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 Dr. Courtney Phillips is equally committed to improving member and provider experience in Medicaid managed care. Enrique Marquez, Chief Program Services Officer 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 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 in this document include: • CPSCO: Chief Program Services Office • MCS: Medicaid and CHIP Services (Department) • 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 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:**	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:	Providers Alliance for Community Services of Texas (PACSTX)				
HHSC Response:	The IDD System Redesign Advisory Committee (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. MCS initiated a number of process improvement efforts including an effort to review the complaints process, the member and provider experience, and improve related processes. Completion and testing of the website update described above is on hold in order to be sure that the changes to the complaints process are appropriately integrated into this communication prior to release. Representatives attended the April 2019 IDD SRAC meeting to discuss these projects and next steps. Additional information is provided at: https://hhs.texas.gov/about-hhs/process-improvement/managed-care-oversight-improvement-initiatives
Date Last Updated:	5/1/2019

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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	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	Attend IDD SRAC meeting to provide overview of managed care oversight improvement projects.	1/30/2019	Completed	
9	Accessible webpage design will be tested by individuals with IDD to ensure it is user friendly.	8/1/2019	Delayed	
10	Accessible webpage will be posted to agency website.	9/1/2019	Delayed	As described above, MCS initiated a number of process improvement efforts including an effort to review the complaints process, the member experience, and improve related processes. Completion and testing of the website update described above is on hold in order to ensure that the changes to the complaints process are appropriately integrated into this communication prior to release.

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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.				

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	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:	5/1/2019

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	Completed	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	Completed	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.	10/19/2018	Completed	The completed report was shared with IDD SRAC on October 19, 2018. 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 and is posted on the HHSC website at

				https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/STAR-Kids-Pre-Implementation-Report-052617.pdf. The final summary report which will include post-implementation measure results will be shared with the advisory committee in summer 2019.

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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:**	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 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. The rules were published, comments received, and modifications made based on feedback. HHSC will continue to work with the Behavioral Health Advisory Committee on questions and feedback on activities as appropriate.				
Date Last Updated:	6/4/2019				

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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	Post medical benefit policies for public comment.	Summer 2016	Completed	
2	Adopt Texas Administrative Code rules.	8/31/2018	Completed	Rules were adopted on 10/12/2018.

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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:	4/12/2019				

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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	Complete	
7	(RFP) Contract Awarded	12/31/2018	Complete	
8	Vendor Transition	3/1/2019	Complete	Targeted Date pushed out due to negotiations for transition.
9	Stakeholder evaluation of vendor deliverables	5/1/2019	On Target	
10	PMES Testing	9/1/2019	On Target	
11	PMES Implementation (TPI no longer used - system live)	3/1/2020	On Target	Target date pushed out because the transition started 3/3/19 instead of January.
12	Vendor Operations of PMES	3/1/2020	On Target	Target date pushed out because the transition started 3/3/19 instead of January.

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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:**	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:	Medicaid CHIP Services (MCS) added information to the 834 Enrollment File and associated Capitation files in April, 2017 to confirm Managed Care Organizations (MCOs) are informed of members gained and lost (as well as of MCO enrollments gained and lost). Additionally, MCS instructed the Eligibility and Enrollment Workgroup to continue to evaluate cases to determine if ongoing systematic issues exist. Since the spring of 2017, MCS Program Enrollment and Support (PES) has worked with Access and Eligibility Services (AES) to identify issues that contribute to provider recoupments, and has worked to identify and suggest system solutions				

	to address providers' concerns (including a new monthly report from Enrollment Broker to highlight duplicates). Specifically, between spring 2017 and spring 2018, MCS PES has: • Added recertification data to the MCO files to help maintain members' eligibility by reminding members to submit their recertification documents; • Improved the data files to contain information that will help the MCOs track member movement between MCOs if the members request to change plans; and • Worked with AES to produce draft requirements to track potential duplicate errors in enrollment to reduce provider abrasion. After taking these steps, PES has not received additional examples of issues contributing to adverse provider recoupments since May 2018. PES continues to look for opportunities to improve data shared with MCOs to further reduce the potential for segments with a retroactive loss of eligibility. As a result of these collective efforts, MCOs are receiving more accurate information about clients, there is better information exchange between AES and MCS, and MCS is seeing a reduction in the number of duplicate IDs – all of which reduces the potential for retroactive eligibility removal (by reducing billing challenges for impacted providers). At this point, there is no outstanding work for PES to conduct to officially complete this item. If additional issues or examples are raised, HHSC will work with TMA to appropriately address them.
Date Last Updated:	5/1/2019

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	Completed/ Other	
2	Add values to current interfaces to provide additional member information to MCOs.	4/2017	Complete	

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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:	4/11/2019

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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 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	Review DME issues with advocates/stakeholders.	6/1/2018	Completed	Meeting with advocates/stakeholders held to revisit current concerns regarding the delivery of DME to Medicaid Managed Care members across programs.
13	Convene stakeholders to discuss issues of concern.	11/1/2018	Completed	Beginning in November 2018, HHSC staff convened DME providers, managed care organizations, and advocates for individuals who use DME to discuss stakeholder concerns. Meetings occur every 6-8 weeks and are anticipated to conclude in late 2019. Each meeting has a focus on a specific concern shared by stakeholders.
14	Amend Uniform Managed Care Manual to include required template for all MCO denial letters	9/1/2019	On Target	

