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

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

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

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

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

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Table 1: Explanation of Response Fields

Agenda / Division	The abbreviation of the agency and division leading this response. Responses include: • COS: Chief of Staff • CPSCO: Chief Program Services Office • FSD: Financial Services Division • MCS: Medicaid and CHIP Services • 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.
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
API	Atypical Provider Identifier
ASC	Ambulatory Surgical Center
BHIAC	Behavioral Health Integration Advisory Committee
CAHPS	Consumer Assessment of Healthcare Providers & Systems
CHAT	Children's Hospital Association of Texas
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CVO	Credentialing Verification Organization
DADS	Department of Aging and Disability Services
DD	Developmental Disability
DME	Durable Medical Equipment
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
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HMO	Health Maintenance Organization
HPM	Health Plan Management
HSRI	Human Services Research Institute
IDD	Intellectual and Developmental Disabilities
LARC	Long Acting Reversible Contraception
LIDDA	Local Intellectual and Developmental Disability Authorities
LTSS	Long-term Services and Supports
MCO	Managed Care Organization
MCS	Medicaid and CHIP Services (division)
MHPAEA	Mental Health Parity and Addictions Equity Act
MSS	Medical Social Services
NA	Not Applicable
NAIP	Network Access Improvement Project
NASUAD	National Association of States United for Aging and Disabilities
NCI-AD	National Core Indicators - Aging and Disabilities
NPI	National Provider Identifier
PA	Prior Authorization
PACSTX	Providers Alliance for Community Services of Texas
PCP	Primary Care Physician
PDL	Preferred Drug List

Acronym	Definition
PPAT	Private Providers Association of Texas
PPS	Prospective Payment System
RRT	Research and Resolution
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SRAC	System Redesign Advisory Committee
SSI	Supplemental Security Income
SSLC	State Supported Living Centers
STAR	State of Texas Access Reform
STP	Significant Traditional Provider
TAHP	Texas Association of Health Plans
TBD	To Be Determined
THA	Texas Hospital Association
THSteps	Texas Health Steps
TIERS	Texas Integrated Eligibility Redesign System
TMA	Texas Medical Association
TMHP	Texas Medicaid and Healthcare Partnership
TPI	Texas Provider Identifier
TPS	Texas Pediatric Society
TSHA	Texas Speech-Language-Hearing Association
UMCC	Uniform Managed Care Contract
UMCM	Uniform Managed Care Manual
VDP	Vendor Drug Program

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	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:	Private Providers Association of Texas (PPAT)				
HHSC Response:	Senate Bill (SB) 760 and rules issued by the Centers for Medicare & Medicaid Services (CMS) require HHSC to establish minimum access standards, including time and distance, for managed care organization (MCO) provider networks for certain provider types. As part of this analysis, HHSC staff completed the following activities: • compared HHSC existing provider access standards to other state Medicaid programs as well as Medicare standards established by CMS; • conducted literature reviews; • analyzed geo-maps, MCO network adequacy data and out-of-network utilization charts, and provider termination information; • requested HHSC external quality review organization (EQRO) conduct an analysis of best practices for developing provider access standards and monitoring MCO compliance with established standards; • reviewed annual survey results and "secret shopper" information collected by HHSC EQRO; • developed methodology for "secret shopper" and "provider referral" studies in the context of access requirements; • met with numerous stakeholder groups and reviewed stakeholder feedback provided at a public forum held on 11/30/2015; and				

