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. HHSC responses were shared directly with stakeholder groups in February 2016, an update was posted to the website on April 11, 2016, and quarterly updates will continue to be shared on the website.

Recently appointed Executive Commissioner Charles Smith is equally committed to improving member and provider experience in Medicaid Managed Care. Gary Jessee, Deputy Executive Commissioner of the Medical and Social Services division, holds responsibility for coordination and implementation of this project and monitoring its progress.

In the July 2016 update, work plans have been developed to provide more detail about the agency response and plans for next steps. 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. In addition, staff in the Medicaid and CHIP Division will reach out to stakeholder groups that provided feedback to discuss the responses and confirm the recommendations have been understood correctly and responses are clear from the perspective of the stakeholder. Questions about this project can sent to MedicaidManagedCare@hhsc.state.tx.us.

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Table 1: Explanation of Response Fields

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

Table 2: Abbreviations Used in Document

Acronym	Definition
ACA	Affordable Care Act
APRN	Advanced Practice Registered Nurses
API	Atypical Provider Identifier
ASC	Ambulatory Surgical Center
BHIAC	Behavioral Health Integration Advisory Committee
CDS	Consumer Directed Services
CHAT	Children's Hospital Association of Texas
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
COS	Chief of Staff
CVO	Credentialing Verification Organization
DADS	Department of Aging and Disability Services
DMO	Dental Maintenance Organization
DUR	Drug Utilization Review
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
FDA	Food and Drug Administration
FFS	Fee-for-service
FSD	Financial Services Division
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission
HMO	Health Maintenance Organization
HPM	Health Plan Management
IDD	Intellectual and Developmental Disabilities
LIDDA	Local Intellectual and Developmental Disability Authorities
LTSS	Long-term Services and Supports
MCD	Medicaid and CHIP Division
MCO	Managed Care Organization
MHPAEA	Mental Health Parity and Addictions Equity Act
NA	Not Applicable
NAIP	Network Access Improvement Project
NPI	National Provider Identifier
PA	Prior Authorization
PACSTX	Providers Alliance for Community Services of Texas
PCP	Primary Care Physician
PDL	Preferred Drug List
PPAT	Private Providers Association of Texas
PPS	Prospective Payment System
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SRAC	System Redesign Advisory Committee
STAR	State of Texas Access Reform
STP	Significant Traditional Provider
TAHP	Texas Association of Health Plans

Acronym	Definition
TBD	To Be Determined
TDI	Texas Department of Insurance
THA	Texas Hospital Association
THSteps	Texas Health Steps
TMA	Texas Medical Association
TMHP	Texas Medicaid and Healthcare Partnership
TPI	Texas Provider Identifier
TPS	Texas Pediatric Society
UMCC	Uniform Managed Care Contract
UMCM	Uniform Managed Care Manual
VDP	Vendor Drug Program

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**Number:**	1 a-b
Recommendation:	Ensure long-term services and supports (LTSS) providers and families obtain reimbursement for services not covered by managed care organizations (MCOs). Consider an interim option for individuals to receive care when the services are not available through the MCO. Not doing so has the potential to result in unintended, adverse consequences for persons receiving services. This includes developing a process for LTSS providers and families to obtain reimbursement for these services from either MCOs or HHSC. [MCOs are paid to assure access to and improved coordination of care. In cases, however, when families or providers cannot obtain needed care or assistance from the MCO, thus pay for the service out-of-pocket, an MCO's fee remains unchanged.]				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Private Providers Association of Texas (PPAT)				
HHSC Response:	HHSC requires additional information from PPAT to determine whether changes can be implemented to appropriately address this recommendation. The Texas Medicaid program does not have a mechanism to reimburse members for costs of services. MCOs are required to deliver all Medicaid services in a timely manner. HHSC contacted PPAT in May 2016 to ask for examples of services that are not being covered. When the services are identified, HHSC will work to ensure health plans are providing all Medicaid covered services.				
Date Last Updated:	6/30/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Request examples from PPAT.	6/1/2016	Completed	
2	Request meeting with PPAT to discuss the issue.	8/1/2016		
	Review examples to determine issue.	8/1/2016		
3	Develop plan to address issue, as needed.	9/1/2016		

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Agency/Division:	HHSC MCD	**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 new rules issued by the Centers for Medicare & Medicaid Services (CMS) require HHSC to establish minimum access standards, including time and distance, for MCO provider networks for certain provider types. As part of its 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; • met with numerous stakeholder groups and reviewed stakeholder feedback provided at the 11/30/2015 public forum; 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 are currently reviewing stakeholder input, analyzing 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 anticipates the completion of changes to contracts and rules by 3/1/2017. Updates to information about implementation of these SB760 requirements are located on the HHSC website at http://www.hhsc.state.tx.us/medicaid/managed-care/SB760-implementation.shtml.
Date Last Updated:	6/10/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	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	On Target	
4	Reassess and revise proposed provider access standards based on stakeholder feedback.	8/5/2016	On Target	
5	Amend managed care contracts and agency rules as necessary.	3/1/2017	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**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 required by Rider 81 and Rider 82 will provide information on corrective actions taken against MCOs for not meeting network access standards and single case agreements and will be publicly available in September 2016. 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 is hosting a Medicaid Brainstorming Session on September 15, 2016 to address service gaps and solutions for individuals dually diagnosed with IDD and behavioral health conditions. Part of the discussion will address provider shortages and gaps in service provision that members with IDD experience.				
Date Last Updated:	6/22/2016				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Rider 81 and Rider 82 Reports available to the public.	9/2016	On Target	
2	HHSC Medicaid Brainstorming Session to address service gaps and solutions for individuals dually diagnosed with IDD and behavioral health conditions.	9/15/2016	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	1e
Recommendation:	Increase utilization of out-of-network providers where gaps in networks exist. Evaluate utilization of out-of-network providers and if not widely used determine why and, as appropriate, identify ways to increase access to such, particularly in cases when an MCO is experiencing challenges in attracting healthcare providers to their networks.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	PPAT				
HHSC Response:	HHSC is working to strengthen network adequacy requirements and better identify network gaps as part of implementation of SB 760. Rather than emphasizing out-of-network utilization, efforts will focus on helping members access in-network providers. The SB 760 implementation plans include a proposal, currently under development, to require MCO member services staff to better assist with scheduling appointments. This plan would include adding language to member handbooks to inform members that they can access out-of-network providers when both 1) an MCO does not have such a provider in network, and 2) receives a referral from an in-network provider. Updates and information regarding SB 760 implementation can be found at http://www.hhsc.state.tx.us/medicaid/managed-care/SB760-implementation.shtml.				
Date Last Updated:	6/22/2016				

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

	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 MCO out-of-network utilization.	6/1/2016	Completed	
2	Submit proposed contract changes.	9/1/2016	On Target	
3	Amend Member Handbook to include language on accessing out-of-network providers.	11/1/2016	On Target	
4	Contract changes effective.	3/1/2017	On Target	

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Agency/Division:	HHSC MCD	**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:					
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 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. HHSC will explore options to work with the Texas Medicaid and Healthcare Partnership (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:	6/30/2016				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Identify and review existing reports and sources of information to review for more information about provider terminations and feedback.	11/1/2016		
2	Explore options to work with TMHP to recruit providers underrepresented in the Medicaid network.	11/1/2016		
3	Identify next steps to improve provider recruitment.	12/1/2016		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	2a
Recommendation:	Continue to explore ways to improve the MCO on-line directories, including how to improve access to and ease in use of the on-line directories. This includes HHSC continuing to 'ghost' call doctors in each MCO's directory. We recognize the challenges in trying to maintain the accuracy of the MCO Provider Directories, thus appreciate the recent efforts of HHSC and MCOs to improve the MCO Provider Directories. Although efforts are already underway to improve the directories the need for the recommendation to remain in the forefront cannot be overstated. Even if the list of doctors is current and accurate, if it does not include a specialist one needs (such as a psychiatrist or neurologist) the directory is of no value. Directories also serve of no value if doctors for the type care one needs are not taking new patients, refuse to see persons with IDD or are too far away for a family and more importantly for an individual who may not tolerate long drives very well, followed by long waits in a doctor's office. This also places a burden on providers as having to travel out-of-town to take an individual to an appointment typically requires having another staff member present and available to ensure the other persons in a group home setting receive needed care. Such results in increased costs for which providers receive no reimbursement.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	PPAT				
HHSC Response:	The SB 760 workgroup is currently developing critical elements for the MCO online provider directories for inclusion in the UMCM. In addition, the HHSC EQRO is conducting "secret shopper" calls to MCO network providers in the MCOs' provider directories. HHSC solicited stakeholder comments on provider directory standards, including a stakeholder forum on 11/30/2015. These comments were incorporated into draft Provider Directory Standards released for additional comment in May 2016. The updated MCO provider directory standards will include new requirements for both print and online versions of MCO Provider directories. HHSC collected additional feedback during the subsequent SB760 stakeholder forum held on 6/6/2016. HHSC will incorporate the additional comments into revised MCO provider directory standards as appropriate. After adding the revisions, the new draft of the provider directory standards will be provided to the SB 760 workgroup for agreement prior to submission through the HHSC UMCM amendment process.				
Date Last Updated:	6/22/2016				

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	2b
Recommendation:	Require MCOs to find doctors for LTSS clients.				
Additional Stakeholder Background:	If one does not already exist, establish a policy placing the responsibility of finding a doctor on the MCO, not on LTSS providers or families. [Providers and families alike were told prior to the transition that under managed care their burdens in securing access to doctors and other healthcare professionals would be alleviated. To date such has not happened with providers and families spending inordinate amounts of time searching for healthcare providers.]				
Category:	Network Adequacy / Access to Care				
Provided By:	PPAT				
HHSC Response:	HHSC contractually requires Medicaid MCOs to provide service management and coordination to members, including assistance in finding a provider. The HHSC SB760 workgroup is considering additional options to strengthen this requirement as described in response to recommendation 1e. Please see the response to 1e for additional information.				
Date Last Updated:	7/1/2016				

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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 is working with HHSC's Vendor Drug Program (VDP) to develop tools for members and LTSS providers to use to assist in this process. At their 6/15/2016 meeting, the subcommittee discussed recommendations with a representative from VDP, and will review changes made to the tools based on those discussions at their August meeting. Their finalized recommendations will be shared with the full System Redesign Advisory Committee (SRAC) meeting in October.				
Date Last Updated:	6/22/2016				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	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	On Target	
7	Full IDD SRAC Meeting. The subcommittee will present to the committee.	10/31/2016	On Target	

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Agency/Division:	HHSC MCD	**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 recently made recommendations on how to educate and reach out to individuals with IDD about managed care. HHSC will also seek feedback from the IDD SRAC on approaches to educating members on the complaint processes, including how to encourage individuals to formally submit complaints, which will provide HHSC with more accurate complaint data and enable HHSC to address issues as they arise. HHSC will continue to coordinate with the IDD SRAC and the IDD Managed Care Improvement Workgroup as issues arise to inform the MCOs about issues, to work through resolution of issues, and improve service delivery.				

