where opportunities may exist in terms of quality improvement. As described in response to recommendation 22, HHSC is exploring more effective ways to 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 Cost Allocation workgroup, which is working on a two-year project with Medicaid and CHIP MCOs to integrate the new CMS guidance. This effort could support greater payment innovation by MCOs and healthcare providers. MCO contracts have been amended for FY 2017 to allow quality improvement costs to be recorded as medical expense. HHSC received funding through CMS and SAMHSA for a planning grant to establish a certification process for integrated care clinics (mental health, substance use disorder, and limited primary care), and develop a prospective payment model (e.g. bundled payment) to support innovative and effective service provision. HHSC did not receive the planning grant. However, HHSC is exploring ways to leverage the processes and framework developed under the planning grant to potentially pilot innovative and effective care and payment models (i.e. alternative payment model for integrated care (mental health, substance use disorder and primary care services), certification process for integrated care clinics, and use of measures and incentives to promote effective integrated care) On August 30, 2016, HHSC hosted the DSRIP statewide learning collaborative. A major theme of this learning collaborative was value-based contracting. HHSC facilitated a panel discussion on value-based contracting. One of the desired outcomes of this meeting was to communicate the types of information MCOs need to receive in evaluating their willingness to consider value-based contracting. This should be helpful for providers in making future proposals to MCOs. HHSC also developed a value based purchasing roadmap, which will organize all value based purchasing efforts into one document. This document is posted on HHSC's website: https://hhs.texas.gov/sites/default/files//documents/about-hhs/process-improvement/quality-efficiency-improvement/draft-texas-vbp-apm-roadmap-august-2017.pdf
Date Last Updated:	11/6/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Develop new tracking tool (for MCO annual submissions).	7/31/2016	Completed	
2	Submit new tracking tool through internal channels for distribution to MCOs.	7/31/2016	Completed	
3	Additional data to website (if determined to be useful).	7/31/2016	Completed	
4	Communication to stakeholder (to include link to data on quality webpage and dedicated email box).	7/31/2016	Completed	
5	MCO submit data via new tool.	11/30/2016	Completed	
6	Identify and evaluate VBP models for cost and quality outcomes.	5/1/2018	In Progress	HHSC has engaged University of Texas-Dell Medical School (with funding by Episcopal Health Foundation) to assist HHSC with the activities listed below. • Review care delivery and evaluation experiences in other states to inform Texas efforts • Focused analysis of HHSC data to inform and provide a baseline for reform initiatives. Analysis would confirm areas of greatest opportunity for improvement through value-based care reforms • Organize and moderate a symposium with key stakeholders to review initial findings and develop possible next steps to strengthen the Texas Medicaid program • Propose alternative care/payment models and tools to support program improvement for HHSC consideration

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Agency/Division/Department:	HHSC Ombudsman	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	24
Recommendation:	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?				
Additional Stakeholder Background:					
Category:	Service Coordination / Member Assistance				
Provided By:	Coalition of Texans with Disabilities				
HHSC Response:	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 Office of the State Long-term Care Ombudsman became part of the HHS Office of the Ombudsman on September 1, 2017. 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 Office of the Ombudsman has held 11 meetings of the "Managed Care Support Network" which includes HHSC staff that work with Medicaid eligibility, enrollment, and operations, the Long-Term Care Ombudsman, the Department of Family and Protective Services, Aging and Disability Resource Centers, Area Agencies on Aging, enrollment broker (MAXIMUS), and other representatives who interact regularly with consumers and families. Meetings include discussions to determine how to improve consumer protections and ombudsman services as well as how to enhance communication and collaboration among HHS entities that work with or are impacted by managed care. Several participating organizations give presentations to the network to provide members with a better understanding of the work and challenges involved in supporting the delivery of Medicaid managed care services. The network established a contact within the agency that works with Social Security Administration staff. Issues that the network has addressed in the last year include: DMOs not accessing the authorized representative information for their members, organizations obtaining client eligibility information or enhancements to what they already receive, clients losing waiver services when transitioning from nursing facilities to the community, and children's files coming from SSA with no address or				

	authorized representative, bills passed in the 85th Texas Legislative Session impacting Medicaid and CHIP clients, expansion of MBCC and Adoption Assistance into Managed Care, and access to care issues as the result of Hurricane Harvey. Participating organizations benefited from the increase in collaboration and communication among members, especially when reaching out for assistance in resolving managed care client issues.
Date Last Updated:	11/17/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Host first meeting of Managed Care Support Network authorized by SB 760 SECTION 3 (including the Long-term Care Ombudsman, 17 other HHS offices and three other state agencies).	5/19/16	Completed	
2	Second meeting of the Network.	6/16/16	Completed	
3	Outreach meetings with community organizations assisting Medicaid managed care clients.	Ongoing	Ongoing	
4	Hosted third meeting of the Managed Care Support Network	7/21/16	Completed	
5	Hosted fourth meeting of the Managed Care Support Network	8/25/16	Completed	
6	Continued to host monthly meetings of the Managed Care Support Network		Completed	The network has been established and continues to meet on a regular basis.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	25 / 34c / 67
Recommendation:	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.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/9/2016. The recommendation was further explained to include the following recommendations: • Address direct care staff training needs related to the care of clinically complex and ventilator dependent individuals. • Request revisions to the state plan to allow access to in-home respiratory therapy services. • Include home health agencies in the home-based care for ventilator-dependent consumer discussions.				
Category:	Network Adequacy / Access to Care				
Provided By:	Coalition of Texans with Disabilities/ EveryChild, Inc./Texas Council for Developmental Disabilities/Arc of Texas/Disability Rights Texas				
HHSC Response:	HHSC is committed to ensuring individuals with ventilators are able to remain in the community successfully or are able to transition to the community if in a nursing facility. On 2/23/2016, HHSC convened a ventilator services workgroup of stakeholders, agency staff, 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 and MCO service coordinators on these specialized services. On 3/21/2016, HHSC and DADS staff met internally to discuss and review materials submitted by community advocates after the 2/23/16 meeting with stakeholders. On 4/18/2016, HHSC held a meeting with MCO workgroup participants to get feedback on the proposal submitted by stakeholders, give an update on the status of transitioning nursing facility residents into the community, and request MCOs send relevant current policies and procedures to HHSC. In May 2016, HHSC Utilization Review nurses began a targeted review of service plans and service provision for ventilator dependent residents residing in the community.				

	In June 2016, HHSC Utilization Review completed the targeted review of ventilator-dependent individuals and provided findings to each of the MCOs. On July 14, 2016, HHSC reconvened the interdisciplinary ventilator workgroup comprised of external stakeholders, state staff, and the managed care organizations (MCO). The MCOs reviewed portions of a combined ventilator PowerPoint presentation that provided high-level details on their processes for managing clinically complex individuals. On August 5, 2016, HHSC met with the Texas Association for Home Care and Hospice to discuss transitioning ventilator-dependent individuals to the community. On October 13, 2016 the MCOs provided an update on all ventilator-dependent members who transitioned from the nursing facility to the community in SFY 16. HHSC will continue to explore opportunities for improving and enhancing care for ventilator-dependent members.
Date Last Updated:	11/17/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Initial meeting of Ventilator Services Workgroup, (includes agency staff, MCOs, and external stakeholders).	2/23/16	Completed	
2	Internal agency workgroup meeting.	3/21/16	Completed	
3	Meeting with MCO Service Coordinators.	4/18/16	Completed	
4	Conference call with MCO Service Coordinators.	6/15/16	Completed	
5	Meeting with Ventilator Services Workgroup.	7/14/16	Completed	
6	Follow-Up conference call with MCOs.	9/19/16	Completed	
7	Quarterly Ventilator Services Workgroup.	10/13/16	Completed	
8	MCOs to provide a presentation on ventilator services to the Promoting Independence Advisory Council (PIAC).	1/19/2017	Postponed/ Completed	The meeting exceeded the scheduled time and concluded prior to the MCOs presentation.
9	Meeting with the Coalition of Texans with Disabilities and staffer from Rep. C. Turner's office	12/7/2016	Completed	

10	MCO Service Coordinator Quarterly Report of ventilator-dependent nursing facility members	1/13/2017	Cancelled	Stakeholders agreed to receive updated ventilator information during the PIAC meeting scheduled Jan 19.
11	MCO Service Coordinator Quarterly Report of ventilator-dependent nursing facility members	1/13/2017	Completed	
12	A copy of the MCO Ventilator Care Services PPT provided to the PIAC Stakeholders	1/1/2017	Completed	
13	Update to PIAC on the number of STAR+PLUS and nursing facility ventilator dependent members.	1/19/2017	Completed	
14	Meeting with Tennessee's TennCare Program Representatives	2/27/2017	Completed	
15	Review of the STAR+PLUS MCOs managing complex medical needs hospital transition team policies.	3/31/2017	Completed	
16	Quarterly Ventilator Services Workgroup	4/18/2017	Cancelled	No stakeholder updates; meeting cancelled
17	Update to PIAC on the number of STAR+PLUS community and nursing facility ventilator dependent members.	4/25/2017	Completed	
19	MCOs to provide updates on all NF ventilator dependent members.	7/17/2017	Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	32 a-f / 35 / 73
Recommendation:	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 FFS 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.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/9/2016. The representatives provided feedback that this HHSC response did not fully address the recommendations, and the following additional information was added for consideration: • There is a concern that individuals are not receiving equipment that is authorized. • Particular concern when leaving facilities. • Consider reviewing trends and data regarding delays between authorization and provision of an item. • Recommend a thorough review of the inconsistencies among MCOs, not based solely on complaints but research into claims analysis. • Consider a secret shopper approach.				