	• reviewed complaints related to network adequacy as well as survey results from the Consumer Assessment of Healthcare Providers and Systems that show member satisfaction with MCO provider networks. Using this information and data, HHSC staff developed a draft proposal for revising existing distance and appointment availability standards as well as creating new travel time standards. HHSC shared the draft proposal at the stakeholder forum on 6/6/2016. HHSC staff reviewed stakeholder input, analyzed the impact these new standards would have on existing MCO networks, comparing the proposed standards to standards for commercial insurance, and identifying all contract provisions and rules that would need to be amended to implement the proposed access standards. HHSC made 3/1/2017 managed care contract changes and will revise rules after contract changes are effective. Any access standards not included in the 3/1/2017 contract amendment will be included in subsequent amendments. This will likely include access standards for urgent care and other acute care services. Network adequacy standards for LTSS will be included in 9/1/2018 managed care contracts. For additional information related to the revised network adequacy process, please contact MedicaidCHIP_Network_Adequacy@hhsc.state.tx.us
Date Last Updated:	11/1/2018

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

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

	other network adequacy standards to meet requirements of CMS rules.			
7	Publish agency rules as necessary to include revised access standards.	11/1/2018	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**Number:**	1d
Recommendation:	Explore increasing single case agreements for persons with intellectual and developmental disabilities (IDD). Explore options for increasing the number of 'single case' agreements MCOs reportedly have in an effort to ensure persons with IDD have at least the same access to care they had prior to the 9/1/14 transition. [When will the reports called for in Rider 81 related to Medicaid Managed Care Organization Network Adequacy Action Report and, more importantly, Rider 82 related to Assessment of Single Case Agreements be available?]				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	PPAT				
HHSC Response:	All Medicaid MCOs are contractually required to provide members with access to covered services and service management/coordination, including assistance in finding a provider. HHSC assesses liquidated damages when an MCO fails to provide a covered service. Additionally, HHSC is currently collecting data on single case agreements as part of the last transition of acute care for people with IDD and will share the analysis with stakeholders. HHSC reports on Rider 81 and Rider 82 were combined into one report and provide information on corrective actions taken against MCOs for not meeting network access standards and single case agreements. The Combined Report on Medicaid Managed Care Provider Network Adequacy, Monitoring, and Violations was available for the public February 2017. Here is the link to access the report: https://hhs.texas.gov/sites/default/files//Combined%20reports%20SB760%20and%20Riders%2081%20and%2082%20PDF.pdf HHSC requires MCOs to develop networks that can sufficiently serve their members, but also encourages MCOs to enter into single case agreements when absolutely necessary to ensure each member has access to necessary services. HHSC will continue monitoring efforts to ensure members access Medicaid benefits, including services for individuals with IDD and related conditions.				

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	HHSC and the Hogg Foundation hosted a Medicaid Brainstorming Session on September 29, 2016 to address service gaps and solutions for individuals dually diagnosed with IDD and behavioral health conditions. Part of the discussion addressed provider shortages and gaps in service provision that members with IDD experience. HHSC reviewed the feedback provided during the brainstorming session, sent the brainstorming notes to all external stakeholders to ensure all information was collected accurately and completely, and identified next steps for the recommendations and the workgroup. The IDD System Redesign Advisory Committee (SRAC) will continue this discussion. Refer to the transition to managed care IDD SRAC subcommittee for future information.
Date Last Updated:	11/13/17

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

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

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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, to require MCO member services staff to better assist with scheduling appointments. HHSC has amended managed care contracts effective in March 1, 2017 to require MCOs to provide three-way calling between a member or authorized representative, member services hotline staff, and provider's office to ensure that appointments are made in a timely fashion. Members will have the choice to either participate in three-way calling or receive a list of providers in their area. Staff have received feedback from stakeholders that many members are unaware that a prior authorization or referral may be required to access out-of-network non-emergency covered services. Staff are-considered options for adding a section to member handbooks that discusses how members can access out-of-network services. However, HHSC believes efforts to amend contracts to improve members' ability to access in-network services are the best use of agency resources at this time. Updates and information regarding SB 760 implementation can be found at https://hhs.texas.gov/services/health/medicaid-and-chip/provider-information/senate-bill-760				
Date Last Updated:	03/01/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Review MCO out-of-network utilization.	6/1/2016	Completed	
2	Submit proposed contract changes.	9/1/2016	Completed	
3	Contract changes related to telephone appointment assistance effective.	3/1/2017	Completed	1) HHSC has focused some efforts on amending contracts to improve members' ability to access in-network services; 2) HHSC will not be updating the UMCM at this time