	The IDD SRAC recommended that the MCOs, Local Intellectual and Developmental Disability Authorities (LIDDAs), and the LTSS Department of Aging and Disability Services (DADS) waiver providers meet routinely through regional healthcare collaborations to address operational issues and specific case issues. Regional healthcare collaboration meetings may assist in resolving day-to-day operational 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 meets regularly, reviewed the complaint process during their April and June 2016 meetings, and will make recommendations on a more user-friendly guide for individuals and families, including key differences between the complaint and appeal processes. The quality subcommittee's recommendations will be presented to the full IDD SRAC in July 2016 for additional feedback. In August 2016, the IDD SRAC will present the final recommendations to HHSC executive leadership for approval. HHSC is also exploring the possibility of meetings at the local level.
Date Last Updated:	6/20/16

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	On Target	
2	Full IDD SRAC presents final recommendations to HHSC executive leadership.	8/31/2016	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: 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 will research whether changes can be implemented to obtain and publish the requested data information in the future, as well as explore ways to leverage the EQRO reports for inclusion of the requested data. HHSC 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 surveys of Medicaid and Children's Health Insurance Program (CHIP) managed care members to obtain feedback on healthcare. HHSC is reviewing and assessing data, including complaint data, and complaints related to network adequacy and prior authorizations, for inclusion in the House Bill 3523 Legislative Report due to the legislature in September 2016.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Research to determine if the EQRO data collection process could specify experiences of individuals with intellectual and developmental disabilities.	Fall 2016	Ongoing	
2	Submit House Bill 3523/ Senate Bill 7 IDD Legislative Report.	9/30/2016	On Target	

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Agency/Division:	HHSC MCD	**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:					
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 of members and providers in Medicaid Managed Care. HHSC will analyze the final rule to determine if additional changes to Managed care contracts or policies are necessary. 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.
Date Last Updated:	6/22/2016

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

	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, and determine impact to this issue.	8/31/2016		

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Agency/Division:	HHSC MCD	**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 Managed Care Organization. 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 be 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.				
Date Last Updated:	7/1/2016				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Meet with THA, and determine next steps.	8/30/2016		

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	6b
Recommendation:	Challenges with different MCO processes. With the recent STAR Kids program awards, HHSC now contracts with 20 MCOs throughout the State, many of which have different requirements for credentialing and service authorization. In addition, many of the MCOs subcontract behavioral health services to behavioral health organizations that also have with different processes.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Council of Community Centers				
HHSC Response:	In order to offer choices to our clients in their managed care plan, HHSC contracts with a large number of MCOs. We are committed to finding ways to help providers navigate the differences and are working toward modernizing and streamlining our enrollment and credentialing systems. HHSC is working towards these goals through the implementation SB 1150 (83R), the Texas Association of Health Plans (TAHP) uniform credentialing process, and TDI's standard prior authorization as described below. **SB 1150** Following the passage of SB 1150 (83R), HHSC developed the following Provider Protection Plan, which was added to the UMCC and all managed care contracts, effective September 2013. **UMCC 8.1.4.12 Provider Protection Plan** The MCO must comply with HHSC's provider protection plan requirements for reducing the administrative burdens placed on Network Providers, and ensuring efficiency in Network enrollment and reimbursement. At a minimum, the plan must comply with the requirements of Texas Government Code § 533.0055, and: • Provide for timely and accurate claims adjudication and proper claims payment in accordance with UMCM Chapters 2.0 through 2.3. • Include Network Provider training and education on the requirements for claims submission and appeals, including the MCO's policies and procedures (see also Section 8.1.4.6, "Provider Relations Including Manual, Materials and Training.") • Ensure Member access to care, in accordance with Section 8.1.3, "Access to Care," and the UMCM's Geo-Mapping requirements (see UMCM Chapters 5.14.1 through 5.14.4.) • Ensure prompt credentialing, as required by Section 8.1.4.4, "Provider Credentialing and Re-credentialing."				

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

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

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

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Agency/Division:	HHSC MCD	**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 TDI 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 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 is currently conducting a review of the Mental Health Rehabilitation and Mental Health Targeted Case Management benefit, including any potential changes to the utilization management guidelines. As part of this review process, there will be opportunities for stakeholders to provide feedback on any proposed changes. HHSC continues to refine the medical benefit policy for mental health rehabilitative services and mental health targeted case management. This includes a review of relevant governance documents (including the state plan, Texas Administrative Code, and other applicable reference material). Should any change to the utilization review process for these services be made, it will be included as part of the medical benefit policy for the services, and stakeholders will be given an opportunity to provide feedback. HHSC anticipates posting the policies for public comment in summer 2016. In addition, HHSC policy staff are drafting rules for the managed care section of the HHSC Texas Administrative Code to address these benefits.				
Date Last Updated:	6/22/2016				

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

	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		
2	Adopt Texas Administrative Code rules.	Spring 2017		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: 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 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, TSHA supports the establishment of care standards for Medicaid beneficiaries transitioning from one delivery system to another.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				

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Provided By:	Texas Rehab Providers Council/Outpatient Independent Rehabilitation Association/Texas Speech-Language-Hearing Association
HHSC Response:	At this time, HHSC cannot mandate to MCOs which benefits require prior authorization or that MCOs follow the same processes for prior authorization. HHSC will continue to explore other opportunities to help providers better understand MCO processes.
Date Last Updated:	April 11, 2016

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**Number:**	8
Recommendation:	Require acceptance of online referrals. Currently providers have the ability to fax referrals for specialist services, but an online option could speed up the process.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Children's Hospital Association of Texas (CHAT)				
HHSC Response:	HHSC is exploring online options for prior authorizations, which may simultaneously address concerns related to online referrals. HHSC finalized a new chapter to its UMCM that includes critical elements and functionality that must be part of each MCO's website. The chapter is posted on the HHSC website with an effective date of 7/1/2016. MCOs will be provided a timeline to execute the UMCM 3.32 system requirements with a projected implementation date of 1/1/2017. Although MCOs will be required to accept online prior authorization requests in 3.32, acceptance of online referrals by MCOs is not a requirement. HHSC staff believe this plan will address the issue described by CHAT. HHSC staff will contact CHAT to confirm that this solution will address the issue.				
Date Last Updated:	6/30/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	New UMCM Chapter 3.32 finalized which includes critical elements and functionality that must be part of each MCO website, including acceptance of online prior authorization requests. It is posted on HHSC website with the effective date of 7/1/2016.	6/1/2016	Completed	
2	HHSC staff will contact CHAT to confirm that this solution will address the issue described.	7/31/2016		
3	MCOs implement new website functionality as required in UMCM 3.32.	1/1/2017		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	9
Recommendation:	Ensure that formulary requirements agree with standard of care and does continuously change. Additionally, when it does change, ensure pharmacists are aware of the change in time to update their systems.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	CHAT				
HHSC Response:	HHSC uses a very broad formulary to allow prescribers to choose the appropriate treatment for their patient. The members of the advisory committees that recommend prior authorization criteria are practicing physicians and pharmacists who, together with state staff, attempt to ensure that the standard of care remains available with minimum limitations. As HHSC implements a new Drug Utilization Review (DUR) Board, additional attention can be given to this recommendation. HHSC will work with its Preferred Drug List (PDL) vendor and DUR Board to ensure that drugs designated as 'Preferred' include clinically-accepted, standard first-line treatments. HHSC posts changes on its website after DUR Board recommendations are made and again prior to their implementation. Stakeholders are notified of changes via e-mail. HHSC will review additional methods of communication. HHSC convened the new DUR Board on April 29, 2016. New communications will be applied prior to the July 2016 implementation of the revised PDL.				
Date Last Updated:	7/1/2016				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Notify prescribers, via provider associations, of changes to the PDL effective late July 2016.	7/20/2016	On Target	
2	Remind DUR Board at next meeting of importance of offering clinically appropriate products as preferred.	7/29/2016	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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, HHSC has announced the intention to solicit proposals by December 2016 for the procurement of a Provider Management and Enrollment System to further streamline the enrollment process.				

	The MCOs are working on a collaborative project that will improve the MCO credentialing process for all MCOs participating in Texas Medicaid Managed Care programs. TAHP issued a Request for Proposals (RFP) for the development, implementation, and management of a Texas Statewide Consolidated CVO for Medicaid health plans. The CVO is intended to simplify the administrative process for providers seeking to deliver quality care to Texans enrolled in a Medicaid health plan. Vendors will be required to submit proposals to TAHP by 10/2/2015. 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.
Date Last Updated:	7/1/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	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.	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.	12/31/2016		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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:	HHSC-VDP has added tools on its web site to simplify the process for a provider or patient to learn what prior authorization (PA) criteria have been implemented by each MCO. HHSC will contact its PDL vendor to request a change to the published PDL to add Clinical PA information, and estimate the potential cost, if any, and create a timeline for implementation. HHSC will modify the UMCM to add MCO reporting requirements to identify their implemented Clinical PA to support an updated web tool.				
Date Last Updated:	7/12/2016				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Submit proposed UMCM changes for quarterly reports from MCOs.	6/30/2016	Completed	
2	Develop processes to consolidate quarterly MCO reports into a single document.	9/15/2016	On Target	
3	Review and correct MCO first quarterly report.	10/10/2016	On Target	
4	Compile and post first MCO quarterly report.	10/15/2016	On Target	
5	Begin quarterly MCO Clinical PA reporting process.	11/30/2016	On Target	
6	Incorporate Clinical PA links into PDL document.	2/1/2017	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	11b
Recommendation:	Limit changing drugs from preferred to non-preferred status on the PDL to annual revisions.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	With few exceptions, individual drug classes are only reviewed and changed once per year. Semi-annual updates to the PDL only affect half the drugs. State law requires quarterly reviews of drugs for the PDL.				
Date Last Updated:	4/11/2016				