	• Support for the role of managed care UR area's review of DME service provision in STAR+PLUS HCBS waiver program. • Concern about MCOs using state-supported living centers (SSLCs) for wheeled mobility vendors. There is a need to compare between providers in the community and SSLC providers and to establish parameters around that mode of purchase including consumer consent around procuring wheelchair from SSLC.
Category:	Benefits
Provided By:	Disability Rights Texas/Every Child, Inc./Texas Council for Developmental Disabilities/The Arc of Texas
HHSC Response:	HHSC is committed to improving processes to address concerns regarding the provision of medically-necessary DME through Medicaid MCOs. An internal meeting was convened to discuss these concerns and to identify next steps. HHSC will include DME/Adaptive Aid components in the FY 2017 STAR+PLUS HCBS utilization reviews. As a result, additional data regarding HCBS will be produced and evaluated for potential modifications to MCO requirements. Effective 3/1/2017 the UMCC and UMCM have been revised to require MCOs to provide quarterly data regarding members enrolled in STAR+PLUS, STAR Health and STAR Kids whose items or services have been reduced, denied, or terminated. An additional step that HHSC will undertake is to review options to improve training for both providers and MCOs. It is critical that providers and MCO staff have a thorough understanding of the Medicaid DME benefits and the related processes for approval and provision of the benefits. Effective 2017, MCO websites must allow providers to submit PA requests and include online processes to permit the following: submission of electronic claims and any related documentation requested by the MCO; submission of claims appeals and reconsiderations, and submission of clinical data. The website also must include email addresses for receipt of provider complaints. Provider directories must include an explanation of referral processes to providers such as OB/GYNs, behavioral health, and family planning. 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. A report analyzing closed DME complaints was prepared for Health Plan Management (HPM) review to enable trending and analysis regarding specific MCOs that receive the most complaints as well as the reasons for the complaints. In addition, HHSC is requesting specific examples from DME providers to determine which barriers providers are experiencing. These issues will be researched by HHSC and discussed with the MCOs. HHSC is also working to address issues related to the content and specificity of MCO denial notices including addressing a member's right to appeal and providing information about the appeal and fair hearing process to

	accompany the denial notice. HHSC is also committed to including an opportunity for stakeholder comment prior to adding the requirement to MCO contracts and manuals. Stakeholders are requested to submit complaints and examples of untimely assessments to the HHSC Ombudsman (clients) or HHSC HPM (members and providers): HHSC Ombudsman Phone: 1-866-566-8989 HHSC Ombudsman Online: https://hhs.texas.gov/ombudsman HHSC HPM Email: HPM_complaints@hhsc.state.tx.us or STAR.Health@hhsc.state.tx.us (for complaints specific to the STAR Health program) In response to stakeholder request for information about use of SSLCs for wheeled mobility vendors: HHSC does not have approval at this time from CMS for SSLCs to provide services to the community.
Date Last Updated:	11/17/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HHSC will convene an internal workgroup to brainstorm actions that can be taken to address the requestors concerns not already addressed in the response.	8/31/2016	Completed	
2	Host webinar for MCOs regarding medical policy for mobility aids.	10/30/2016	Completed	
3	HPM compiles report on closed DME complaints received in FY 2016.	11/20/2016	Completed	
4	Obtain specific examples from DME providers to determine which barriers providers are experiencing.	12/15/2016	Requested	
5	Enhanced MCO websites implemented.	5/1/2017	Completed	Enhanced MCO websites have been implemented and reviewed. HPM is currently following up on minor outstanding items.
6	Contract and manual changes effective to require MCOs to provide quarterly data regarding items or services have been reduced, denied, or terminated.	3/1/2017	Completed	

7	Assess DME complaints and potential next steps (internal).	1/30/2017	Completed	Analysis did not result in the identification of any DME complaint-related trends, but HPM will continue to monitor future complaint data.
8	Meet with internal workgroup to discuss DME complaints findings and utilization review results to determine appropriate actions and next steps.	6/1/2017	Completed	
9	HPM and MCO conference calls to discuss complaint trends.	9/1/2017	Completed	After researching complaint data, received from January 1, 2017 to October 31, 2017; only inquiries and complaints about preferred providers were identified as a trend. Due to these contacts, HHSC Program/Policy and Legal areas met with MCOs to clarify policies around Member choice and the processes, by which, the MCO shall capture and update member DME provider selections.
10	Review options to improve training.	9/1/2017	Completed	
11	Complete a random sample review of HCBS members, discuss outcomes with each MCO, and publish annual Utilization Review report.	11/1/2017	Completed	
12	Amend Uniform Managed Care Manual to include required template for all MCO denial letters	3/1/18	On Target	
13	Review DME issues with advocates/stakeholders at State Medicaid Managed Care Advisory Committee.	6/1/2018	On Target	
14	Present and discuss proposed MCO Denial Notice Template at State Medicaid Managed Care Advisory Committee	6/1/2018	Delayed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	34a / 67
Recommendation:	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.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, The Arc of Texas, and Disability Rights Texas on 8/12/2016. The representatives provided feedback that the response to this issue should go beyond the handbook, and that ongoing systematic training for services coordinators is needed. In addition, it was suggested that this training be developed outside of HHSC by individuals with experience helping children transition from nursing facilities.				
Category:	Service Coordination / Member Assistance				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas/ Disability Rights Texas				
HHSC Response:	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 have access to service coordination. The STAR Kids service coordinator is expected to assist the individual in locating and coordinating all Medicaid acute care and long term services and supports. This includes coordination to facilitate a smooth transition from an institutional setting to the community. The STAR Kids program also includes extensive requirements regarding transition planning for children aging out of STAR Kids into STAR+PLUS. The STAR+PLUS Handbook was revised to make HHSC expectations for MCO service coordinators and their responsibilities for members in a nursing facility and other programs (e.g., intellectual and developmental disability (IDD) waivers and 1915(i)) clear. STAR+PLUS contract changes effective 9/1/16 include additional required service coordination training and assessment requirements regarding a member's change in condition and MCO responsibilities for reassessment and authorization of additional services. The STAR Kids contract and Handbook provide detailed instructions regarding MCO service coordinator responsibilities for all members. The STAR+PLUS contract was amended, effective September 1, 2017, to add relocation functions to MCO service coordination. Appendix XXX, drafted by relocation contractors, HHSC staff, and MCOs, was added to the STAR+PLUS Handbook to clarify the respective roles and responsibilities of MCO service coordinators and relocation contractors				