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	1f
Recommendation:	Improve provider recruitment and retention. Collect data on why acute care providers will not contract with MCOs or do, then drop out within months, followed by making, as appropriate, needed changes to enhance acute care provider recruitment and retention across the MCO networks.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with PPAT on 8/8/2016. PPAT provided feedback that retention is impacted by issues with billing, and provider challenges with submitting a claim that will be accepted without needing changes before processing (clean claim).				
Category:	Network Adequacy / Access to Care				
Provided By:	PPAT				
HHSC Response:	HHSC contractually requires Medicaid MCOs to notify HHSC of provider terminations in accordance with Uniform Managed Care Manual (UMCM) Chapter 5.4.1.1, "Provider Termination Report." Additionally, MCOs that do not meet the UMCM Chapter 5.14.8 State of Texas Access Reform (STAR) and STAR+PLUS Geo-Mapping Report standards—which monitor acute care provider types such as primary care physician (PCP), obstetrician/gynecologist, orthopedic surgeon, cardiologist, general surgeon, urologist, ophthalmologist, outpatient behavioral health provider, acute care hospital, and nursing facility—typically submit UMCM 5.15 Special Exception Request for variance of mileage. HHSC acknowledges this issue and appreciates continued stakeholder feedback. HHSC coordinates with provider associations and collects feedback on strengths and challenges within the Medicaid managed care program with the ultimate goal of improving the program and increasing the number of providers that are willing to participate. In addition, HHSC staff are using data and reports to better understand provider terminations and feedback. Texas Medicaid and Healthcare Partnership (TMHP) conducts presentations at health-related institutions related to Medicaid State Programs (e.g., THSteps Medical and Dental, Children with Special Health Care Needs, Case Management for Children and Pregnant Women, etc.) to recruit new Medicaid providers. HHSC will explore additional options to work with the TMHP to recruit providers underrepresented in the Medicaid network. HHSC also meets with targeted stakeholder groups to discuss issues related to shortages of providers accepting certain populations, specifically individuals with IDD. Work on this issue is ongoing, and HHSC is continually seeking and collecting data related to this topic.				

	HHSC confirmed that MCOs have processes in place to address provider billing challenges and issues. If a provider is still facing a billing challenge and is not getting the support needed from the MCO to submit a clean claim, the provider should write to HPM_Complaints@hhsc.state.tx.us so that the issues can be tracked and HHSC can work with the appropriate MCO to resolve this issue.
Date Last Updated:	11/1/2018

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Identify and review existing reports and sources of information to review for more information about provider terminations and feedback.	9/1/2017	Completed	
2	Discuss billing challenges with MCOs during the MCO one-on-one meetings to find out if they are seeing this issue, and steps they are taking to address the issue.	5/23/2018	Completed	Delayed scheduling so date updated.
3	Identify next steps to improve provider recruitment including options to assess and address issues with billing and submitting a claim that will not need changes before processing.	6/1/2018	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	2a
Recommendation:	Continue to explore ways to improve the MCO online directories, including how to improve access to and ease in use of the online 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 has developed critical elements for the MCO online provider directories for inclusion in the UMCM. These will be proposed to MCOs in October 2016 for a November 2016 effective date. 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.				