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	11c
Recommendation:	Provide rationale for changing a drug status from preferred to non-preferred.				
Additional Stakeholder Background:	When a drug's status on the preferred list is changed (e.g. from preferred to non-preferred), provide the rationale for the change so that physicians understand HHSC's justification for the revision.				
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	Currently, a limited explanation of the rationale for the change is posted for every reviewed drug class. The information posted explains the primary clinical or fiscal factors that the committee considered in making their recommendation. HHSC will work with its PDL vendor and DUR Board to explore options for enhancing the published rationale without divulging confidential information.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Capture rationale at next DUR Board Meeting.	07/29/2016	On Target	
2	If new descriptions are developed to explain the rationale for changes, the new descriptions will be included in the next PDL (effective January 2017).	1/30/2017	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	11d
Recommendation:	Improve access to clinical edits in Epocrates.				
Additional Stakeholder Background:	For physicians using Epocrates, establish electronic mechanism to convey whether a drug/drug class is subject to an additional clinical edit, provide a mechanism to easily and quickly access the edit, and indicate which HMOs use the same edit.				
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	The VDP formulary is currently available to providers via Epocrates and each drug includes a link to inform prescribers whether it is subject to additional clinical PA criteria. An Epocrates limitation prevented the link from working on iOS products, but has recently been upgraded. Additionally, VDP will review the provided clinical PA criteria for added ease of use. Epocrates is a third party tool. It does not provide sufficient space to include information about each MCO's clinical PA criteria. HHSC will work with its Prospective DUR vendor that manages the Texas Medicaid Epocrates contract. The best, feasible option for improved communication of Clinical PA criteria will be identified and an implementation plan will be developed.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Consult with Epocrates regarding feasible options.	8/31/2016	On Target	
2	Develop scope of work and obtain high-level estimate from Prospective DUR vendor.	9/30/2016	On Target	
3	Execute contract amendment, if necessary.	11/30/ 2016	On Target	
4	Approve vendor's implementation plan.	11/30/2016	On Target	
5	Revise Clinical PA criteria in Epocrates for First 10 drug classes.	1/31/2017	On Target	
6	Complete revision of all Clinical PA criteria in E-Pocrates for all drug classes.	5/31/2017	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	11e
Recommendation:	Implement expedited communications to notify MCOs and physicians of drug shortages.				
Additional Stakeholder Background:	If there is a drug shortage, adopt an expedited communication plan so that HHSC and HMOs can quickly communicate with network physicians what product to use instead.				
Category:	Communications				
Provided By:	TMA / TPS				
HHSC Response:	When HHSC makes off-cycle formulary or PDL changes to address sudden shortages or other industry problems, the agency's GovDelivery service is used to notify subscribers by e-mail. Beginning 5/1/2016, when HHSC becomes aware of drug shortages, it will notify applicable associations so they can notify their members.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Develop template and formal communication process for Drug Shortage Notices.	8/31/2016	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**Number:**	11f
Recommendation:	Revise requirements managing drug benefit to the package insert instead of indication. Legacy Food and Drug Administration (FDA) reviews of drugs excluded pediatric, obstetric and geriatric patients, meaning many drugs do not have official FDA approval for treatment of those populations. This creates unnecessary hassles for physicians who may be required to obtain prior approval to use a drug for a non-label population even though there is clinical evidence supporting such usage.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	Federal law allows state Medicaid programs to go beyond the FDA indications of a drug when setting its coverage criteria. It allows states to use evidence from medical compendia; especially to support appropriate off-label use. HHSC relies on this medical evidence to expand access to treatments. HHSC will make contact with TMA/TPS to gain clarification on this recommendation.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Schedule meeting with TMA/TPS to discuss this issue.	7/31/2016	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	11g
Recommendation:	When the DUR Board considers a clinical edit, publicize the justification for the proposal and the entity that recommended it.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	At DUR Board meetings, the objective of the proposed clinical prior authorization (PA) requirement is presented and discussed. HHSC and contracted MCOs are the entities that recommend clinical PA requirements. HHSC will work with its Prospective DUR vendor to enhance the explanation of the objective in the Clinical Prior Authorization document. This recommendation will be applied to PA criteria approved by the DUR Board after September 2016.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Collaborate with Prospective DUR vendor on requirements for enhanced reporting on PA proposals.	8/31/2016	On Target	
2	At Fall DUR Board meeting, apply new requirements.	10/14/ 2016	On Target	

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Agency/Division:	HHSC MCD	**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:	6/20/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Draft and publish request for proposal for Provider Management and Enrollment system.	TBD		

Agency/Division:	HHSC MCD	**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:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS /Coalition of Texans with Disabilities				
HHSC Response:	HHSC has established a Provider Recoupment Workgroup to research recoupment issues and identify potential systems changes with the goal of reducing the number of recoupments. The workgroup is partnering with MCOs to identify reasons for recoupments. The workgroup also reviewed interfaces with the federal government and other circumstances that resulted in duplicate recoupment cases. HHSC aims to reduce and minimize as many recoupments as possible and will research all options, including recoupment from FFS or private insurance, rather than the provider, as appropriate.				

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	Work of the HHSC Provider Recoupment Workgroup is ongoing.
Date Last Updated:	6/30/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Add values to current interfaces to provide additional member information.	9/30/2016	On Target	
2	Review encounter data logic for recoupments to determine the feasibility to offset any potential MCO costs with an adjustment to their Experience Rebate.	1/31/2017	Ongoing	

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Agency/Division:	HHSC Financial Services	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**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:	HHSC is considering ways to alleviate this concern. MCOs might consider using an add-on billing code rather than a different provider type. Update to be provided on future posting.				
Date Last Updated:	6/30/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Review issue and determine next steps.	9/30/2016		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: 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 is researching into this option to provide the public with a more streamlined method for researching FFS and MCO benefits and claims submissions.				
Date Last Updated:	6/30/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Research options.	9/30/2016		
2	Determine feasibility.			
3	Notify stakeholders of feasibility.			

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	16
Recommendation:	HHSC should encourage MCOs to “gold star” provider practices that can show a history of proper utilization of medical services and waive certain prior authorization requirements.				
Additional Stakeholder Background:	Prior authorizations can be replaced with retroactive reviews of a physician’s services provided followed by education when needed.				
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	Health plans currently are able to utilize this practice. HHSC will coordinate with TAHP to survey the health plans and determine whether changes can be implemented to appropriately address this recommendation. TAHP surveyed health plans about this activity and shared information with HHSC that some MCOs are doing this, and others are addressing this issue through alternative methods. HHSC will explore this issue and determine whether changes to the UMCC or UMCM could help to encourage adoption of this practice.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Review contract and manual language to determine whether clarifications are needed to encourage this process.	9/30/2016		

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	20
Recommendation:	Increase data collection and screening efforts to improve the accuracy and completeness of the data reported by Medicaid MCOs. THA recommends increasing efforts to screen the information reported in the Medicaid encounter database. Years ago, the agency implemented policy changes to screen Medicaid inpatient FFS data and created the Medicaid Blue Ribbon file. The Blue Ribbon information has been used numerous times over the years to measure the impact of proposed and post-implementation policy changes. The same data collection and screening procedures should be applied to inpatient and outpatient data provided by the Medicaid MCOs.				
Additional Stakeholder Background:	During the November 9, 2016 stakeholder meeting with Executive Commissioner Traylor, Mr. John Hawkins, THA, provided the following additional information: Mr. Hawkins recognized that there will be continued growth through data collection on the MCO side and just found out that there was some level of comfort with the old Blue Ribbon File in FFS that was provided. There were some edits applied to the data that allowed for analysis between fiscal years. There is a desire to continue to improve the encounter data since so many pay-for-performance decisions will be based on that data.				
Category:	Network Adequacy / Access to Care				
Provided By:	THA				
HHSC Response:	HHSC implemented a version of the FFS Blue Ribbon file in the Managed Care in 2015. HHSC is in the process of revising the requirements that are stipulated by the MCOs to providers for claims submission. In addition, a project to review and enhance editing and monitoring of submitted encounter data has been initiated and development work will begin in the Fall of 2016.				
Date Last Updated:	6/20/2016				

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

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

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Agency/Division:	HHSC-MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	22
Recommendation:	Promote adoption of innovative payment models. The BHIAC developed recommendations to encourage the use of innovative payment models for managed care providers. Traditional FFS provider reimbursement is the most common form of payment in both the Texas FFS and managed care models. This payment model reimburses for specific services. For behavioral health providers, these services generally include counseling sessions, mental health rehabilitative services, and targeted case management. Behavioral health professionals provide many services that are not reimbursed under the FFS payment model, such as: provider-to-provider communication, phone conversations with members, services provided by multiple providers in the same group on the same day, and member navigation. These vital yet uncompensated services could be captured through alternative payment structures in a way that achieves meaningful health outcomes and cost efficiencies. The BHIAC recommendation is consistent with emerging federal policies. The CMS proposed managed care rule revisions (May 2015) and the Substance Abuse and Mental Health Services Administration (SAMHSA) grant for Certified Community Behavioral Health Clinics both encourage states to develop value-based, alternative payment models for managed care providers.				
Additional Stakeholder Background:	During the November 9, 2016 stakeholder meeting with Executive Commissioner Traylor, Ms. Danette Castle, Texas Council of Community Centers, provided the following additional information: Ms. Castle noted their support of integration of care and integration of financing. They believe that integration of care cannot truly be reached without integration of financing. The next step is to look at alternative payment mechanisms. She encouraged HHSC to look at BHIAC recommendations again as they were strong recommendations that included innovative payment approaches. They are also pleased that the state submitted, by Rider 79 direction, the certified community behavioral health centers and clinics planning grant through SAMHSA with CMS involvement, we think that will be a great place in which these alternative payment mechanisms can be looked at as we work to integrate better mental health, substance abuse, and physical health components for people and move the dial in terms of the ability to serve people well and cost effectively.				
Category:	Alternative Payment Mechanisms				
Provided By:	Texas Council of Community Centers				
HHSC Response:	HHSC is exploring ways to more effectively recognize medical costs when setting MCO rates. This is an activity driven in part by CMS policy changes on what counts as administrative vs. medical costs. HHSC has established a Quality Improvement Cost Allocation workgroup, which is working on a two-year project with Medicaid-CHIP MCOs to integrate the new CMS guidance. This effort could support greater payment innovation by MCOs and healthcare providers.				