	related to transitioning individuals in nursing facilities to the community. Effective March 1, 2018, the Uniform Managed Care Manual (UMCM) will be amended to include a requirement for MCOs to provide relocation outcome information on a quarterly basis. HHSC staff are working on a policy to strengthen MCO transition coordination with Local Intellectual and Developmental Disability Authorities (LIDDAS) for individuals with IDD who are in a nursing facility. HHS convened a workgroup of agency staff, contractors, and MCOs, to improve processes and policies related to a member's transition to the community. This workgroup is focused on clarifying roles and responsibilities related to transition and discharge planning, working across service areas when members discharge to another part of the state, ensuring member's health and safety, and promoting independence. The workgroup is managed by the Money Follows the Person team. The workgroup completed its new policy guidelines for transitioning individuals from a nursing facility in one service area to community-based services in another service area. The policy was published as Appendix XXIX in the STAR+PLUS Handbook September 1, 2017.
Date Last Updated:	11/21/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	STAR+PLUS Handbook Update.	9/01/17	Completed	
2	STAR+PLUS Contract Changes.	9/01/2016	Completed	
3	Begin transition workgroup.	Fall 2016	Completed	
4	STAR Kids Handbook Published and Effective.	11/01/2016	Completed	
5	STAR Kids Contract Effective.	11/01/2016	Completed	
6	Ongoing workgroup	Continues until complete	Completed	HHSC is addressing systematic barriers faced by MCOs and their members. Following the clarification of expectations for transitions from facilities to the community, particularly transitions from a facility to a community in which the MCO does not operate, HHSC will address transitions from facilities other than nursing facilities and transitions to programs other than STAR+PLUS HCBS. This work is ongoing and includes MCOs, state staff, and community organizations.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**Number:**	34b / 67
Recommendation:	Improve access to hospital level of care.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/12/2016. The representatives provided feedback that a broader discussion is needed with a larger stakeholder group about the approach to this issue.				
Category:	Network Adequacy / Access to Care				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas/Disability Rights Texas				
HHSC Response:	HHSC submitted a concept paper to CMS with a proposal for serving medically fragile adults through the 1115 waiver. HHSC discussed this concept paper with CMS in February 2016. In June, CMS sent a list of follow-up questions to HHSC. HHSC discussed again with CMS in July, October, and December 2016. CMS sent an additional question to the state on January 17, 2017 and the state responded. HHSC will keep stakeholders informed of the progress as the concept is further developed. 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 direction, HHSC will amend the 1115 waiver and develop an assessment tool and process for this benefit.				
Date Last Updated:	12/4/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Develop and submit concept paper.	3/1/2016	Completed	
2	Discuss with CMS.	8/1/2016	Ongoing	
3	Update stakeholders regarding CMS response.	11/1/2016	Ongoing	
4	Contingent upon CMS and legislative leadership approval to move forward with concept, draft proposal to estimate rates and other aspects of feasibility.	1/1/2017	Ongoing	

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Improving Member and Provider Experience in Medicaid Managed Care

Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	34 d / 100 / 101
Recommendation:	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.				
Additional Background:					
Category:	Stakeholder engagement and feedback				
Provided By:	PPAT / EveryChild, Inc. / Texas Council for Developmental Disabilities / The Arc of Texas				
HHSC Response:	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 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 in August 2016. In October 2015, HHSC notified MCOs of online training developed by The Tennessee Department of IDD (TennCare) and Vanderbilt Kennedy Center for primary care providers working with individuals with IDD designed to help educate physicians and other prescribers about the appropriate use of psychotropic medications for individuals with IDD. The notice also included information about a similar program for individuals with IDD, family members, and conservators that				

	will help them understand the appropriate use of psychotropic medications in terms they can understand. MCOs were encouraged to share information about the trainings with providers, members with IDD, and their families. The notice and links to the training can be accessed on the HHSC website at https://hhs.texas.gov/services/health/medicaid-chip/provider-information/mco-notices/2015-notices-alerts-managed-care-organizations. At the January 28, 2016 IDD SRAC meeting, the committee voted to submit a letter to the Executive Commissioner to expand the Network Access Improvement Project (NAIP) program across Texas. The letter encourages funding an educational component to provide incentive payments for additional physician training to serve persons with IDD and an enhanced payment for the additional time needed for certain complex cases. The letter also requests that HHSC develop a comprehensive educational program for primary care and specialty physicians to enhance physicians' understanding of how to better treat their patients with IDD. The letter was submitted to the Executive Commissioner on 2/24/2016. On 6/3/2016 DADS released a free online training for people who care for, support, or advocate for people with IDD. This 6-part e-learning training series was developed by DADS and DSHS to educate direct service workers and others about behavioral health needs of people who have an IDD and a co-occurring behavioral health condition. This training looks at challenging behavior in a new way, emphasizes the importance of supporting mental wellness in individuals with an IDD, and includes a module for trauma-informed care for individuals with IDD. HHSC notified all MCOs of the training on 6/10/2016. The Mental Health Wellness for Individuals with an Intellectual or Developmental Disability training can be accessed online at http://www.mhwidd.com/. This item is closed. For future information or updates refer to IDD SRAC transition to managed care subcommittee for stakeholder opportunities to engage.
Date Last Updated:	11/13/17

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HHSC notified MCOs of online training for primary care providers working with individuals with IDD and training for members with IDD and their families. The notice encouraged MCOs to share information about the training with providers, members with IDD and their families.	10/2/2015	Completed	
2	IDD SRAC recommended expansion of NAIP to include additional funding related to training on serving persons with IDD and development of an	2/24/2016	Completed	

	educational program for primary care and specialty providers serving persons with IDD.			
3	DADS released training to educate direct service workers and others about behavioral health needs of people who have an IDD and a co-occurring behavioral health condition.	6/3/2016	Completed	
4	HHSC notified MCOs of the DADS online training.	6/10/2016	Completed	
5	HHSC requested feedback regarding survey criteria from Transition to Managed Care SRAC Subcommittee meeting in August 2016.	8/2/2017	Completed	
6	HHSC Quality Assurance will review the feedback from the subcommittee and develop possible solutions to survey individuals with IDD and family members.	10/3/17	Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	34e / 67
Recommendation:	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.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, The Arc of Texas, and Disability Rights Texas on 8/12/2016. The representatives provided feedback that stakeholders need to be more involved with this process, that transitions between settings are not adequately addressed, and that there needs to be greater transparency of assessments and denials based on assessments need review.				
Category:	Service Coordination / Member Assistance				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas/ Disability Rights Texas				
HHSC Response:	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 coordinators are 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 and 1915(i)) have been made. STAR+PLUS contract changes effective 9/1/16 included additional required service coordination training and assessment requirements regarding a member's change in condition. HHSC encourages contracted MCOs to develop innovative solutions to issues with care, such as transitions from facilities to the community or between MCOs. Requiring certain innovations, such as a complex care unit, could inhibit some of this innovation by forcing MCOs to use a certain model, and would likely require additional funds to make mandatory. HHSC does place best practices as a contractual requirement when one surfaces. For example, one MCO began requiring service coordinators to conduct a monthly check-in after long term services and supports are authorized to ensure their				

	member is receiving what they were authorized and what they need. HHSC implemented a similar requirement that the MCOs, at a minimum, ensure that members receive authorized services within a certain timeframe. Transparency in assessment, authorizations, and denials is important to HHSC and to our federal partners. HHSC is implementing new transparency requirements related to denials as part of the new federal Medicaid managed care rules and continues to work with MCOs to make necessary technology changes to increase transparency over time. HHS convened a workgroup of agency staff, contractors, and MCO, to improve processes and policies related to a member's transition to the community. This workgroup is focused on clarifying roles and responsibilities related to transition and discharge planning, working across service areas when members discharge to another part of the state, ensuring member's health and safety, and promoting independence. The workgroup is managed by the Money Follows the Person team. The workgroup completed its new policy guidelines for transitioning individuals from a nursing facility in one service area to community-based services in another service area. The policy was published as Appendix XXIX in the STAR+PLUS Handbook September 1, 2017. HHSC staff are working on a policy to strengthen MCO transition coordination with Local Intellectual and Developmental Disability Authorities (LIDDAS) for individuals with IDD who are in a nursing facility. The STAR Kids and STAR+PLUS MCOs are finalizing a checklist to be used by each MCO when a member transitions from one Medicaid managed care organization to another Medicaid managed care organization and from one Medicaid managed care program to another Medicaid managed care program (i.e. STAR Kids to STAR). This checklist will help ensure each MCO is providing all necessary documents to the receiving MCO. This may include: service plans, authorizations, historical information, transition plans, etc. Additional stakeholders will be engaged for input as part of the workgroup. Additional requirements related to service coordinator action may require legislative direction, should the result increase MCO or HHSC costs related to service coordination.
Date Last Updated:	11/8/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	STAR+PLUS Handbook Update.	3/01/17	Completed	The STAR+PLUS Handbook moved to biannual updates. As a result, this item was not updated. HHSC is aiming for a 3/1 effective date.
2	STAR+PLUS Contract Changes.	9/01/2016	Completed	
3	Begin transition workgroup.	Fall 2016	Completed	
4	STAR Kids Handbook Published and Effective.	11/01/2016	Completed	