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	HHSC collected additional feedback during the subsequent SB760 stakeholder forum held on 6/6/2016. HHSC incorporated the additional comments into revised MCO provider directory standards as appropriate.
Date Last Updated:	03/10/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Develop 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	Completed	
4	Begin fielding 2016 Appointment Availability study.	8/23/16	Completed	
5	Complete 2015 Appointment Availability Study report.	11/1/16	Completed	
6	Amend managed care contracts and agency rules as necessary.	3/1/2017	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	2b
Recommendation:	Require managed care organizations (MCOs) to find doctors for long-term services and supports (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:	Private Providers Association of Texas (PPAT)				
HHSC Response:	HHSC contractually requires Medicaid MCOs to provide service management and coordination to members, including assistance in finding a provider. The HHSC Senate Bill (SB) 760 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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	3a
Recommendation:	Evaluate the expedited appeal, service authorization and prior authorization process for IDD clients.				
Additional Stakeholder Background:	Require plans to create an expedited appeal, service authorization and prior authorization process in order to resolve immediate issues that require resolution within timeframes more quickly than what is permissible in the Medicaid managed care manual, which is 30 days in most situations. For example, the 72 hour emergency medication provision is not sufficient in cases when the medication is dispensed on Friday, because if the IDD provider or family is unable to resolve the issue with the MCO on Monday, then the client goes without the medication for an indefinite period of time or the provider or family is forced to pay for the medication.				
Category:	Network Adequacy / Access to Care				
Provided By:	Providers Alliance for Community Services of Texas (PACSTX)				
HHSC Response:	The Uniform Managed Care Contract (UMCC) Section 8.1.21.2, "Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies," permits a pharmacy to fill consecutive 72-hour supplies if the prescriber's office remains unavailable. The MCO must reimburse the pharmacy for the temporary supply. Additionally, if the prescriber's office calls the MCO's prior authorization (PA) call center, the MCO must provide a PA approval or denial immediately. The 72-hour emergency medication provision is intended to ensure members have access to needed medications even when a prescriber is not available by allowing the pharmacy to dispense and be reimbursed for a 72-hour supply of the medication. HHSC is actively working to make sure providers, members, and MCOs understand the process and have tools to utilize it. This topic was the focus of discussions of the IDD Managed Care Improvement Workgroup on 9/22/2015, 10/5/2015, 2/8/2016, and 5/2/2016, and is now being discussed in the IDD System Redesign Transition to Managed Care Subcommittee. HHSC will coordinate with the subcommittee to identify recommendations to improve the process and ensure individuals, providers, physicians, and pharmacies are aware of the process. The subcommittee worked with a representative from HHSC's Vendor Drug Program (VDP) to develop a prescription education information flyer for members and LTSS providers to use to assist in this process. At their October 2016 and December 2016 meetings, the subcommittee reviewed a draft, discussed recommendations for the flyer, and provided feedback to the representative from VDP. The flyer was sent to HHSC Communications and Media Services to ensure the language and format is accessible for individuals with IDD. The subcommittee and full committee reviewed the final document during their October 2017 meeting and voted to finalize and publish the document.				
Date Last Updated:	11/13/17				

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

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

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	4 / 34d / 51 / 6
Recommendation:	Increase provider network non-discrimination standards. Certain individuals, based on their disability or complex needs, are struggling to locate and access health care in a timely manner and without having to travel farther than they did prior to Medicaid managed care expansion. We offer the following analysis and considerations, consistent with recent Affordable Care Act (ACA) proposed guidelines to insurers regarding non-discrimination. HHSC should adopt, increase awareness and enforce clear standards in contracts and rules that an individual shall not, on the basis of race, color, national origin, sex, age, or disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/9/2016. These organizations provided feedback that it is important for HHSC to ensure MCOs know their role with home and community based services (HCBS) settings standards and person-setting planning.				
Category:	Network Adequacy / Access to Care				
Provided By:	Disability Rights Texas/EveryChild, Inc./ Texas Council for Developmental Disabilities/The Arc of Texas				
HHSC Response:	HHSC contractually requires Medicaid MCOs to comply with state and federal anti-discrimination laws. **Section 7.05** ***Compliance with state and federal anti-discrimination laws.*** (a) MCO agrees to comply with state and federal anti-discrimination laws, including without limitation: (1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*); (2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); (3) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq.*); (4) Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107); (5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688); (6) Food Stamp Act of 1977 (7 U.S.C. §200 *et seq.*); and (7) The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement. MCO agrees to comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued pursuant to these laws. These laws provide in part that no persons in the United States may,				