	Additionally, HHSC has received funding through CMS/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 will also apply for a demonstration grant. HHSC is also interested in partnering with stakeholders and MCOs on facilitating innovative payment models. Sec 8.1.7.8.2 of the Texas Medicaid UMCC already encourages value-based contracting. HHSC met internally to discuss potential contract changes for fiscal year 2017. HHSC determined that the contract language that is in place will be sufficient for the next contract cycle. However, the deliverable associated with the contract provision (MCO submitted tracking tool and narrative description of their payment models) is being modified to help ensure accurate data collection. This will further enable HHSC's ability to track MCO progress in this area.
Date Last Updated:	6/30/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	The templates for the Quality Improvement tracking tool section of the Financial Statistical Reports (FSRs) will be designed and distributed to the MCOs.	6/1/16	Complete	
2	MCOs will begin reporting Quality Improvement Costs to HHSC on their FSRs.	9/1/2016		
3	HHSC is in the process of producing a de-identified summary document to post onto HHSC's quality website of current innovative payment models being used in managed care. In addition, the tracking tool used to capture and monitor MCO use of value-based payment models are being reviewed for revision to capture additional information.	10/1/17		
4	The SAMHSA Grant project requires identification of special populations for different prospective payment system (PPS) rates. HHSC staff will begin working with the eight potential project sites to identify these populations. This will drive cost reporting and PPS development. The locations are a mix of rural, urban, and hybrid areas.	12/1/17		

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Agency/Division:	HHSC-MCD	**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 is considering changes to the managed care contract. HHSC met internally to discuss potential contract changes for fiscal year 2017 and determined that the contract language in place will be sufficient for the next contract cycle. However, the deliverable associated with the contract provision (MCO submitted tracking tool and narrative description of their payment models) is being modified to help ensure accurate data collection. This will further enable HHSC to track MCO progress in this area. The value based purchasing (VBP) summary document for 2015 will be posted on the VBP webpage: http://www.hhsc.state.tx.us/hhsc_projects/ECI/Value-Based-Payments.shtml				

	HHSC recently 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 (http://www.hhsc.state.tx.us/hhsc_projects/ECI/Data-Reports.shtml) 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. HHSC has 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 will also apply for a demonstration grant. Please see the response to recommendation 22 for ongoing updates on these activities. On August 30, 2016, HHSC will host the DSRIP statewide learning collaborative. A major theme of this learning collaborative will be value-based contracting. MCOs and DSRIP providers will. HHSC will facilitate a panel discussion on value-based contracting. One of the desired outcomes of this meeting will be 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.
Date Last Updated:	6/30/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Develop new tracking tool (for MCO annual submissions).	7/31/2016	On Target	
2	Submit new tracking tool through internal channels for distribution to MCOs.	7/31/2016	On Target	
3	MCO submit data via new tool.	11/30/2016	On Target	

4	Additional data to website (if determined to be useful).	7/31/2016	On Target	
5	Communication to stakeholder (to include link to data on quality webpage and dedicated email box).	7/31/2016	On Target	

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Agency/Division:	HHSC Ombudsman	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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 Health and Human Services (HHS) Transition Plan submitted to the Legislature indicates the State Long-Term Care Ombudsman will be administratively attached to the HHS Office of the Ombudsman. SB 760, 84th Legislature, Regular Session, 2015, directs the HHS Office of the Ombudsman to coordinate a network of entities to provide support and information services to Medicaid managed care consumers. The 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. Meetings will include discussion to determine how to improve consumer protections and ombudsman services. HHSC will develop a plan for the SB 760 network and seek input and feedback from the network of entities.				
Date Last Updated:	6/28/2016				

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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:					
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 successfully remain in the community, 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 external 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. The next workgroup meeting is scheduled for 7/14/2016. 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.				
Date Last Updated:	6/23/2016				

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

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

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	27
Recommendation:	Texas Medicaid coverage should be expanded to include coverage for services provided by Psychology predoctoral interns and postdoctoral fellows who are in the process of acquiring the supervised experience required for independent licensure as a Psychologist, when these services are supervised by a Licensed Psychologist who is a Medicaid provider. Under chapter 501 of the Texas Occupations Code, a licensed psychologist may delegate psychological services to a provisionally licensed psychologist, a newly licensed psychologist who is not eligible for managed care panels, a person who holds a temporary license, and a person who is in the process of acquiring the supervised for independent licensure – which includes predoctoral interns and postdoctoral fellows. However, Texas Medicaid does not allow the supervising Licensed Psychologist to bill for the services of trainees at either the predoctoral or postdoctoral levels. Importantly, such services are provided within the context of accredited training programs that entail rigorous supervisory requirements, and under the close supervision of a licensed provider (as mandated by Texas Law under the Texas State Board of Examiners of Psychologists). Moreover, psychology predoctoral interns and postdoctoral fellows under supervision have typically exceeded both the educational requirements and the hours of supervised clinical experience than are required for independent licensure for LPCs and LCSWs.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	CHAT				
HHSC Response:	The policy was posted on HHSC's Medical Policy Review webpage for stakeholder comments: http://www.hhsc.state.tx.us/medicaid/MPR/index.shtml. HHSC received feedback back from stakeholders on the proposed policy and is currently reviewing all comments. Stakeholders requested that HHSC consider extending the delegation to include postdoctoral fellows, as this would align with the occupational code. HHSC is currently updating policy language and working on the fiscal analysis. Once the fiscal analysis is finalized, a briefing with HHSC leadership will be scheduled. If the fiscal estimate exceeds $500,000, the Legislative Budget Board will have to approve the funding associated with the policy change. Finally, a rate hearing would be required to implement the policy changes. Timeline is dependent upon prioritization within the medical policy review process.				
Date Last Updated:	6/17/2016				

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	28
Recommendation:	Texas Medicaid should include coverage for services without the patient present for clients under the age of 20 (e.g., 90846). It is standard of care for services provided to children and adolescents to have sessions with parents in which the child or adolescent is not present. In fact, evidence-based interventions require sessions of this type (e.g., Parent Management Training for disruptive behavior). Currently, Texas Medicaid will not cover services in which the child or adolescent patient is not physically present (e.g., 90846). This deprives children and adolescents who are Medicaid recipients of the highest quality, most evidence-based assessment and treatment services.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	CHAT				
HHSC Response:	The policy was posted on HHSC's Medical Policy Review webpage for stakeholder comments: http://www.hhsc.state.tx.us/medicaid/MPR/index.shtml. HHSC received feedback back from stakeholders on the proposed policy and is currently reviewing all comments. HHSC is currently updating policy language and working on the fiscal analysis. Once the fiscal analysis is final and has been reviewed by leadership, a rate hearing will be required to implement the policy changes. If the fiscal estimate exceeds $500,000, the Legislative Budget Board will have to approve the funding associated with the policy change. Timeline is dependent upon prioritization within the medical policy review process.				
Date Last Updated:	6/17/2016				

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

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

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

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

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

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	31 / 33 / 38
Recommendation:	Texas Medicaid coverage should include peer support services. Improve access to mental health and substance use peer services provided by certified peer specialists. To accomplish this, HHSC should develop rules to define peer services, identify the requirements for certification, and specify supervision requirements. This needs to be done to ensure that quality services are available. We have accomplished a lot in this area already but the timing is right for refining and expanding. MCOs should be educated on the benefits of peer support services and encouraged to make these services available. Currently, peers are approved providers of mental health rehab services, but "peer support services" do not always align with rehab services. Additionally, LMHAs are currently the only providers of rehab services so until "peer support services" are validated as a reimbursable service, where these services can be provided will continue to be limited. Similar to peer support for individuals with mental illness, implement peer support services as a Medicaid paid benefit for people with developmental disabilities.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	Disability Rights Texas/TMA/TPS/Hogg Mental Health Foundation				
HHSC Response:	HHSC staff are working with the Office of Mental Health Coordination and other stakeholders to determine the feasibility of adding peer support services to the Medicaid program. Depending on the findings of the group, legislation and/or an appropriation may be needed. HHSC staff are working to develop cost assumptions and an exceptional item may be considered. Staff is also drafting policy language for input from the peer support services workgroup.				
Date Last Updated:	6/28/2016				

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

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

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Agency/Division:	HHSC MCD	**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:					
Category:	Benefits				
Provided By:	Disability Rights Texas/Every Child, Inc./Texas Council for Developmental Disabilities/The Arc of Texas				
HHSC Response:	MCOs are required to assess members within the timeframes outlined in their contract. HHSC will review these timelines to ensure they are reasonable and will continue to monitor MCOs to ensure the assessments are happening in a timely manner. HHSC staff conduct desk reviews of standard operating policies and procedures, including prior authorization of DME. HHSC ensures that authorizations for DME follow Medicaid policy, federal, and state laws. HHSC will consider the concerns identified here and is committed to strengthening the oversight process in this area.				