5	STAR Kids Contract Effective.	11/01/2016	Completed	
6	Ongoing workgroup		Completed	This work is ongoing and includes MCOs, state staff, and community organizations.
7	Transparency and access to assessments		Completed	Assessments range from 1 to up to 60 pages. Systems changes to post assessments to a portal or printing/faxing/emailing assessments have costs not currently included in MCO capitation. HHSC continues to work with MCOs to enhance MCO systems over time to address this concern without requiring additional appropriations. MCOs will identify changes that can be made at no cost to address this concern. HHSC continues to explore additional requirements related to service coordination.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	39
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	Hogg Foundation for Mental Health				
HHSC Response:	The 2016 federal regulations require that mental health parity apply to Medicaid MCOs to ensure that financial requirements (such as co-pays and deductibles), non-quantitative limits (such as prior authorization), and quantitative treatment limitations (number of treatments allowed) for mental health or substance use disorder (MH/SUD) benefits are generally no more restrictive than requirements or limitations applied to medical and surgical benefits. Parity between MH/SUD and medical/surgical benefits occurs within each of the four classifications specified by CMS (inpatient, outpatient, emergency services, and pharmacy) and not at the individual benefit level. HHSC currently requires in its contract that all MCOs comply with all applicable parity regulations. CMS issued regulations on March 29, 2016, providing guidance to the Medicaid program about implementing and monitoring MHPAEA. The Centers for Medicare and Medicaid Services granted Texas an extension of its parity compliance to December 2, 2017. HHSC has conducted a full analysis its Medicaid and CHIP program for parity and as required by regulation, submitted documentation to CMS and posted on its state Medicaid website required information. HHSC has updated the managed care contracts requiring MCOs to comply with parity requirements and to provide HHSC with all required information for it to conduct the parity analysis. HHSC continues to engage stakeholders updates regarding compliance with the federal rules.				
Date Last Updated:	12/12/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Conduct analysis of federal rules.	12/1/2016	Completed	
2	Amend managed care contracts.	9/30/2017	Completed	
3	Engage stakeholders.	10/31/2017	Completed	
4	Finalize analyses.	11/15/2017	Completed	
5	Post state's parity compliance on state website.	12/2/2017	Completed	
6	Document compliance to CMS.	12/2/2017	Completed	
7	Amend managed care manuals.	4/30/2018	On Target	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	40
Recommendation:	Ensure full access to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The 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 MCOs have full access to EPSDT mandated services as stipulated in the Texas Medicaid Manual.				
Additional Stakeholder Background:	This issue was discussed in a meeting with TSHA on 8/16/2016, and it was clarified that this issue specifically relates to MCO compliance with HHSC medical policy regarding the amount, duration, and scope of treatment provided by the MCOs. TSHA believes some MCOs are not following the medical policy outlined in the Texas Medicaid Provider Procedure Manual.				
Category:	Benefits				
Provided By:	TSHA				
HHSC Response:	MCOs are required to provide EPSDT services (also known as THSteps in Texas) to all members 0 through 20 years of age, including all services in the TMPPM (See UMCC 8.1.3.2). EPSDT mandated services are stipulated in Medicaid policy and the Texas Medicaid Provider Procedures Manual. MCOs must provide services in the same amount, duration, and scope as those services are offered in Traditional Medicaid. To help address potential inconsistencies between MCOs, HHSC will issue policy guidance in the Uniform Managed Care Manual, effective 9/1/17, to provide additional definition and clarification around HHSC's expectations for amount, duration, and scope.				
Date Last Updated:	3/20/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	HHSC will request examples of instances where an MCO has placed a treatment cap from THSteps.	7/31/2016	Complete	
2	HHSC will review examples and determine appropriate next steps.	10/31/2016	Complete	HHSC is still reviewing examples and working with MCOs to determine the processes they used and next steps.
3	Submit changes to the Uniform Managed Care Manual, effective 9/1/17, to provide additional	3/1/2017	Complete	

	definition and clarification around HHSC's expectations for amount, duration, and scope.			

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	42
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Claims				
Provided By:	CHAT				
HHSC Response:	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. If the provider is using MedID this should address this issue, but HHSC will request examples of situations in which this occurred to review and identify next steps.				
Date Last Updated:	12/4/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Request examples from CHAT.	6/1/2016	Completed	
2	Review additional examples to determine issue.	4/1/2017	Complete	Staff continue to research examples provided. Most examples were fee-for- service and not Managed Care claims. HHSC Operations Management will work with Health Plan Management to obtain more examples for Managed Care Claims.
3	Coordinate with MCOs to identify next steps.	3/1/2018	Ongoing	Due to limited resources, this has not been completed. Due date revised.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	50
Recommendation:	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.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, The Arc of Texas, and Disability Rights Texas on 8/12/2016. The representatives provided feedback that this issue could be addressed without the expense if files were shared electronically through the member portal. It was also noted that this transparency is critical to ensure that members understand the assessments that are being used to make decisions, and can identify any inaccuracies that may have occurred. There was concern that there is a high possibility for error due to the phrasing of questions, and that families could be better prepared if assessments were provided in advance.				
Category:	Communications				
Provided By:	Every Child, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas				
HHSC Response:	HHSC had a brief discussion with MCOs regarding the provision of all assessments to members. MCOs cited a significant cost barrier as the reason they only provide this information to members who request it. For example, the Community First Choice assessment is at least 20 pages. Providing this assessment not only to the provider but also to the member would require significant printing and mailing expense, which is currently not included in the capitation rate. MCOs noted a willingness to provide this information to any member who asks. HHSC is adding a contract requirement to the March, 2018 update of the STAR Kids contract requiring the MCOs to provide a member's STAR Kids Screening and Assessment within seven days of the member requesting a copy. Transparency in assessment, authorizations, and denials is important to HHSC and to our federal partners. HHSC is implementing new transparency requirements related to denials as part of the new federal Medicaid managed care rules and continues to work with MCOs to make necessary technology changes to increase transparency (and spread the cost of changes) over time. Any additional requirements related to printing, mailing, or building portals to share assessment information outside of a request from a member will require additional funding in MCO rates.				
Date Last Updated:	11/8/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Provide an update regarding CFC assessment improvement to IDD system Improvement Workgroup	11/18/16	Completed	
2	Explore feasibility of posting member assessments for LTSS in the member portal in STAR+PLUS within existing funding.	12/31/2016	Completed	Within existing funding, building member portal capabilities to house assessments is not feasible.
3	Provide an update regarding CFC assessment improvement to Promoting Independence Advisory Committee	1/19/2017	Completed	
4	Incorporate input from stakeholders and continue to address recommendations	12/1/2017	Completed	HHSC will continue to explore additional opportunities for member and provider portals with existing funding.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	55
Recommendation:	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 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.				
Additional Stakeholder Background:	In March 2012, the state began using the main dentist model for delivering dental care. Under this model, the main dental home provider supports the ongoing relationship with the client including all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. As the coordinator of a child's dental care, the main dental home provider also coordinates referrals to dental specialists. HHSC must require that the DMOs adhere to the main dentist model as defined in rule and in contract.				
Category:	Contract Provisions				
Provided By:	Texas Dental Association				
HHSC Response:	HHSC conducts provider directory verification for the DMOs on a quarterly basis to identify inaccurate directory listings. HHSC may review DMO directory listings and request additional information from DMOs regarding credentialing practices and network adequacy as needed. Additionally, both DMOs regularly monitor network rosters for accuracy, contact providers to validate provider network rosters, and monitor claims activity to identify inactive providers. Monitoring of provider networks and the accuracy of provider directories are also topics under active review with the SB 760 workgroup. HHSC convened a main dental home workgroup of dentists, the Texas Dental Association, and the DMOs to review HHSC's main dental home policy and related procedures. As a result of this workgroup, the current procedures for member assignment will remain in place. However, additional clarification of operational procedures will be added to the UMCM. HHSC has implemented, for a limited time, monitoring of main dental home changes as reported by the DMOs to better identify trends and patterns that may require additional attention. Because TMHP does not limit the number of locations for which a dental practice can enroll in Medicaid, the DMOs may credential providers at those locations for which they are enrolled in Medicaid. Some providers have a need to be affiliated with multiple locations, such as traveling providers. Providers hold the ultimate responsibility for ensuring that their				

	directory listings with TMHP and HHSC are accurate, and for notifying the DMOs if they are no longer active providers. In addition, DMOs actively review their rosters for inactive provider locations with no claims activity, and follow up with providers to ensure rosters are as accurate as possible. Providers may be listed at four locations in the DMO provider directories.
Date Last Updated:	12/4/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Main dental home workgroup meeting.	February 2016	Completed	
2	Implement monitoring tools for main dental home changes.	Spring 2016	Completed	
3	Complete monitoring of main dental home changes.	September 2017	Ongoing	
4	Clarification of main dental home operational procedures added to UMCM	September 2018	Delayed	Additional review required to determine what UMCM changes are appropriate especially related to the impact of value-based purchasing and alternative payment models on this UMCM chapter.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	58
Recommendation:	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 (SB 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"				
Additional Stakeholder Background:					
Category:	Contract provisions				
Provided By:	AARP				
HHSC Response:	In accordance with Government Code 533.00251(e), HHSC is developing nursing facility (NF) credentialing and minimum performance standards and plans to submit contract amendments in September 2017 to be effective March 1, 2018. Currently the contract includes standard significant traditional provider (STP) provisions statewide for nursing facilities in STAR+PLUS that will expire February 28, 2018. 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, the any willing provider policy is in contract, but there is no expiration date. MCOs must enter into Network Provider Agreement with any willing NF-provider, including new providers and those that have gone through a change in ownership after Sept. 1, 2013. The NF STP provision and any willing provider provision are separate requirements from the credentialing and minimum performance standards. HHSC plans to implement these standards when the STP provision expires. Once NF credentialing and minimum performance standards are developed, the any willing provider provision will need to be updated in the contract. A meeting was held with associations, MCOs, and NF providers on 3/15/16 requesting their input on MCO credentialing standards for NFs. HHS surveyed the STAR+PLUS MCOs and the Medicare-Medicaid plans (MMP) about credentialing and re-contracting of NFs and skilled nursing facilities (SNFs). Additional meetings were scheduled to obtain further input. HHSC met with AARP on 2/21/2017 to discuss feedback and ideas under discussion. HHSC incorporated AARP's feedback into the draft high level proposal.				