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

	In addition, HHSC will continue to meet with stakeholder groups to discuss issues related to shortages of providers accepting certain populations, specifically individuals with IDD, and will coordinate with MCOs to ensure compliance with federal HCBS settings rules. The IDD SRAC will continue this discussion. Refer to the transition to managed care and day habilitation and employment IDD SRAC subcommittee for future information.
Date Last Updated:	11/1/2018

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Finish analysis of new CMS managed care rules effective 2016 and 2017, and determine impact to this issue.	7/31/2017	Completed	Staff have completed analysis of federal regulations related to discrimination and have determined that UMCC Section 7.05 requires MCO compliance with all state and federal discrimination laws, including without limitation: • Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*); • Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); • Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq.*); • Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107); • Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688 regarding education programs and activities; • Food and Nutrition Act of 2008 (7 U.S.C. §2011 *et. Seq.)*; and

				• The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable.
2	Contract changes proposed related to member choice of provider.	3/1/2017	Completed	
3	Contract changes submitted.	9/1/2018	Completed	HHSC staff have determined that managed care contracts require MCOs to ensure member choice of providers as required by federal law. HHSC will make additional contract amendments as needed to further clarify MCO requirements regarding provider choice.
4	HHSC will ensure MCOs understand their role in regards to compliance with the federal HCBS settings rule.	3/1/2022 and Ongoing	Ongoing	HHSC is continuing to work with stakeholders concerned with programs serving individuals with IDD as well as MLTSS HCBS services to ensure Texas is in compliance with the federal HCBS rule by March 2022. This work will be ongoing over the next several years as HHSC works with stakeholders to develop a remediation plan, obtain CMS approval of that plan, and implement the plan by the deadline. The IDD SRAC will continue this discussion. Refer to the transition to managed care IDD SRAC subcommittee for future information.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	5
Recommendation:	Analyze outpatient and emergency room services use. Perform a comprehensive analysis of Medicaid outpatient clinic and Emergency Room use by Service Delivery Area by MCO. Compare the actual utilization of Medicaid outpatient and ER services to Healthcare Effectiveness Data and Information Set (HEDIS) standard use rates by age group to identify which MCOs in which markets have high rates of outpatient and emergency room care. The analysis must be performed by age group because the HEDIS standard for utilization of service varies dramatically for clients of different ages. While 100% compliance with HEDIS standards may not be feasible for the Texas Medicaid population, the standards serve as a widely-used, widely-credible standard for managed care delivery nationwide. The analysis can be completed by measuring the actual number of visits per 1,000 by age group.				
Additional Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Hospital Association (THA)				
HHSC Response:	HHSC currently is analyzing outpatient services and emergency department visits by plans and service areas; however, this data is not being compared with the HEDIS standard. HHSC met with THA to discuss this recommendation, and provided initial information. THA indicated that no further information is needed at this time, and this will be revisited if THA determines that additional information is needed in the future.				
Date Last Updated:	11/1/2018				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Meet with THA, and determine next steps.	2/1/2018	Completed	
2	Provided initial data	4/1/2018	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**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				

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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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	6b
Recommendation:	Challenges with different MCO processes. With the recent State of Texas Access Reform (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 Uniform Managed Care Contract (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 Uniform Managed Care Manual (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