	HHSC will review managed care DME-related complaints on a quarterly basis. This will enable trending and analysis regarding specific MCOs that receive the most complaints as well as the reasons for the complaints. Stakeholders are requested to submit complaints and examples of untimely assessments to the HHSC Ombudsman (clients) or HHSC Health Plan Management (HPM) (members and providers): HHSC Ombudsman Phone: 1-877-787-8999 (Toll-Free) Online: https://www.hhsc.state.tx.us/ombudsman/complaint-process.shtml HHSC HPM Email: HPM_complaints@hhsc.state.tx.us or STAR.Health@hhsc.state.tx.us (for complaints specific to the STAR Health program) HHSC is reviewing the contractual timelines by which MCOs are required to assess members, and will continue to ensure the assessments are happening in a timely manner. Additionally, HHSC is reviewing the recommendations that would also affect Medicaid FFS policies. New UMCM Chapter 3.32 includes critical elements and functionality that must be part of each MCO website. The chapter is posted on the HHSC website with an effective date of 7/1/2016. MCOs will be provided a timeline to execute the UMCM 3.32 system requirements with a projected implementation date of 01/01/2017. The website requirements for MCOs include: accept online PA requests, email address for provider complaints, online process to permit submission of electronic claims and any related documentation requested by the MCO, online process to permit the submission of claims appeals and reconsiderations, and an online process to permit the submission of clinical data. In addition, the MCO provider directories must provide information that explains the referral process to providers such as family planning, OB/GYNs, behavioral health, etc.
Date Last Updated:	6/23/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	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	On Target	
2	HPM and MCO conference calls to discuss complaint trends.	TBD		

3	Conference calls with HPM, MCO, and providers to discuss complaint trends.	TBD		
4	Enhanced MCO websites implemented.	1/1/2017	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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:					
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 coordinator will be 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 will also include extensive requirements regarding transition planning for children aging out of STAR Kids into STAR+PLUS. The STAR+PLUS Handbook is under revision 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, 1919(i)) clear and will be effective late summer 2016. STAR+PLUS contract changes effective 9/1/16 will 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 is operational 11/1/16. The STAR Kids contract and Handbook provide detailed instructions regarding MCO service coordinator responsibilities for all members.				
Date Last Updated:	6/22/2016				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	STAR+PLUS Handbook Update.	09/01/2016	On Target	
2	STAR+PLUS Contract Changes.	09/01/2016	On Target	
3	STAR Kids Handbook Published and Effective.	11/01/2016	On Target	
4	STAR Kids Contract Effective.	11/01/2016	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**Number:**	34b / 67
Recommendation:	Improve access to hospital level of care.				
Additional Stakeholder Background:					
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 will discuss again with CMS in July 2016. 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 leadership feedback, HHSC will amend the 1115 waiver and develop an assessment tool and process for this benefit.				
Date Last Updated:	6/22/2016				

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

	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	Complete	
2	Discuss with CMS.	8/1/2016	Ongoing	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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 http://www.hhsc.state.tx.us/medicaid/managed-care/mco-resource-docs/2015/143.pdf. 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 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/.
Date Last Updated:	6/29/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	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 educational program for primary care and specialty providers serving persons with IDD.	2/24/2016	Completed	

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 will request feedback from Transition to Managed Care SRAC Subcommittee meeting in August 2016.	9/1/2016	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: 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:					
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 coordinator will be expected to assist the individual in locating and coordinating all Medicaid acute care and long term services and supports, which includes coordination to facilitate a smooth transition from an institutional setting to the community. The STAR Kids program will also include extensive requirements regarding transition planning for children aging out of STAR Kids into STAR+PLUS. The STAR+PLUS Handbook changes regarding expectations for members in a nursing facility and other programs (e.g. IDD waivers, 1919(i)) will be effective late summer 2016. STAR+PLUS contract changes effective 9/1/16 will include additional required service coordination training and assessment requirements regarding a member's change in condition. The STAR Kids contract is operational 11/1/16. 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.				

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	Transparency in assessment, authorizations, and denials is important to HHSC and to our federal partners. HHSC will implement new transparency requirements related to denials as part of the new federal Medicaid managed care rules. HHSC has started a service coordination workgroup related to SB 760 and will ensure this recommendation is considered as part of that workgroup.
Date Last Updated:	6/22/2016

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

	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.	09/01/2016	On Target	
2	STAR+PLUS Contract Changes.	09/01/2016	On Target	
3	STAR Kids Handbook Published and Effective.	11/01/2016	On Target	
4	STAR Kids Contract Effective.	11/01/2016	On Target	

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Agency/Division:	HHSC COS	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	36
Recommendation:	Collaborate with physicians and other stakeholders to develop an interconception care program for women at risk for low-birth weight babies or premature delivery. Our organizations strongly support HHSC's plan to automatically enroll women into the women's health program when they lose pregnancy Medicaid coverage 60 days postpartum (the new process will begin in July 2016). Providing women timely access to family planning and preventive health screenings will help women to better time and space their pregnancies and to detect chronic conditions earlier. However, if a physician determines the patient needs ongoing chronic care management or treatment, few resources exist. Women with a prior premature delivery or a chronic illness, such as hypertension or diabetes, are at greater risk of poor birth outcomes, thus jeopardizing not only the health of the mother and baby but also increasing Medicaid birth-related costs. A healthy pregnancy begins well before conception. Establishing an interconception care program that provides treatment of chronic conditions will help achieve our mutual goals of improving the health of women and their babies.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	TMA / TPS				
HHSC Response:	HHSC's Better Birth Outcomes Workgroup is working to improve access to women's preventative, interconception, prenatal, and perinatal health care. Some of the initiatives related to interconception care include: - Automatic enrollment of eligible women into Healthy Texas Women program after pregnancy coverage expires began on July 1, 2016. - Healthy Texas Women Website - comprehensive website to educate women and providers about the array of family planning and primary care services available and how to navigate between the different programs. (https://www.healthytexaswomen.org/) - Someday Starts Now - DSHS program developed to help Texas communities decrease infant mortality using evidence-based interventions. The website features tools for providers in the healthcare and community settings, Life Planning and Birth Planning Tools, videos on the importance of breastfeeding, partner involvement, and preconception health as well as information for men and women of childbearing age for before, during, and between pregnancies. (https://www.dshs.state.tx.us/healthytexasbabies/Someday-Starts-Now.doc) Additionally, the Women's Health Advisory Committee created by Senate Bill (SB) 200 of the 84th Legislature (Regular Session) will advise HHSC on women's health programs. This advisory committee began meeting in September 2015				

	(https://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/whac.shtml). This committee worked with HHSC to develop the new women's health programs. HHSC is committed to improving access to interconception care and encourages continued stakeholder feedback through the Women's Health Advisory Committee.
Date Last Updated:	7/20/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Automatic enrollment of eligible women into Healthy Texas Women program after pregnancy coverage expires.	7/01/2016	Completed	
2	HHSC will launch Healthy Texas Women and the revised Family Planning program.	7/01/2016	Completed	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**Number:**	37
Recommendation:	Eliminate prior authorization for medical drug screens. Texas Medical Board rules regarding chronic pain specify physicians must conduct random drug screens. By requiring prior approval, physicians cannot fulfill that requirement for Medicaid patients. This limits physicians' ability to properly screen patients at high risk for opioid abuse. Further, we have received information that when physicians do attempt to follow Medicaid requirements, the form requires individual authorization for each component of the drug test rather than allowing the entire panel to be completed. This is a non-standard approach -- physicians do not bill for individual components for these tests. Thus codes are not easily obtained.				
Additional Background:					
Category:	Benefits				
Provided By:	TMA / TPS				
HHSC Response:	HHSC will work with stakeholders to identify which drug screens are not being covered and circumstances where prior authorization may have been inappropriately applied. In FFS Medicaid, there is no prior authorization requirement for drug screens. HHSC requested additional information from TMA and TPS to identify drug screens that are not being covered and circumstances where prior authorization may have been inappropriately applied.				
Date Last Updated:	6/30/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Obtain examples from TMA/TPS of this issue occurring.	8/1/2016		
2	HHSC review the examples, reach out to health plans to obtain additional information, and determine root cause of issue.	9/1/2016		
3	Develop recommended solution.	10/1/2016		

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Agency/Division:	HHSC MCD	**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:	Mental Health Parity generally requires MCOs to ensure that financial requirements (such as co-paysand deductibles), non-quantitative limits (such as prior authorization), and quantitative treatment limitations (such as a set number of days allowed) for mental health or substance use disorder benefits are generally no more restrictive than requirements or limitations applied to medical and surgical benefits. HHSC currently requires that all MCOs comply with all applicable parity regulations. CMS issued regulations on March 29, 2016 providing guidance to Medicaid program about implementing and monitoring MHPAEA. The recent rules more clearly outline parity requirements specifically for Medicaid and CHIP members. The rules: • Require equal treatment of behavioral health conditions to physical health conditions • Prevent MCOs from imposing less favorable benefit limits (quantitative and non-quantitative) to mental health and substance use disorder treatment compared to physical health • Requires that all individuals receiving any service through Texas Medicaid or CHIP MCOs are protected by mental health parity, even if some services are provided in FFS • Specifically require the state and MCOs to determine which Medicaid services are included in each of four categories used in a parity analysis: inpatient, outpatient, emergency care, and prescription drugs. The financial requirements and treatment limits applicable to mental health or SUD must be no more restrictive than the predominant financial requirements and treatment limits that apply to substantially all medical and surgical benefits.				

	• Clarify that parity provisions do not apply to clients who receive all services through FFS. • Allows states to include the costs of compliance in payments to MCOs. • Requires compliance by October 2017. HHSC is still in the process of conducting a full analysis of the impact. Managed care contracts will need updating, and HHSC will engage stakeholders and keep them updated as it moves toward state compliance with the new federal rules. Overall, the rules represent a significant change in how HHSC monitors and evaluates mental health parity compliance. The rules will influence how managed care contracts operationalize parity regulations, and how plans are to make parity determinations. HHSC anticipates further state guidance from CMS. Meanwhile, HHSC continues to track and address parity complaints and requires that health plans comply with all applicable elements of MHPAEA.
Date Last Updated:	6/22/2016

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

	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		
2	Amend managed care contracts.	9/30/2017		
3	Engage stakeholders.	TBD		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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:					
Category:	Benefits				
Provided By:	Texas Speech-Language-Hearing Association				
HHSC Response:	MCOs are required to provide EPSDT services (also known as THSteps in Texas) to all ~~child~~ members 0 through 20 years of age, including all services in the TMPPM (See UMCC 8.1.3.2). In accordance with the Code of Federal Regulations (Sec. 441.50 (Basis and purpose)), the EPSDT program, known as Texas Health Steps (THSteps), ensures for the provision of screening, diagnosis, and treatment services for individuals 0-20 years of age. This includes periodic dental screening, diagnostic, and treatment services. Section 1905(r)(5) of the Social Security Act requires that any medically necessary healthcare service listed in the Act be provided to EPSDT clients, even if the service is not available to the rest of the Medicaid population under the state's Medicaid plan. A service is medically necessary when it corrects or ameliorates the client's disability, physical or mental illness, or chronic condition. EPSDT mandated services are stipulated in Medicaid policy and the Texas Medicaid Provider Procedures Manual. HHSC will work with stakeholders, including Texas Speech-Language-Hearing Association, to identify any inconsistencies among the plans and work to remedy them.				
Date Last Updated:	6/22/2016				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HHSC will request examples of instances where an MCO has placed a treatment cap from THSteps.	7/31/2016	Ongoing	
2	HHSC will review examples and determine appropriate next steps.	9/30/2016		