	The NF credentialing stakeholder workgroup comprised of state staff and key stakeholders, will work together in developing the credentialing and performance standards. The workgroup will consider how to prevent the implementation of these standards from resulting in access to care issues.
Date Last Updated:	12/4/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Nursing facility provider meeting held requesting feedback from providers, associations and MCOs.	3/15/2016	Completed	
2	Nursing facility provider meeting held reiterating that feedback is being requested.	4/25/2016	Completed	
3	STAR+PLUS conference call asking MCOs to submit in writing the credentialing criteria they will use once STP status for nursing facility providers expires and how each MCO will handle contracting with NF as well.	6/1/2016	Completed	
4	Requested criteria received from the MCOs.	6/13/2016	Completed	
5	Meet with AARP to discuss feedback received.	2/21/2017	Completed	
6	Obtain feedback from other relevant stakeholders.	2/1/2017 through 8/31/2017	Ongoing	
7	Revise UMCC and UMCM to incorporate changes for 3/1/2018 effective date.	9/1/2017	Completed	
8	Determine if a Texas Administrative Code rule amendment is needed.	TBD		
9	Negotiate contract amendments	10/1/2017 through 2/28/2018	On Target	
10	Dependent upon contract amendment negotiations, new STAR+PLUS credentialing standards become effective. All STAR+PLUS MCOs must use the state-identified credentialing standards to credential NFs seeking to participate in STAR+PLUS.	3/1/2018	On Target	
11	Revise UMCM to incorporate minimum performance standards	TBD	On Target	
12	Dependent upon contract amendment negotiations, by December 31, 2018, the MCO must complete	12/31/2018	On Target	

	credentialing of all NFs that are in its network as of March 1, 2018.			
13	Monitor NF performance on standards	TBD	Ongoing	
14	Annual review and reassessment of standards and modification of standards with submission of contract amendments as needed	TBD	Ongoing	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	61
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Claims				
Provided By:	CHAT				
HHSC Response:	MCOs are contractually required to upload eligibility files in a timely manner. HHSC requested examples of this occurring from CHAT and will work to address issues using these examples. In reviewing the examples provided, it was determined that one solution to address this issue would be to institute a daily transfer of information (daily file) from the enrollment broker to the MCO for all members. This is currently in place for members in STAR Kids, STAR+PLUS, STAR Health, and pregnant women and newborns within STAR. HHSC explored the feasibility of implementing this for the remaining members of the STAR program, and determined that this would be feasible. A plan to implement this in 2018 is underway. Providers can stay informed about further progress on this effort through communication with managed care organizations.				
Date Last Updated:	11/2/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Obtain examples from CHAT of this issue occurring.	8/1/2016	Completed	
2	HHSC review the examples, reach out to health plans to obtain additional information, and determine root cause of issue.	11/1/2016	Completed	Examples received and staff currently reviewing to determine next steps.
3	Develop recommended solution.	2/1/2017	Completed	

4	Determine feasibility of implementing daily file for remaining members of STAR program.	12/1/2017	Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	62 a-c / 63 / 64
Recommendation:	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 online 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 online 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.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with PPAT on 8/8/2016 and it was noted that families need more information about how to file a complaint and information provided should address family concerns about retaliation.				
Category:	Service Coordination / Member Assistance				
Provided By:	PPAT				
HHSC Response:	HHSC HPM realizes the importance of the services being provided to customers and is committed to providing as many options as possible to file complaints and inquiries regarding Medicaid Managed Care. HHSC HPM 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 HPM receives complaints from both members and 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 received by the Office of the Ombudsman. The Office of the Ombudsman has held 11 meetings of the "Managed Care Support Network" that includes HHSC, staff that work with Medicaid eligibility, enrollment, and operations, the Department of Family and Protective Services, Aging and Disability Resource Centers, Area Agency on Aging, enrollment broker (MAXIMUS), and other representatives who interact regularly with consumers and families to provide support and information services to Medicaid managed care consumers. HHSC HPM coordinates with members, providers, other internal staff, stakeholders, and MCOs to review trends, issues, and resolution of inquiries and complaints received. HHSC HPM also makes recommendations to the HHSC HPM Teams and management regarding remedies and corrective action for egregious cases. MCOs who retaliate against members are in violation of their contract (UMCC section 8.2.6.1) and HHSC HPM can place the MCO on Corrective Action Plans, as well as administer monetary sanctions for any violation of the contract. Allegations of any discriminatory or punitive action against a complainant are entered in the HHS Enterprise Administrative Reporting and Tracking system (HEART); and researched by HHSC HPM, HHSC Medicaid CHIP Policy and potentially HHSC Legal. The reference to the Contact@hhsc.state.tx.us" email address has been removed from the agency's website. To report complaints to HHSC, consumers should call the HHS Office of the Ombudsman or make an online submission at https://hhs.texas.gov/ombudsman . Providers can submit complaints to 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 coordinated with stakeholder groups to create flyers 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 HPM will determine the feasibility of implementing an electronic form for complaints submission.
Date Last Updated:	11/17/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HPM participate in quarterly IDD Quality Subcommittee.	4/11/2016	Completed	
2	HPM participate in quarterly IDD Quality Subcommittee.	9/29/2016	Ongoing	
3	HPM participate in Texas Consumer Direction committee	02/28/2017	Completed	HPM presented the complaints process to the group.
4	Host first meeting of Managed Care Support Network authorized by SB 760 SECTION 3 (including the Long-term Care Ombudsman, 17 other HHS offices and three other state agencies).	5/19/16	Completed	
5	Second meeting of the Network.	6/16/16	Completed	
6	Outreach meetings with community organizations assisting Medicaid managed care clients.	Ongoing	Ongoing	
7	Create consumer-friendly outreach materials that can be shared with Medicaid managed care clients.	7/1/16	Completed	
8	Update UMCM with related changes.	1/04/2017	Completed	
9	Internal document created identifying appropriate program areas to funnel complaints.	7/22/15	Completed	
10	Review of MCO complaint and appeals data from nursing facility residents.	10/15/2016	Completed	Webinar with the MCOs, to discuss the requirements of the data, was held on 09/07/2016. All appropriate MCOs were present.
11	Regular coordination meeting between MCS HPM staff and HHS Office of the Ombudsman.	Ongoing	Ongoing	
12	Meeting to review complaints reported to HPM teams on a quarterly basis, focusing on any specific trends that are noticed.	Next meeting March 2017	Completed and Ongoing	Detailed complaint trends were discussed with all internal areas in August 2016, for all MCOs and DMOs.
13	Hosted third meeting of the Managed Care Support Network	7/21/16	Completed	
14	Hosted fourth meeting of the Managed Care Support Network	8/25/16	Completed	
15	Hosted fifth meeting of the Managed Care Support Network	9/22/16	Completed	

16	Hosted sixth meeting of the Managed Care Support Network	10/20/16	Completed	
17	Hosted seventh meeting of the Managed Care Support Network	11/17/16	Completed	
18	Hosted eighth meeting of the Managed Care Support Network	12/29/16	Completed	
19	Continue to host ongoing meetings of the Managed Care Support Network		Completed	The network has been established and continues to meet on a regular basis.

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Agency/Division/Department:	HHSC Ombudsman / MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	65 / 66
Recommendation:	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.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/9/2016. These representatives suggested that the ombudsman consider hiring an individual with a developmental disability to help present the material to individuals with DD and to test materials in an effort to improve communication. There were concerns shared about the service coordination workgroup activities and inclusion of DD advocates in those meetings.				
Category:	Service Coordination / Member Assistance				
Provided By:	Disability Rights Texas/ EveryChild, Inc./Texas Council for Developmental Disabilities/The Arc of Texas				
HHSC Response:	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 Office of the State Long-term Care Ombudsman became part of the HHS Office of the Ombudsman on September 1, 2017. 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. 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 Office of the Ombudsman has held 11 meetings of the "Managed Care Support Network" that includes HHSC staff that work with Medicaid eligibility, enrollment, and operations, the Long Term Care Ombudsman, the Department of Family and Protective Services, Aging and Disability Resource Centers, Area Agency on Aging, enrollment broker (MAXIMUS), and other representatives who interact regularly with consumers and families. 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 coordinated with stakeholder groups to create flyers for clients that include a simple explanation of the complaint process and list the most critical numbers to call for health and emergencies. The Office of the Ombudsman worked with HHS programs areas and community organizations to develop IDD consumer friendly outreach material.				