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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/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	6c
Recommendation:	Seek feedback from stakeholders on utilization management protocols. The state has made significant strides towards a streamlined credentialing process, and now requires all MCOs to accept prior authorization requests on the standardized Texas Department of Insurance form. HHSC's managed care contracts also require MCOs to follow established utilization management protocols when reviewing targeted case management and mental health rehabilitation service requests (see HHSC's UMCM, Chapter 15); however, these protocols are currently under review. Any changes to the utilization management protocols should be fully-vetted with the Behavioral Health Integration Advisory Committee (BHIAC) and other interested stakeholders, and should promote streamlined and consistent application.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Council of Community Centers				
HHSC Response:	HHSC reviewed the Mental Health Rehabilitation and Mental Health Targeted Case Management benefit, including any potential changes to the utilization management guidelines as part of the rules development process and the medical benefit policy. HHSC has not made any modification to the utilization management protocols. HHSC has published the medical benefit policy for mental health rehabilitative services and mental health targeted case management in the Texas Medicaid Provider Procedure Manual. The rules for the managed care section of the HHSC Texas Administrative Code to address these benefits also do not make any modifications to the existing utilization management protocols. The rules were published, comments received, and modifications made based on feedback. HHSC will continue to work with the Behavioral Health Advisory Committee on questions and feedback on activities as appropriate.				
Date Last Updated:	6/4/2019				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Post medical benefit policies for public comment.	Summer 2016	Completed	
2	Adopt Texas Administrative Code rules.	8/31/2018	Completed	Rules were adopted on 10/12/2018.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	7 / 18-19 / 21
Recommendation:	Streamline MCO prior authorization requirements. - Standardization of elements of a "good" physician order" & uniformity in how guidelines are adopted and how requirements are applied for PA. We ask all MCO's follow CMS guidelines for what they will accept as a "good order" based on CMS elements of an order. Also, we ask all of our MCO's follow TMHP guidelines in how PA requirement are applied to PA guidelines. For example, Some require auth for a service while others do not require auth for that same service. Standardization of review amongst MMC plans for PA determination on pediatric –rendered durable medical equipment (DME) services, such as oral supplementation requirements would be very beneficial to the patient. - Authorization requirements that are consistent and align with TMHP requirements. This should not only include the parameters by which they authorize, but also the manner in which it occurs. MCOs are not using the Universal Authorization form with the exception of CHC. They will accept the form, but continue to require their own forms as well. This also applies to TMHP. To further increase consistency of the authorization process providers should be allowed to submit all necessary documents to the MCO directly once the primary care physician (PCP) has ordered and approved services, by signing the plan of care and or the initiation of services by signing the initial order. This would align with TMHP's processes. - Authorization process should originate on the therapy provider. We are getting push-back from the physicians. Several MCO s have instituted policy making the PCP responsible for submitting all authorization paperwork. This has caused delays in delivery of services. - Existing prior authorization procedures vary substantially between MCOs. Prior authorization procedures and documentation requirements should align with those outlined in the Texas Medicaid Manual. Additionally, providers should have the authority to submit prior authorization requests directly to the MCO provided the ordering physician has reviewed the plan or care and signed all required documents. When continuation of services is needed for an additional period of time requiring reauthorization, it is imperative that the process be completed without an interruption of service provision. Additionally, Texas Speech-Language-Hearing Association (TSHA) supports the establishment of care standards for Medicaid beneficiaries transitioning from one delivery system to another.				

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Additional Stakeholder Background:	HHSC met with TSHA in the summer of 2016 and received additional information clarifying that some of the items listed in this recommendation continue to be issues, especially as it relates to prior authorization requirements and MCOs.
Category:	Network Adequacy / Access to Care
Provided By:	Texas Rehab Providers Council/Outpatient Independent Rehabilitation Association/TSHA
HHSC Response:	At this time, HHSC cannot mandate to MCOs which benefits require prior authorization or that MCOs follow the same processes for prior authorization. HHSC will continue to explore other opportunities to help providers better understand MCO processes. HHSC is exploring how best to address the issue related to MCOs not accepting a faxed PA request based on letterhead or fax cover page. Currently, there is no law, rule, or contract requirement to prevent MCOs from implementing this type of policy to help control therapy utilization. HHSC currently requires MCOs to ensure continuity of care when an individual transitions from FFS or another managed care program into their plan. See Section 8.2.1 of the UMCC. Each MCO has medical director and other clinical staff that can discuss specific cases or processes with therapy providers. These staff can be accessed using each MCO's provider relations hotline. HHSC requests therapy providers send requests to HPM_Complaints@hhsc.state.tx.us with an indication of whether a member's access to care is of concern due to a PA request response, or lack thereof. MCOs are required to respond timely to access to care complaints when HHSC makes them aware of such complaints. Effective 3/1/2017, MCO websites must allow providers to submit PA requests and include online processes to permit the following: submission of electronic claims and any related documentation requested by the MCO; submission of claims appeals and reconsiderations, and submission of clinical data. The website also must include email addresses for receipt of provider complaints.
Date Last Updated:	11/1/2018