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Agency/Division:	HHSC MCD	**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:	6/20/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Request examples from CHAT.	6/1/2016	Completed	
2	Review examples to determine issue.	7/1/2016	Pending	
3	Coordinate with MCOs to identify next steps.	8/1/2016		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	43
Recommendation:	Expedite processing of new providers to facilitate claims processing. Timely processing of new providers for claim determination. Once we receive attestation from TMHP many Managed Care Plans take up to 60 days to update their system, which causes delays in payment to providers. It would be beneficial for TMHP and the Managed Care Organizations to work from the same attestation system to prevent delays in providers being added to the Managed Care Plans.				
Additional Stakeholder Background:	During the November 9, 2016 stakeholder meeting with Executive Commissioner Traylor, Ms. Kathy Eckstein, Children's Hospital Association of Texas, expressed concern over the length of time for managed care plans to update their system.				
Category:	Claims				
Provided By:	CHAT				
HHSC Response:	Upon further review of this recommendation it was noted that additional information may be needed. This issue concerns the length of time it takes to update the system rather than the expedited credentialing process underway in SB760. HHSC staff will reach out to CHAT to discuss and obtain examples to determine next steps.				
Date Last Updated:	6/23/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Obtain examples from CHAT of this issue occurring.	07/31/2016		
2	HHSC review the examples, reach out to health plans to obtain additional information, and determine root cause of issue.	08/31/2016		
3	Develop recommended solution.	09/30/2016		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	44
Recommendation:	Require consistency of claim denial reasons for both TMHP and MCOs. We receive claim denials for the same reason, but we receive different Denial codes from the Managed Care Plans and TMHP. This is an administrative burden for the provider's staff when attempting to rectify denials for the same reason.				
Additional Stakeholder Background:					
Category:	Claims				
Provided By:	CHAT				
HHSC Response:	All adjudication entities are required to use HIPAA code values in communicating with providers. HHSC will coordinate with CHAT to ~~address~~ understand the specifics of the reported issue, and then work with MCOs to address the issue.				
Date Last Updated:	6/20/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Request examples from CHAT of this having occurred.	6/1/2016	Completed	
2	Review examples to determine issue.	7/1/2016	Pending	
3	HPM work with MCOs to address the issue.	9/1/2016		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**Number:**	45
Recommendation:	Ensure Texas Medicaid recognizes all appropriate claims modifiers. If a modifier is not covered, the Medicaid FFS or MCO provider manual should list any modifiers that are not recognized. Reducing physician frustration and practice costs.				
Additional Stakeholder Background:	During the November 9, 2016 stakeholder meeting with Executive Commissioner Traylor, Dr. John Holcomb, TMA, provide the following additional information: Dr. Holcomb noted that Medicaid in the past has not recognized add-on services that Medicare has recognized. If add-on codes are not allowed, a physician does two procedures the same day, but only gets paid for one which is unfair. If the physician cannot get paid for both, it should at least be recognized.				
Category:	Claims				
Provided By:	TMA / TPS				
HHSC Response:	All adjudication entities are required to use HIPAA code values in communicating with providers. Information should be made available by the adjudicator that specifies allowable modifiers for claims processing. To address this issue in FFS would take a significant amount of resources and time. It is not cost effective to do so at this time with the transition to managed care. HHSC will reach out to TMA/TPS no later than August 1, 2016 to schedule a meeting to further discuss this issue to be sure the issue was fully understood and to better understand any issue impacts in managed care.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Reach out to TMA/TPS	August 1, 2016	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	46
Recommendation:	Texas Medicaid should include reimbursement to physicians for venipuncture performed and analyzed in the physician's in-office lab. Revise the payment policy to reimburse physicians for venipuncture performed and analyzed in the physician's in-office lab. The Medicaid manual (section 9.2.41.2 Laboratory Handling Charge) states that a physician may bill a laboratory handling charge for obtaining a specimen via venipuncture or catheterization and sent to an outside lab. Many physicians have in-office, moderately complex labs and run many tests in house. The current policy does not reimburse them for the staff costs or supplies of obtaining the specimen.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	TMA / TPS				
HHSC Response:	HHSC requires additional information from TMA/TPS to determine whether changes can be implemented to appropriately address this recommendation; Medicaid currently provides reimbursement for numerous laboratory procedures and to numerous provider types. HHSC will follow-up with TMA and TPS to identify in-office lab services not covered.				
Date Last Updated:	6/21/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Request examples from TMA and TPS.	7/1/2016	Completed	
2	Obtain examples of this issue occurring.	7/31/2016		
3	HHSC review the examples, reach out to health plans to obtain additional information, and determine root cause of issue.	8/31/2016		
4	Develop recommended solution.	9/30/2016		

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**Number:**	48
Recommendation:	HHSC should require Dental Maintenance Organizations (DMOs) to share their client outreach efforts with the dentist provider so that both can work together to help remove barriers that prevent clients from utilizing their dental benefits and missing appointments. Clients breaking dental appointments are a problem for dentist providers and the DMOs. Both DMOs allow providers to log a client's broken appointment into the DMO provider portal. However, that is where the information sharing stops. The DMOs do not communicate with the provider about efforts to help the client keep appointments. Broken appointments are a costly and unnecessary expense for providers and a concern for the state about client benefit utilization.				
Additional Stakeholder Background:	During the December 8, 2016 stakeholder meeting with Executive Commissioner Traylor, Ms. Diane Rhodes, Texas Dental Association, provided the following additional information: Broken appointments continue to be an issue for providers, and DMOs have systems where providers can log broken appointments. The recommendation is for increased coordination between DMOs and providers about the information collected, so both can work together to eliminate broken appointments by addressing the individual reasons a patient may not be making appointments.				
Category:	Communications				
Provided By:	Texas Dental Association				
HHSC Response:	Providers have the ability to refer a patient who frequently misses appointments to the THSteps Outreach & Informing Unit for follow-up. DMOs are required by contract to train providers about the availability of the THSteps Outreach & Informing Unit's services. DMO member handbooks emphasize the importance of keeping or properly rescheduling appointments. And DMO member advocates conduct activities to identify members who miss appointments so they can help minimize barriers to care. HHSC will work with the DMOs to identify possibilities for sharing information on outreach activities to reduce missed appointments. HHSC will review procedures utilized by the THSteps Outreach and Informing Unit to better inform the review of the DMOs' operational procedures regarding frequently missed appointments. HHSC will then review the issue with the DMOs to determine if operational refinements can be made to achieve improved communication.				
Date Last Updated:	6/27/2016				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Research THSteps Outreach & Informing Unit policies and procedures.	7/31/2016	On target	
2	Based on results of research, review DMO operational procedures by DMOs to determine if procedures can be refined further.	8/31/2016	On target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	49
Recommendation:	Ensure that the "authorized representative" designation is shared with the DMO and can be accessed by the client as needed to avoid interruption of care in situations where the primary head of household is not available to accompany the client to the dentist's office. Previously, only the client's head of household could change a client's primary dentist or managed care dental plan. Many times, the client's grandparent or other family member will bring to them to the dental visit instead of the head of household. In situations where a change in the main dentist needs to happen for treatment to occur, the accompanying family member is not authorized to make such a change, and unless the dentist can make verifiable contact with the head of household, the dentist has to send the client home until the head of household or guardian is available.				
Additional Stakeholder Background:					
Category:	Communications				
Provided By:	Texas Dental Association				
HHSC Response:	HHSC will review the process of sharing names of authorized representatives to identify areas where changes can be made to improve the process. HHSC is currently analyzing the legal implications of this change and will inform the Texas Dental Association of the outcome. In addition, HHSC will obtain examples of this issue occurring to better understand the situation.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Obtain examples from TDA of this issue occurring.	8/1/2016		
2	HHSC review the examples, reach out to health plans to obtain additional information, and determine root cause of issue.	9/1/2016		
3	Develop recommended solution.	10/1/2016		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: 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:					
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.				
Date Last Updated:	6/22/2016				

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	52a
Recommendation:	Require MCOs to share meaningful and actionable data with physicians. Require MCOs to share meaningful and actionable data with network physicians, such as notification of patient emergency department usage and prescription data, as well as providing confidential comparative data on their practice's utilization and costs. Further, some health plans indicate they meet at least quarterly with network physicians to review performance data and practice issues. This promotes dialogue between the physicians and MCOs as well as opportunities for the MCO to be aware of hassles experienced by physicians and patients that might not otherwise be elevated.				
Additional Stakeholder Background:					
Category:	Communications				
Provided By:	TMA / TPS				
HHSC Response:	HHSC will survey plans to find out how frequently they share data with physicians and acute care providers and will consider implementing a contract requirement if appropriate.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Develop and send survey to MCOs and TAHP.	9/1/2016	On Target	
2	Compile and follow-up as needed on survey responses.	10/1/2016		
3	Research possible solutions resulting from survey responses in consultation with TAHP.	11/1/2016		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	52b
Recommendation:	Require MCOs to promptly notify physicians when the practice's assigned provider representative has changed. We frequently receive calls from physicians who have attempted to resolve complaints with a plan, but were stymied because their provider representative kept changing, often without notice, requiring the practice to start again with the resolution process.				
Additional Stakeholder Background:					
Category:	Communications				
Provided By:	TMA / TPS				
HHSC Response:	HHSC will survey plans to find out what their processes are to share this information with physicians and will consider implementing a contract requirement if appropriate.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Develop and send survey to MCOs and TAHP.	9/1/2016	On Target	
2	Compile and follow-up as needed on survey responses.	10/1/2016		
3	Research possible solutions resulting from survey responses in consultation with TAHP.	11/1/2016		

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**Number:**	54
Recommendation:	Clarify the responsibilities of all subcontractors regarding Electronic Data Interchange transactions within the MCO contracts. MCOs that are using transportation logistic companies are not contracting with companies who can receive and accept ANSI electronic files. Establishes continuity of electronic reporting from subcontractors to contractors who are required to report data electronically to HHSC. Also reduces the administrative burden for transportation providers (ambulance and other entities).				
Additional Stakeholder Background:					
Category:	Contract provisions				
Provided By:	Acadian Ambulance Service of Texas				
HHSC Response:	The HHSC contract requires the MCOs, and, by extension, their subcontractors, to comply with all state and federal regulations. HHSC believes that applies in the case of transportation companies specifically with regard to ANSI/HIPAA formatting for their electronic remittances. HHSC will reach out Acadian Ambulance Service no later than 8/1/2016 to schedule a meeting to discuss potential solutions.				
Date Last Updated:	7/1/2016				