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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:**	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:	Medicaid CHIP Services (MCS) added information to the 834 Enrollment File and associated Capitation files in April, 2017 to confirm Managed Care Organizations (MCOs) are informed of members gained and lost (as well as of MCO enrollments gained and lost). Additionally, MCS instructed the Eligibility and Enrollment Workgroup to continue to evaluate cases to determine if ongoing systematic issues exist. Since the spring of 2017, MCS Program Enrollment and Support (PES) has worked with Access and Eligibility Services (AES) to identify issues that contribute to provider recoupments, and has worked to identify and suggest system solutions				

	to address providers' concerns (including a new monthly report from Enrollment Broker to highlight duplicates). Specifically, between spring 2017 and spring 2018, MCS PES has: • Added recertification data to the MCO files to help maintain members' eligibility by reminding members to submit their recertification documents; • Improved the data files to contain information that will help the MCOs track member movement between MCOs if the members request to change plans; and • Worked with AES to produce draft requirements to track potential duplicate errors in enrollment to reduce provider abrasion. After taking these steps, PES has not received additional examples of issues contributing to adverse provider recoupments since May 2018. PES continues to look for opportunities to improve data shared with MCOs to further reduce the potential for segments with a retroactive loss of eligibility. As a result of these collective efforts, MCOs are receiving more accurate information about clients, there is better information exchange between AES and MCS, and MCS is seeing a reduction in the number of duplicate IDs – all of which reduces the potential for retroactive eligibility removal (by reducing billing challenges for impacted providers). At this point, there is no outstanding work for PES to conduct to officially complete this item. If additional issues or examples are raised, HHSC will work with TMA to appropriately address them.
Date Last Updated:	5/1/2019

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	Completed/ Other	
2	Add values to current interfaces to provide additional member information to MCOs.	4/2017	Complete	

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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.				

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	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. HHSC will review and reassess standards and modification of standards as needed.
Date Last Updated:	4/17/2019

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	Completed	

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.	4/1/2018	Completed	It was determined that this was not needed.
9	Negotiate contract amendments	10/1/2017 through 2/28/2018	Completed	
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	Completed	
11	Submit changes to UMCM to incorporate minimum performance standards.	9/1/2019	Delayed	In the last quarter of 2019, the workgroup made progress in identifying possible metrics for performance standards; however, progress was delayed due to the workload associated with the Texas legislative session.
12	Require that MCOs complete credentialing of all NFs that are in its network as of 3/1/2018 by 6/30/2019.	12/31/2018	Completed	
13	Determine roles and responsibilities for monitoring NF performance on standards.	9/1/2019	Delayed	This milestone is dependent upon the completion of milestone 11, which was 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:**	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. Initial options were reviewed, and a high-level estimate received to collect this information. HHSC has explored additional alternatives and held meetings internally to discuss next steps. The Texas Association of Health Plans (TAHP) is leading an MCO workgroup which developed a member transfer process, which includes PA transfer information, for certain programs. At the request of HHSC, TAHP expanded the scope of their project to encompass all programs, including CHIP. The PA transfer process developed by the workgroup does not require HHSC intervention or technology changes. TAHP has collaborated with MCOs to develop a manual process to transfer existing PA from one plan to another for STAR Kids and STAR+PLUS, and is currently working to implement this in CHIP. This manual process is not appropriate for use in the STAR program, so automated options may be explored once federal rules related to this issue are published. Draft rules indicate that				

	an automated process may be required. HHSC will continue to monitor progress to confirm that this effort will meet this need.
Date Last Updated:	4/25/2019

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	
2	Research alternative solutions and determine associated costs. This step includes obtaining stakeholder feedback.	4/1/2018	Completed	
3	Obtain feedback from TAHP about options to automate this processing in the STAR program.	9/1/2019	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:**	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.				

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	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. These efforts will be developed and led by the Office of Transformation for greater agency impact and coordination. In addition, HHSC 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:	4/12/2019

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	Meet with staff in the Advisory Committee Coordination Office to share information about the project, and transfer responsibilities.	9/1/2018	Completed	This project is being transferred to the Advisory Committee Coordination Office for agency wide development.
6	Develop draft HHSC policy outlining expectations for meeting supports for inclusion of individuals with IDD.	8/1/18	Completed	

7	Add draft components to the HHSC facilitation guide, outlining expectations for meeting supports for inclusion of individuals with IDD.	10/1/18	Completed	
8	Finalize HHSC policy.	10/1/18	Completed	
9	Develop plans for meeting ongoing training needs.	10/1/18	Completed	
10	Finalize HHSC facilitation guide.	10/1/18	Completed	
11	Analyze project needs and develop new project timeline.	1/1/2019	Completed	
12	Conduct training for HHSC staff and committee members.	9/1/2019	On Target	Training will be developed utilizing information presented to HHSC staff by the Texas Council for Developmental Disabilities, Texas Advocates, and the Arc of Texas. An orientation handbook is being developed for committee members and committee chairs.