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Meet with TSHA	8/16/2016	Completed	

2	Research examples of MCO-specific issues	8/31/2016	Completed	
3	Follow up with TSHA about possible solutions for PA fax/letterhead concern	4/1/2018	Completed	
4	Obtain additional detailed examples to help inform HHSC staff about the issues	4/20/2018	Completed	Examples were reviewed and are being addressed on an individual case basis, but there does not appear to be a need for further policy guidance development on this issue at this time. HHSC will continue to work with TSHA to address any future issues.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: X 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. 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 believed that this plan would address the issue described by CHAT. However, after further consultation with CHAT it was determined that this recommendation does specifically relate to referrals and reducing the administrative burden associated with faxing referrals. HHSC requested additional documentation about the administrative burden of this process. This item will be closed until additional documentation is received and reviewed.				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	New UMCM Chapter 3.32 finalized which includes critical elements and functionality that must be part of each MCO website, including	6/1/2016	Completed	

	acceptance of online prior authorization requests. It is posted on HHSC website with the effective date of 7/1/2016.			
2	HHSC staff will contact CHAT to confirm that this solution will address the issue described.	7/31/2016	Completed	
3	MCOs implement new website functionality as required in UMCM 3.32.	1/1/2017	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	10 a-b
Recommendation:	Shorten timeline for physician enrollment and credentialing in Medicaid. Require Medicaid MCOs to simultaneously process physician credentialing applications while the physician pursues Medicaid enrollment via TMHP. Currently, physicians must submit a Medicaid enrollment application then await receipt of a Texas Provider Identifier (TPI) number(s) before beginning the (health maintenance organization (HMO) credentialing process. TMA and Texas Pediatric Society (TPS) frequently receive complaints from physicians that the entire process takes 6 months or more to become enrolled in Medicaid, credentialed by the HMOs, and then begin seeing HMO patients. Some plans indicate they will initiate the credentialing process while awaiting a physician's TPI number, but this is not standard practice because some HMOs interpret the HHSC-HMO rules to preclude establishing a parallel process. Once TMHP finalizes a physician's Medicaid enrollment, the information should be expeditiously transmitted to the HMO to allow the plan to complete credentialing. Further, HMOs should be required to honor the TMHP effective date regardless of whether the HMO has completed the credentialing process and pay claims retroactive to that date so that physicians can begin seeing patients more quickly. By allowing physicians and other acute care providers to simultaneously pursue Medicaid enrollment and HMO credentials, the state will expedite physician enrollment into HMO networks.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	HHSC is committed to improving the enrollment and credentialing systems and processes, and is currently taking action to streamline this process. Physicians will notice some of the up-front changes immediately. Most of them will expedite reenrollment by reducing the need for printing and mailing documents, like proof of licensure. Among the changes: •System updates that make the portal compatible with more recent Internet browsers; •The ability to immediately upload supporting documentation; •An e-sign feature that allows physicians to sign the enrollment agreement electronically; •Instructions on how to upload documents and submit the application using an e-signature; and •Guidance and more accurate error messages to avoid application mistakes before submission.				