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

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

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Agency/Division:	HHSC MCD	**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 2013, 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. 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. 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.
Date Last Updated:	6/22/2016

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

	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.	TBD		

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

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

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

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: 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:	HHSC is considering options to strengthen this process. Currently the contract includes standard significant traditional provider (STP) provisions statewide for nursing facilities in STAR+PLUS. The MCO must treat a nursing facility as an STP if it holds a valid certification, license, and contract through DADS as of Sept. 1, 2013. Additionally, MCOs must enter into Network Provider Agreement with any willing nursing facility provider that includes new providers and those that have gone through a change in ownership after Sept. 1, 2013. STP status is extended for the 1st three operational years of a Medicaid MCO, with nursing facility status as STP expiring on February 28, 2018. A meeting was held with associations, MCOs, and NF providers on 3/15/16 requesting their input on MCO credentialing standards for NFs. Additional meetings were scheduled to obtain further input. A meeting will be scheduled with AARP to discuss feedback and ideas under discussion.				
Date Last Updated:	7/5/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	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.	9/1/2016	On Target	
6	Obtain feedback from other relevant stakeholders.	10/1/2016		
7	Revise UMCC and UMCM to incorporate changes.	TBD		
8	Determine if a Texas Administrative Code rule amendment is needed.	TBD		

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

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

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

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

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Obtain examples from CHAT of this issue occurring.	8/1/2016		
2	HHSC review the examples, reach out to health plans to obtain additional information, and determine root cause of issue.	9/1/2016		
3	Develop recommended solution.	10/1/2016		

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Agency/Division:	HHSC Ombudsman and MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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 on-line form for reporting to the Ombudsman and sending an email to contact@hhsc.state.tx.us (an option noted when one clicks on the link to the ombudsman form) and inform stakeholders. Note: Some stakeholders have been told any of the 3 options can be used to submit a complaint about the Medicaid managed care program. Consider consolidating the 3 options if no distinct differences exist. Consider offering persons who access the HHSC complaint email box the option to either send their complaint via email or use a form similar to the Ombudsman on-line form. The form should be revised to include a question as to whether the issue pertains to an MCO, and if so, which one, as well as a question that asks the person to identify if the issue pertains to a person in a nursing facility, a person with IDD, etc.				
Additional Stakeholder Background:					
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 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 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 and HHSC HPM can place the MCO on Corrective Action Plans, as well as administer monetary sanctions for any violation of the contract. To report complaints directly to HHSC: https://www.hhsc.state.tx.us/ombudsman/ or HPM_complaints@hhsc.state.tx.us The HHSC/DADS Long-Term Care Ombudsman has requested nursing facility specific data from the MCOs on a monthly basis to determine the types, as well as the volume, of complaints received related to nursing facility members. HHSC/DADS/Office of Ombudsman are coordinating with stakeholder groups to create flyers and magnets for clients that include a simple explanation of the complaint process and list the most critical numbers to call for health and emergencies. HHSC staff also participate in monthly coordination meetings with the Office of the Ombudsman to ensure member needs are met. HHSC will determine the feasibility of implementing an electronic form for complaints submission.
Date Last Updated:	7/6/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HPM participate in quarterly IDD quality subcommittee.	4/11/2016	Completed	

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2	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	
3	Second meeting of the Network.	6/16/16	Completed	
4	Outreach meetings with community organizations assisting Medicaid managed care clients.	Ongoing	Ongoing	
5	Create consumer-friendly outreach materials that can be shared with Medicaid managed care clients.	7/1/16	On Target	
6	Update UMCM with related changes.		In Progress	
7	Internal document created identifying appropriate program areas to funnel complaints.	7/22/15	Completed	
8	Review of MCO complaint and appeals data from nursing facility residents.	09/1/16	On Target	
9	Regular coordination meeting between MCD HPM staff and HHS Office of the Ombudsman.	8/1/16	Ongoing	
10	Meeting to review complaints reported to HPM teams on a quarterly basis, focusing on any specific trends that are noticed.	Next meeting August 2016	Ongoing	
11	HPM participate in quarterly IDD Quality Subcommittee.	Next meeting TBD	Ongoing	

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Agency/Division:	HHSC Ombudsman and MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: 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:					
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 HHS Transition Plan submitted to the Legislature indicates the State Long-Term Care Ombudsman will be administratively attached to the HHS Office of the Ombudsman. Any trends or global issues identified through complaints initiate a deeper HHSC review of the MCO or provider and their processes either by a desk review, onsite review, or secret shopper call. 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 HHSC/DADS Long-Term Care Ombudsman has requested nursing facility specific data from the MCOs on a monthly basis to determine the types, as well as the volume, of complaints received related to nursing facility members. HHSC/DADS/Office of Ombudsman are coordinating and working with stakeholder groups to create flyers and magnets for clients that include a simple explanation of the complaint process and list the most critical numbers to call for health and emergencies. HHSC is currently looking at the roles of service coordinators and ways to strengthen the roles of the MCO provider relations teams, especially when serving IDD populations. Stakeholders will be invited to participate in HHSC's service				

	coordination workgroup, which will ensure specific client needs are being met. HHSC is also facilitating a service coordination workshop for MCOs and agency staff to discuss issues discovered through complaint trends, communication with stakeholders, and the roles and responsibilities of service coordinators.
Date Last Updated:	6/28/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	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	Regular coordination meeting between MCD HPM staff and HHS Office of the Ombudsman	8/1/16	Ongoing	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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 is in the process of developing interim policy changes for dental anesthesia. The new interim policy changes were distributed to several dental stakeholders and the DMOs to review and comment. HHSC will review the comments and may make additional changes to the policy as deemed appropriate. The implementation date is expected in the fall of 2016. The issue of dental anesthesia administered in ASCs is connected to the review of anesthesia policy that is currently underway. Actions of a proposed workgroup are dependent upon the timeline for anesthesia policy review.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Implement Interim Anesthesia Policy.	10/31/2016	On Target	
2	Anesthesia Workgroup Meetings.	1/1/2017	On Target	
3	Long-term Anesthesia Policy Completion and revision of Criteria for Dental Therapy Under General Anesthesia Form.	6/1/2017	On Target	

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

	Stakeholders are requested to submit complaints and examples of inaccurate "Find a Dentist" or "Referring Dentist" rosters or dental plan provider directories to the HHSC Ombudsman (clients) or HHSC HPM (members and providers): HHSC Ombudsman Phone: 1-877-787-8999 (Toll-Free) Online: https://www.hhsc.state.tx.us/ombudsman/complaint-process.shtml (Internet Explorer only) HHSC HPM Email: HPM_complaints@hhsc.state.tx.us
Date Last Updated:	6/23/2016

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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 (i.e. THSteps Medical and Dental, CHSCN, CPW, etc.) 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 ~~and~~ to collect feedback on strengths, challenges, and possible solutions to provider participation in the Medicaid program.				
Date Last Updated:	June 30, 2016				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Meet with TMHP to discuss training components and consider additional information to be added.	8/1/2016		
2	Review this recommendation further to determine additional next steps.	10/1/2016		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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:					

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Category:	Network Adequacy / Access to Care
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. HHSC is in the process of reviewing mileage and other network adequacy standards. Currently, HHSC contractually requires MCOs to comply with various network adequacy metrics including but not limited to: wait times for appointments, mileage standards, and out-of-network utilization. MCOs that are not in compliance are required to develop a corrective action plan to improve access SB 760 and new 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 draft proposal was shared at the SB 760 stakeholder forum on June 6. HHSC is currently reviewing stakeholder input, analyzing 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 anticipates that changes to contracts and rules will be completed by March 1, 2017. In regards to monitoring, the S.B. 760 workgroup is considering ways to utilize HHSC's EQRO or possibly another third-party contractor to assist with ensuring MCOs comply with established 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.
Date Last Updated:	6/10/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	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	On Target	
4	Amend managed care contracts and agency rules as necessary.	3/1/2017	On Target	

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	74f
Recommendation:	Ensuring data regarding network adequacy is publicly disclosed and requiring MCOs to report publicly on the impact of their provider networks on access to care.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas				
HHSC Response:	SB 760 requires HHSC to submit to the Legislature and make public a biennial report containing information on Medicaid members' access to healthcare services in managed care.				
Date Last Updated:	6/10/2016				

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

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

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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. HHSC is currently reviewing stakeholder input, analyzing 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 anticipates that changes to contracts and rules will be completed by March 1, 2017.				
Date Last Updated:	6/10/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	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	On Target	
4	Amend managed care contracts and agency rules as necessary.	3/1/2017	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: 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. Recognizing this, HHSC is exploring the possibility of requiring MCOs to respond to a member request within a specified timeframe that fits within current requirements related to member and service coordinator hotlines.				
Date Last Updated:	6/22/2016				

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

	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.	8/1/2016	On Target	
2	Draft proposed contract language.	9/1/2016	On Target	

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**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 is hosting a Medicaid Brainstorming Session on September 15, 2016 to address service gaps and solutions for individuals dually diagnosed with IDD and behavioral health conditions. Part of the summit discussion will include provider shortages and gaps in service provision that members with IDD experience. DADS released a free online training in June 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				

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	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/.
Date Last Updated:	6/23/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	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.	9/15/2016	On Target	

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

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

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

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

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

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

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Improving Member and Provider Experience in Medicaid Managed Care

Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	79
Recommendation:	Share the implementation timeline for SB 760.				
Additional Stakeholder Background:	AARP and other consumer organizations are looking to the Commission for a full and comprehensive implementation of all the provisions of SB 760, including the provisions on support and information services, provider access standards (including information on provider-to-recipient ratios, liquidated penalties, default enrollment sanctions), and provider network directories. SB 760 took effect on September 1, 2015. To date, it's not clear what steps HHSC has taken to comply with SB 760.				
Category:	Network Adequacy / Access to Care				
Provided By:	AARP				
HHSC Response:	HHSC is currently in the process of developing a detailed implementation plan for SB 760. The implementation plan will include major milestones and timelines and will be shared on the SB 760 webpage once it is completed. The SB 760 webpage can be found at: http://www.hhsc.state.tx.us/medicaid/managed-care/SB760-implementation.shtml.				
Date Last Updated:	6/10/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Develop implementation plan.	7/22/2016	On Target	
2	Post implementation plan on SB 760 webpage.	7/22/2016	On Target	