	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. Additional information about these activities can be found in the response to recommendation 34e / 67.
Date Last Updated:	11/17/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Host first meeting of Managed Care Support Network authorized by SB 760 SECTION 3 (including the Long-term Care Ombudsman, 17 other HHS offices and three other state agencies).	5/19/16	Completed	
2	Second meeting of the Network.	6/16/16	Completed	
3	Outreach meetings with community organizations assisting Medicaid managed care clients.	Ongoing	Ongoing	HHSC held a managed care stakeholder meeting on 07/26/2016 to discuss various topics, including the number/types of complaints received by HPM, for every program type, since January 1, 2016; including the time to resolve complaints. Additionally, stakeholders were educated on how to file member and provider complaints. HHSC will continue to hold these forums in the future.
4	Regular coordination meeting between MCS HPM staff and HHS Office of the Ombudsman	Ongoing	Ongoing	
5	Hosted third meeting of the Managed Care Support Network	7/21/16	Completed	
6	Hosted fourth meeting of the Managed Care Support Network	8/25/16	Completed	
7	HHS Office of Ombudsman is developing presentation and outreach material that will provide STAR Kids families with an overview of the Ombudsman Office. The office will offer organizations that work with STAR Kids clients the opportunity to present feedback during the production of this material.	10/31/16	Completed	
8	Continued to host monthly meetings of the Managed Care Support Network		Completed	The network has been established and continues to meet on a regular basis.

9	HHS Office of Ombudsman is developing presentation and outreach material that will provide clients with a developmental disability with an overview of the Ombudsman Office. The office will offer organizations that work with IDD clients the opportunity to present feedback during the production of this material.	5/31/17	Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	68
Recommendation:	Closely monitor that the DMOs are only allowing clients to receive dental treatment at an ambulatory surgical center (ASC) under general anesthesia when the situation clearly dictates the treatment modality. Within Medicaid, there is an increase in the number of 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.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	Texas Dental Association				
HHSC Response:	HHSC has implemented a Medicaid policy that requires prior authorization for all therapeutic dental treatment performed under level 4 (deep sedation) or general anesthesia on children 0 through 6 years of age. This policy applies to treatment in all inpatient or outpatient settings, including ambulatory surgical centers (ASCs). The policy requires dental providers to provide client-specific documents and information to support the prior authorization request, which is reviewed by the DMO or TMHP (as applicable). Medical services in a medical facility necessary to facilitate therapeutic dental treatment must also be prior authorized by the MCO or TMHP (as applicable). Medicaid data indicates that treatment under level 4 sedation or general anesthesia is more likely to occur on children under seven (7) years old. This policy provides a reasonable method to ensure that dental treatment at ASCs under general anesthesia is an appropriate treatment modality based on medical necessity.				
Date Last Updated:	11/9/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Anesthesia Workgroup Meetings.	1/1/2017	Completed	Meeting held 11/9/2016. No additional meetings are scheduled at this time.
2	Implement Interim Anesthesia Policy.	7/1/2017	Completed	Interim Anesthesia policy implemented.

3	Long-term Anesthesia Policy Completion and revision of Criteria for Dental Therapy Under General Anesthesia Form.	7/1/2017	Completed	HHSC has determined that the long-term anesthesia policy, consisting of proposed revisions to the "Criteria for Dental Therapy Under General Anesthesia" form, is not an appropriate action at this time. HHSC will evaluate the impact of the interim anesthesia policy as data becomes available to determine if additional changes to the Criteria form would facilitate improved service delivery to Medicaid clients.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	70
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	PACSTX				
HHSC Response:	HHSC coordinates with provider associations and collects feedback on strengths and challenges within the Medicaid program. In addition, HHSC reviewed information related to this issue as part of the process to develop network adequacy standards to implement SB760. There was a public forum on June 6, 2016 to discuss related proposals. In addition, TMHP conducts presentations at health-related institutions related to Medicaid State Programs (e.g. THSteps Medical and Dental, Children with Special Health Care Needs, Case Management for Children and Pregnant Women, etc. to recruit new Medicaid providers. HHSC staff will meet with TMHP to discuss additional information that may be included in these presentations in the future. HHSC will continue to coordinate and work with provider associations and advocates to collect feedback on strengths, challenges, and possible solutions to provider participation in the Medicaid program. The TMHP contract includes outreach to providers. HHSC met with TMHP recently about outreach for CHIP and new requirements on outreach.				
Date Last Updated:	12/4/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Meet with TMHP to discuss training components and consider additional information to be added.	9/1/2017	Complete	
2	Review this recommendation further to determine additional next steps.	9/1/2017	Complete	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	71 / 74 a-e / 74 g / 74 j / 74 l-m

Recommendation:	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:
	  ○ Hospital services and emergency care with a 30 minute drive of or 15 miles from home or workplace.
	  ○ Urgent care where no pre-authorization is required: within 24 hours of request.
	  ○ Urgent care where prior authorization is required: within 48 hours of request.
	  ○ All other requests: within 10 days, but no later than 15 days.
	  ○ 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.
	  ○ 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.				

Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				

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Provided By:	Disability Rights Texas/Every Child, Inc./Texas Council for Developmental Disabilities/The Arc of Texas
HHSC Response:	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. 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 SB 760 and rules issued by the CMS require HHSC to establish minimum access standards, including time and distance, for MCO provider networks for certain provider types. HHSC staff developed a draft proposal for revising existing distance and appointment availability standards as well as creating new travel time standards. The proposal was shared at the SB 760 stakeholder forum on June 6, 2016 and has been refined through subsequent meetings with stakeholders. HHSC has reviewed stakeholder input, analyzed the impact these new standards would have on existing MCO networks, compared the proposed standards to standards for commercial insurance, and identified all contract provisions and rules that would need to be amended to implement the proposed access standards. Changes to contracts related to access standards were effective March 1, 2017. Any access standards not included in the March 1, 2017 contract amendment will be included in subsequent amendments. This will likely include access standards for urgent care and long-term services and supports. In regards to monitoring, the S.B. 760 workgroup will establish a process to ensure MCOs comply with contractual standards. Once standards are established, HHSC will submit to the Legislature and make available to the public a report containing information on Medicaid members' access to healthcare services in managed care. Remaining activities are related to the milestones also reported on in item 1c, so future updates to these action items will be reported in item 1c.
Date Last Updated:	10/26/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Develop provider access standards for MCO provider networks.	6/1/2016	Completed	
2	Conduct stakeholder forum to receive feedback on implementing SB 760.	6/6/2016	Completed	
3	Reassess and revise proposed provider access standards based on stakeholder feedback.	8/15/2016	Completed	
4	Submit proposed access standards to MCOs as part of March 2017 contract amendment	10/1/2016	Completed	

5	Amend managed care contracts as necessary to include initial access standards.	3/1/2017	Completed	
6	Amend managed care contracts as necessary to include long term services and supports and other network adequacy standards to meet requirements of CMS rules.	9/1/2018	On Target	
7	Amend agency rules as necessary to include revised access standards.		Ongoing	See item 1c for further updates.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	74i
Recommendation:	Plans should strive to make primary care services available within 30 minutes or 10 miles of an enrollee's residence.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas				
HHSC Response:	SB 760 and new rules issued by CMS require HHSC to establish minimum access standards, including time and distance, for MCO provider networks for certain provider types. HHSC staff developed a draft proposal for revising existing distance and appointment availability standards as well as creating new travel time standards. The draft proposal was shared at the SB 760 stakeholder forum on June 6, 2016. HHSC reviewed stakeholder input, analyzed the impact these new standards would have on existing MCO networks, compared the proposed standards to standards for commercial insurance, and identified all contract provisions and rules that would need to be amended to implement the proposed access standards. Changes to contracts and rules were effective March 1, 2017. Network adequacy standards for LTSS will be included in September 2018 managed care contracts. Remaining activities are related to the milestones also reported on in item 1c, so future updates to these action items will be reported in item 1c.				
Date Last Updated:	10/26/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Develop provider access standards for MCO provider networks.	6/1/2016	Completed	
2	Conduct stakeholder forum to receive feedback on implementing SB 760.	6/6/2016	Completed	
3	Reassess and revise proposed provider access standards based on stakeholder feedback.	8/15/2016	Completed	
4	Amend managed care contracts as necessary to include long term services and supports and other network adequacy standards to meet requirements of CMS rules.	9/1/2018	On Target	

5	Amend agency rules as necessary to include revised access standards.		Ongoing	See item 1c for further updates.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	74k
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas				
HHSC Response:	HHSC is committed to providing access to quality, cost-effective care. Imposing a 24-hour turnaround time for service coordinators would require round-the-clock service and expecting a registered nurse service coordinator to be available on evening and weekends would have a significant fiscal impact and require legislative appropriation.				
Date Last Updated:	12/7/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	HHSC research what timeframe to require MCOs to respond to a member request.	11/30/2016	Complete	Need more time to consider the best approach for implementing a specified timeframe for service coordinators to respond. HHSC implemented contract changes as listed in the milestones below to address this concern.
2	HHSC now has a contract provision requiring the MCO's Member Services Hotline to assist a Member to find a provider and schedule an appointment while on the phone with the Member.	3/1/17	Complete	
3	HHSC is evaluating a potential change to MCO contracts related to timeframes in which a MCO service coordinator must return a call.	9/1/17	Complete	HHSC has determined that at the current time it is the “warm transfer” requirement in milestone number 2 is an adequate solution to the problem.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**Number:**	76
Recommendation:	Ensure that the MCOs are ready, willing and able to provide mental health services to individuals with 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.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Hogg Foundation for Mental Health				
HHSC Response:	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. HHSC and the Hogg Foundation hosted a Medicaid Brainstorming Session on September 29, 2016 to address service gaps and solutions for individuals dually diagnosed with IDD and behavioral health conditions. Part of the summit discussion included provider shortages and gaps in service provision that members with IDD experience. DADS released a free online training in June 2016 for people who care for, support, or advocate for people with IDD. This 6-part e-learning training series was developed by DADS and DSHS to educate direct service workers and others about behavioral health needs of people who have an IDD and a co-occurring behavioral health condition. This training looks at challenging behavior in a new way, emphasizes the importance of supporting mental wellness in individuals with an IDD, and includes a module for trauma-informed care for individuals with IDD. HHSC notified all MCOs of the training on June				

	10, 2016. The **Mental Health Wellness for Individuals with an Intellectual or Developmental Disability** training can be **accessed online at** http://www.mhwidd.com/**.** This item is moved to the IDD SRAC transition to managed care subcommittee. Stakeholder may identify opportunities to engage in future discussion through the IDD SRAC. HHSC in collaboration with the IDD SRAC will identify opportunities during the system redesign to incorporate MH-IDD recommendations or reconvene the MH-IDD workgroup on an ad hoc basis.
Date Last Updated:	11/13/17

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	DADS released training to educate direct service workers and others about behavioral health needs of people who have an IDD and a co-occurring behavioral health condition.	6/3/2016	Completed	
2	HHSC notified MCOs of the training.	6/10/2016	Completed	
3	HHSC Medicaid Brainstorming Session to address service gaps and solutions for individuals dually diagnosed with IDD and behavioral health conditions.	9/29/2016	Completed	
4	Review feedback obtained during the brainstorming session, and send compiled notes to external stakeholders.	3/1/2017	Completed	
5	Identify opportunities in the IDD System Redesign for MH-IDD recommendations discussed during the brainstorming session to be utilized	9/01/2021	Ongoing	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X (Response and Milestone consolidated to 1C)	**Number:**	80
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Association for Home Care & Hospice				
HHSC Response:	HHSC has developed an implementation plan for SB 760. Based on input HHSC received at the SB 760 Stakeholder Forum that was held on June 2016, staff will develop access standards for LTSS providers as well as monitoring mechanisms to ensure MCOs comply with established standards. HHSC will continue to work with stakeholder groups when developing provider access standards. Remaining activities are related to the milestones also reported on in item 1c, so future updates to these action items will be reported in item 1c.				
Date Last Updated:	10/26/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Review and incorporate feedback from stakeholder forum.	7/12/2016	Completed	

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2	Develop additional access standards for other provider types, including LTSS.	9/1/2017	Ongoing	Initial standards for several LTSS provider types has been developed and will be included in September 2018 contract amendments consistent with the added milestone.
3	Implement contract revisions for provider access standards.	9/1/2018	On Target	HHSC included several contract revisions for provider access standards effective 3/1/2017. Standards for LTSS will be included for the 9/1/2018 contract amendment. See item 1c for further updates.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	81
Recommendation:	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.				
Additional Stakeholder Background:	On 8/16/2016 HHSC met with the TSHA and representatives confirmed that the recommendation was specifically addressing concerns with speech language pathologies rather than all providers.				
Category:	Network Adequacy / Access to Care				
Provided By:	TSHA				
HHSC Response:	Current network adequacy standards require MCOs to ensure that all members have access to age-appropriate primary care providers. Additionally, HHSC is working with our EQRO to survey primary care providers (PCPs) about their experience in obtaining specialist referrals. The current PCP referral study survey examines referring children and adults separately. In addition, there is room for an open response for providers to report their experiences with any specialty (in addition to those explicitly listed in the survey). HHSC does not set rates for services reimbursed by MCOs. MCOs are delegated the responsibility of managing a network and setting rates.				
Date Last Updated:	11/17/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	PCP Referral Study Phase 1 Summary of Results.	8/31/2016	Completed	
2	PCP Referral Study Report.	5/31/ 2018	In Progress	In order to improve on the initial low response rate of less than 12%, additional time is needed to ensure the provider directories are accurate. Toward that goal, the EQRO is contracting with a vendor to call each clinic and validate: 1) up to five names per clinic, 2) address accuracy, 3) plans the provider accepts (CHIP/Medicaid), and 4) provider type. They also ask providers whether they would like to have the survey mailed, faxed, emailed, or completed online. Data collection will be complete in November with a final report slated for spring 2018. The completed report will be shared with IDD SRAC at this time. Ongoing work on this topic will be facilitated through IDD SRAC Since this is also a milestone for item 3c, this item will be closed. Please see item 3c for future updates on this item.
3	UMCC amendment effective for new online provider directory standards effective 3/1/2017.	9/1/2017	Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	83
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Continuity of Care				
Provided By:	Texas Rehab Providers Council				
HHSC Response:	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. HHSC is currently exploring options to share prior authorization content between payers when a member makes a plan change.				
Date Last Updated:	12/4/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Explore options and identify cost involved to make changes to collect and share prior authorization content between payers.	9/1/2017	Complete	Initial options were reviewed, and there was a high-level estimate received to collect this information. HHSC is currently exploring additional alternatives. Meetings have been held internally to discuss next steps, and staff are working to identify resources needed to implement this project.
2	Research alternative solutions and determine associated costs. This step includes obtaining stakeholder feedback.	4/1/18	On Target	
3	Final analysis due to leadership	5/1/18	On Target	
4	Leadership decision to proceed with implementation	6/1/18	On Target	
5	Implement technical solution if required in the approved implementation plan.	TBD	TBD	
6	Update policies and revise contracts if required in the approved implementation plan	TBD	TBD	

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Agency/Division/Department:	HHSC FSD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	85
Recommendation:	More adequately support people with complex medical and physical support needs to achieve community integration in the least restrictive setting to meet their needs.				
Additional Stakeholder Background:					
Category:	Rates				
Provided By:	EveryChild, Inc. / Texas Council for Developmental Disabilities / The Arc of Texas				
HHSC Response:	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. There was a decision to put the high medical needs project for HCS on hold pending the outcome of session due to concerns about availability of funding. Following session, we will make a determination regarding if/when we can initiate benefits.				
Date Last Updated:	03/20/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Present rules to Health and Human Services Executive Council.	9/23/2016	Ongoing	Staff presented these rules to the Health and Human Services Executive Council on 9/23/2016. No vote was taken.
	Proposed rules for HCS high medical needs add-on published in the Texas Register for comment.	October 2016	On Target	
2	Final rule should be adopted and effective, pending appropriation.	TBD	Pending	Final rule is not being adopted. Appropriations for high medical needs services was not received during the 85th Legislative Session. HHSC will not pursue the addition of high medical needs services to the HCS waiver at this time.
3	Rate for HCS high medical needs add-on effective, pending appropriation.	TBD	Pending	NA

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	92
Recommendation:	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.				
Additional Stakeholder Background:					
Category:	Service Coordination / Member Assistance				
Provided By:	TMA / TPS				
HHSC Response:	Like STAR+PLUS, STAR Kids has a service coordinator hotline number that is 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 also has 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 (or the member's preferred communication method) 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 were operational effective 11/1/16.				