Executive Commissioner's Commitment to
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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**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 is developing an implementation plan for SB 760. Based on input HHSC received at the SB 760 Stakeholder Forum that was held on June 6, 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.				
Date Last Updated:	6/21/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Review and incorporate feedback from stakeholder forum.	7/12/2016	On Target	
2	Develop additional access standards for other provider types, including LTSS.	7/19/2016	On Target	
3	Implement contract revisions for provider access standards.	3/1/2017	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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:					
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Speech-Language-Hearing Association				
HHSC Response:	Current network adequacy standards require MCOs to ensure that all members have access to age-appropriate primary care providers. Draft online provider directory standards will include patient age limitations in all provider listings. 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:	6/20/2016				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	PCP Referral Study Phase 1 Summary of Results.	8/31/2016	On Target	
2	PCP Referral Study Report.	1/31/2017	On Target	

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: 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 will explore options to collect and share prior authorization content between payers.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Explore options and identify cost involved to make changes to collect and share prior authorization content between payers.	10/1/2016		

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

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

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

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Agency/Division:	HHSC Financial Services	**Status:**	Under Consideration: No Action to be Taken: In Progress: X 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.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Proposed rules for HCS high medical needs add-on published in the Texas Register for comment.	9/23/2016	On Target	
2	Final rule should be adopted and effective.	12/19/2016	On Target	
3	Rate for HCS high medical needs add-on effective.	1/1/2017		

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	88 / 89
Recommendation:	Establish caseload limits for service coordinators and improve consumer access. Establish adequacy standards for service coordinators, including caseload limits. Many consumers report not knowing their service coordinator or how to contact her. Service coordinators seem overloaded and challenged to provide timely assistance.				
Additional Stakeholder Background:					
Category:	Service Coordination / Member Assistance				
Provided By:	Coalition of Texans with Disabilities/ PACSTX				
HHSC Response:	HHSC recently published a resource document explaining how to find an assigned service coordinator from the five STAR+PLUS MCOs and shared this document with providers and associations. This document resides in Appendix VI of the STAR+PLUS Handbook. 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 method of communication, within 5 days if their service coordinator changes and provide updated contact information. HHSC also added requirements that an MCO notify members in writing with: name of service coordinator, phone number, minimum contacts, and type of contacts, also effective 9/1/2016. HHSC is not going to establish caseload limits at this time.				
Date Last Updated:	6/22/2016				

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

	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 new contract requirements for MCOs regarding notifying members about service coordination.	9/1/16	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: Other:	**Number:**	91
Recommendation:	Allow for a community-based, outside party, like a local authority, to contract with an MCO to provide acute care service coordination.				
Additional Stakeholder Background:					
Category:	Service Coordination / Member Assistance				
Provided By:	EveryChild, Inc., Texas Council for Developmental Disabilities, The Arc of Texas				
HHSC Response:	This option will be available under STAR Kids through an integrated health home contracted with the MCO beginning 11/1/16. STAR Kids MCOs may allow a member to receive service coordination through an integrated health home if the individual providing service coordination and the service coordination structure meet STAR Kids program requirements. The MCO must reimburse a health home that provides service coordination to its members through an enhanced rate structure, a per-member-per-month fee, or other reasonable methodology agreed to between the MCO and Health Home. This is outlined in Attachment B-1, Section 8.1.38.7 of the STAR Kids contract.				
Date Last Updated:	6/22/2016				

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

	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 explore adding this requirement to STAR+PLUS contracts.	Fall 2016		

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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:	The STAR+PLUS and STAR Kids provider handbooks include guidelines on how to best utilize care coordination, as well as instructions on requesting care coordination for those who do not automatically receive this benefit. Every STAR+PLUS and STAR Kids Medicaid ID card has the service coordination hotline on the back so a member may immediately speak to an individual who may authorize long term services and supports. Each STAR Kids member will have access to service coordination (SC). HHSC staff completed one round of statewide information sessions for both providers and families to provide them information regarding STAR Kids, including information on how to access SC and transition planning, in the Winter/Spring of 2015/16. Another round of information sessions will occur toward the end of the Summer 2016. HHSC continues to provide training to MCOs around SC and transition planning in preparation for November 1st implementation of STAR Kids. MCOs will be able to allow a member to receive SC through an integrated health home if it meets STAR Kids program requirements. The MCO must reimburse a health home that provides SC to its members through an enhanced rate structure, a per-member-per month fee, or other reasonable methodology agreed to between the MCO and health home.				

	Like STAR+PLUS, STAR Kids has a service coordinator hotline number that will be on a STAR Kids member ID card, which will be an easy way for families or providers to reach a service coordinator. In addition, MCOs must provide a named service coordinator to any member who requests one, even if they are not in the groups that get one automatically (levels 1 and 2). Everyone in STAR Kids will also have access to transition planning beginning at age 15. A transition specialist at the MCO, working closely with the service coordinator, will help the family with transition planning. This includes activities like assisting members to find adult providers and preparing members for transitioning to STAR+PLUS when appropriate. HHSC has added a requirement to the managed care contracts, effective 9/1/16, which will require the STAR+PLUS MCOs to notify a STAR+PLUS member in writing (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 will be operational effective 11/1/16.
Date Last Updated:	6/22/2016

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

	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	On Target	
2	Conduct STAR Kids Information Sessions.	10/1/16	On Target	
3	Implement STAR Kids.	11/1/16	On Target	

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**Number:**	93
Recommendation:	Seek stakeholder input about access to care issues from stakeholders beyond from just those individuals and entities which interface regularly with HHSC. Although not inclusive, such could be accomplished by conducting stakeholder forums across the state (similar to the 'Listening Sessions' HHSC held) and/or via a survey. Notes: Regardless of the method selected (and if the feedback to be obtained will cross various populations), it is strongly recommended HHSC ensures the feedback/data it collects is identified and analyzed by population. Coupled with the above, the following is recommended: - Any survey conducted should be relatively short and simple and ask questions pertinent to the population from which information is being collected. - Input from stakeholders in the development of the survey should be obtained. - Regardless of which method or methods HHSC decides to use to obtain feedback, the recommendations received and HHSC's response to the feedback (actions it will initiate to address) should be timely and made available to all interested persons. - HHSC include any recommendations offered in the various 2015 SB 7 Advisory Committee Reports and which are not duplicative of recommendations stakeholders submit through this process for review and consideration at the November 9, 2015 meeting.				
Additional Stakeholder Background:					
Category:	Stakeholder engagement and feedback				
Provided By:	PPAT				
HHSC Response:	HHSC strives to engage stakeholders and appreciates suggestions for improving this process. HHSC will explore ways to better engage a broad base of stakeholders. One way in which HHSC already obtains member feedback is through surveys of adult members and parents of child members. These surveys are conducted biannually, and are intended to determine members' level of satisfaction in the Texas Medicaid managed care programs. The surveys include questions to address, among other topics, access to and timeliness of care, including having a usual source of care and the availability of specialized services. HHSC held ~~a~~ two stakeholder forums and completed a stakeholder survey on implementation of SB760. HHSC is currently compiling and reviewing stakeholder responses for consideration in ongoing efforts to improve network adequacy.				

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	HHSC has initiated a new Medicaid and CHIP stakeholder forum as an opportunity to learn about changes to policy that impact the many individuals served by Medicaid and CHIP. The first of these all-inclusive stakeholder meetings will be held on July 26, 2016, 1:00 - 5:00 p.m.
Date Last Updated:	6/30/2016

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	STAR Adult Member Survey.	Summer 2016	On Target	
2	STAR+PLUS Member Survey.	Summer 2016	On Target	
3	STAR Health Caregiver Survey.	Summer 2016	On Target	
4	Conduct all-inclusive stakeholder meeting.	July 26, 2016	On-Target	

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

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

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

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: X No Action to be Taken: In Progress: Complete: Other:	**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:					
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 will be added to the July 28, 2016 IDD SRAC Meeting agenda and HHSC will discuss the feasibility of this survey with MCOs.				
Date Last Updated:	6/22/2016				

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

	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	On Target	
2	HHSC will discuss feasibility with MCOs.	TBD		

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

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

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

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

Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	97 / 98
Recommendation:	Meaningfully inform and include people with DD on councils, workgroups, and committees concerning their health and human services.				
Additional Stakeholder Background:					
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. HHSC has initiated a new Medicaid and CHIP stakeholder forum as an opportunity to learn about changes to policy that impact the many individuals served by Medicaid and CHIP. The first of these all-inclusive stakeholder meetings will be held on July 26, 2016, 1:00 - 5:00 p.m. Through our advisory committees, individuals with disabilities are given opportunities to serve and express their concerns regarding the quality of care received. Several advisory committees are in the process of identifying members as a result of the Executive Commissioner's decisions to reestablish the Texas Council on Consumer Direction and the State Medicaid Managed Care Advisory Committee. These committees—in addition to the 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.				
Date Last Updated:	6/24/2016				

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

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

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

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

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

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

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

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

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Agency/Division:	HHSC MCD	**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. THHSC can use this analysis to get a better understanding of the out-of-network activity. The current out-of-network rules tie the hands of providers and give a big advantage to Medicaid MCOs.				
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.				
Date Last Updated:	7/1/2016				

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

	Milestone	**Targeted Completion Date**	**On Target / Completed / Ongoing**	**If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.**
1	Meet with THA.	9/1/2016		
2	Review this recommendation and determine full scope of activities.			

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Agency/Division:	HHSC MCD	**Status:**	Under Consideration: No Action to be Taken: In Progress: X Complete: 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 Texas specific measures are developed, and when coordinating with the National Association of States United for Aging and Disabilities and Human Services Research Institute. 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 National Association of States United for Aging and Disabilities and Human Services Research Institute 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 will be conducted annually through in-person member surveys administered by HHSC or its contractor. Included in the survey sample will be STAR+PLUS members receiving LTSS through STAR+PLUS HCBS. The first year of surveys will be complete by summer 2016, and HHSC intends to participate on an annual 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:	6/22/2016

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

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

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

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

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