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	If a provider needs to contact an MCO service coordinator, many MCOs post the information in the provider portal. In the event the MCO does not, the provider should call the MCO service coordination line. These phone numbers are in each provider handbook, on the MCO's website, and HHSC posts STAR+PLUS service coordination phone numbers in Appendix VI, STAR+PLUS Inquiries Chart, in the STAR+PLUS Handbook. HHSC is developing something similar for the STAR Kids Handbook. HHSC has several quality initiatives, among them is a move toward value-based purchasing for long term services and supports. In addition, HHSC encourages stakeholders to provide recommendations for program improvements through a variety of mechanisms, including requests for information and model requests for proposal for future contracts. HHSC will take the feedback provided through the Executive Commissioner's Commitment to Improving Member and Provider Experience in Medicaid Managed Care into account when developing future contracts as well as continue through various mechanisms to collect and use valuable stakeholder input.
Date Last Updated:	03/12/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Adopt STAR+PLUS contract changes.	9/1/16	Completed	
2	Conduct STAR Kids Information Sessions.	10/1/16	Completed	
3	Implement STAR Kids.	11/1/16	Completed	
4	Ask for stakeholder input around care coordination, including Health Homes, in a Request for Information (RFI) for new STAR+PLUS contracts	1/30/2017	Completed	
5	Continue to evaluate stakeholder requests around improving care coordination and implement requests, as appropriate		Completed	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**Number:**	95
Recommendation:	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.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with PPAT on 8/8/2016 and in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/9/2016. In both meetings feedback was provided emphasizing the importance of having information about MCOs specific to individuals with IDD. It was specifically noted that an individual with IDD currently has little information with which to determine which plans may best meet their needs.				
Category:	Stakeholder engagement and feedback				
Provided By:	PPAT				
HHSC Response:	HHSC will discuss the feasibility of a satisfaction survey for this population, seeking input from our IDD SRAC as well as the MCOs. This item was added to the July 28, 2016 IDD SRAC Meeting agenda. HHSC shared a copy of the existing CAHPS survey with the IDD SRAC and attended the 10/3/2016 meeting to discuss further the survey and its applicability to the IDD population. In October, IDD SRAC members decided that obtaining specific HEDIS results for individuals with IDD would be more useful. EQRO is running the analysis which should be ready for the December SRAC meeting. See recommendation 3C for information on the STAR Kids focus study as it relates to members with IDD. Additionally, as part of the focus study Texas's External Quality Review Organization is testing additional questions to determine their feasibility and applicability to the STAR Kids population. Since the remaining milestones are also part of item 3c, this item will be closed. Please see item 3c for future updates on this item.				
Date Last Updated:	12/7/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HHSC will seek input from IDD SRAC.	7/28/2016	Completed	
2	HHSC will discuss feasibility with MCOs.	TBD		
3	HHSC Quality Assurance staff to attend IDD SRAC meeting.	10/3/16	Completed	
4	Pre-implementation survey for STAR Kids focus study.	10/31/2016	Completed	
5	STAR Kids pre-implementation focus study final report.	4/30/2017	Completed	Preliminary results from the pre-implementation study were presented to the STAR Kids Advisory Committee at their public meeting on March 1, 2017. The final pre-implementation report was shared with the committee in summer 2017.
6	Post-implementation survey for STAR Kids focus study.	August 2018	On Target	Since this is also a milestone for item 3c, this item will be closed. Please see item 3c for future updates on this item.
7	STAR Kids post-implementation focus study final report.	June, 2019	On Target	Since this is also a milestone for item 3c, this item will be closed. Please see item 3c for future updates on this item.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	97 / 98
Recommendation:	Meaningfully inform and include people with DD on councils, workgroups, and committees concerning their health and human services.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/12/2016. The representatives provided feedback that supports are not provided for all meetings, and shared concerns that feedback is routed through HHSC and not provided directly to legislative leadership.				
Category:	Stakeholder engagement and feedback				
Provided By:	Disability Rights Texas/EveryChild, Inc./Texas Council for Developmental Disabilities/The Arc of Texas				
HHSC Response:	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. Through our advisory committees, individuals with disabilities are given opportunities to serve and express their concerns regarding the quality of care received. These committees—in addition to the IDD SRAC, the BHIAC, Medical Care Advisory Committee, and the STAR Kids Advisory Committee—provide a forum for stakeholder input on policies impacting the delivery of Medicaid managed care services. Using the forums described above, HHSC will continue to consider feedback from families, individuals with disabilities receiving services, and LTSS providers on a number of policies, including ways to alleviate burdensome processes. HHSC will actively seek feedback by adding topics to current appropriate stakeholder forum agendas. After further discussion with stakeholders, MCS leadership directed additional efforts to develop a policy around the supports and processes to be used for councils, workgroups, and committees on which individuals with DD may serve or participate. In addition, MCS will work with The Arc of Texas to provide training and information to employees about the need for these supports and the steps to take for inclusive meetings.				
Date Last Updated:	11/17/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Identify changes needed to ensure participation of individuals participating on councils, workgroups, and committees is meaningful and appropriately supported.	11/30/16	Completed	
2	Develop plans to address issues.	2/1/2017	Completed	
3	Establish internal workgroup to develop policy to outline expectations for supports and process to use to establish an inclusive meeting for individuals with DD that may serve or participate.	6/1/2017	Completed	
4	Coordinate with The Arc of Texas to deliver training for staff.	9/1/2017	Completed	
5	Develop draft MCS policy outlining expectations for meeting supports for inclusion of individuals with IDD.	1/1/2018	On Target	
6	Add draft components to the HHSC facilitation guide, outlining expectations for meeting supports for inclusion of individuals with IDD.	4/1/2018	On Target	
7	Finalize MCS policy.	5/1/2018	Delayed	
8	Conduct training for MCS staff in coordination with The Arc of Texas.	7/1/2018	On Target	
9	Develop plans for meeting ongoing training needs.	7/1/2018	On Target	
10	Finalize HHSC facilitation guide.	TBD	On Target	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	103
Recommendation:	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. HHSC 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.				
Additional Stakeholder Background:					
Category:	Alternative Payment Mechanisms				
Provided By:	THA				
HHSC Response:	HHSC collects information vital to monitoring utilization rates in the program. HHSC will meet with THA to discuss this recommendation, and develop a scope of work to expand the impact analyses. This meeting will be scheduled following the legislative session.				
Date Last Updated:	11/17/2017				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Meet with THA.	2/1/2018	Delayed	
2	Review this recommendation and determine full scope of activities.	TBD		

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	104
Recommendation:	Implement accountability measures linked to reimbursement It is important that HMOs 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.				
Additional Stakeholder Background:					
Category:	Contract Provisions				
Provided By:	ADAPT Texas				
HHSC Response:	HHSC appreciates this information and the recommendation for measures. Currently, there are no national standards or nationally comparable measures for LTSS, which is an important component of Texas' quality assurance program. CMS has begun testing some LTSS measures. This testing will hopefully result in nationally comparable, valid, and reliable measures Texas could adopt. A number of Texas-specific measures have now been developed, but implementation of payment incentives for these measures is on hold due to the need for standardized, nationally recognized measures. LTSS will be included in the value-based payment program when such measures become available. HHSC will take the stakeholder suggested performance indicators into consideration if national measures are developed, and when coordinating with the National Association of States United for Aging and Disabilities (NASUAD) and Human Services Research Institute (HSRI). Note: HHSC would need legislative direction and appropriation to increase the attendant wages, as suggested in this recommendation. HHSC is currently focusing attention on its participation in the NASUAD and HSRI National Core Indicators - Aging and Disabilities (NCI-AD) survey. The NCI-AD survey is intended to collect data that will allow the state to understand, from				

	the member's perspective, how their LTSS impact their quality of life and health outcomes. The survey is conducted biannually through in-person member surveys administered by EQRO. Included in the survey sample are STAR+PLUS members receiving LTSS through STAR+PLUS HCBS. The first year of surveys were completed in May 2016, and HHSC intends to participate on a biannual basis. The 2015-2016 survey domains are: • Community Participation • Choice and Decision-Making • Relationships • Satisfaction • Service/Care Coordination • Access • Safety • Health care • Wellness • Medication • Rights and Respect • Self-Direction • Work • Everyday Living • Affordability • Planning for Future • Functional Competence
Date Last Updated:	11/17/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HHSC to receive first draft of report on NCI-AD results from NASUAD and HSRI.	October 2016	Completed	
2	Analyze survey results and determine next steps.	04/30/2017	Complete	Survey results have been posted to the NASUAD website: http://nci-ad.org/states/TX/. Results were shared with MCOs in Summer 2017. Plans were informed that methodology changed for the 2017-2018 survey and the results of the 2017-2018 survey would be used to establish a baseline and HHSC would evaluate and establish benchmarks for improvement at that time.