	In addition to the above steps, on February 17, 2017 HHSC posted a request for proposals for the procurement of a Provider Management and Enrollment System to further streamline the enrollment process. On March 23, 2017, the Texas Association of Health Plans (TAHP) in collaboration with the Texas Medical Association (TMA) announced a joint effort to reduce red tape and administrative burdens for physicians and health care providers seeking to participate in the Texas Medicaid program. TAHP and TMA have selected Aperture, LLC, for a statewide Credentialing Verification Organization (CVO) contract used by all 20 Medicaid health plans in Texas to streamline the provider credentialing process. Implementing the recommendation to combine the enrollment and credentialing processes would require rule and system changes. HHSC currently provides the MCOs with a Medicaid Provider file every Tuesday that contains a listing of providers enrolled in the Medicaid program. MCOs are currently allowed to begin the credentialing process while providers are in the process of enrolling if they wish to shorten the timeframe. The state is not statutorily allowed to retroactively pay claims for a time period that the provider was not fully enrolled and credentialed. However, HHSC efforts to streamline enrollment through a centralized portal, and TAHP's efforts to streamline credentialing, is expected to significantly shorten the amount of time it takes a provider to become fully enrolled and credentialed. Remaining activities are related to the RFP that is also reported on in item 12, so future updates to these action items will be reported in item 12.
Date Last Updated:	12/4/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HHSC and TAHP finalize approach and credentialing vendor's data requirements. HHSC will work with vendor to identify all data that should be transmitted from TMHP to the credentialing vendor.	To be determined (TBD)		

2	Complete operational and technical changes to operationalize data exchange between TMHP and credentialing vendor	TBD		
3	Provider Management and Enrollment System Request for Proposal Released (RFP)	2/17/2017	Completed	
4	(RFP) Vendor Conference	3/1/2017	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	11a
Recommendation:	Simplify and streamline method for physicians and prescribers to access prior authorization requirements in VDP. Simplify and streamline the Medicaid VDP, which is inordinately complex given that the management of the prescription drug benefit is split between HHSC and the MCOs. It is much too cumbersome for prescribers to determine which drugs or drug classes are subject to additional clinical edits and if there is an edit, which plans also have adopted it. Physicians should have a single location to look up this information rather having to go to each PBMs website to figure it out. Within each drug class on the PDL, include a hotlink so that when a physician views the PDL he/she can immediately determine if there are any associated clinical edit(s) for the entire class of drugs or a particular drug within the class. The link should take the physician to each clinical edit and also name each individual HMO that also has opted to implement the identical HHSC edit or a less stringent version. Currently, physicians must search each individual HMO website to determine which plans have adopted particular clinical edits.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	After further discussion with TMA/TPS VDP envisions the following: • Phase I includes the creation and ongoing maintenance of the "Pharmacy Clinical Prior Authorization Assistance Chart". HHSC will modify the UMCM to add MCO reporting requirements to identify their implemented clinical criteria to support an ongoing, updated chart. • Phase II includes the addition of clinical PA information to the PDL. Any single drug on the PDF that has clinical criteria would have a link to the criteria/requirements. HHSC will contact its PDL vendor to request a change that adds Clinical PA information. This will include an estimate of any potential costs and a timeline for implementation.				
Date Last Updated:	10/31/2017				

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

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

14	Begin quarterly MCO Clinical PA reporting process.	11/30/2016	Completed	
15	Replace "Texas Medicaid Pharmacy Prior Authorization" video on the vendor drug website with one-page document explaining the process as an interim step until video can be updated.	12/15/2016	Completed	
16	Incorporate Clinical PA links into PDL document.	2/1/2017	Completed	
17	Work with TMA and TPS to obtain feedback from providers and administrators to test the revised tutorial (to replace the previous video).	3/1/2017	Completed	
18	Work with TMA and TPS to identify providers and administrators to test the revised PDL document prior to full launch.	3/17/2017	Completed	
19	Work with THSteps to update and revise tutorial to include clinical prior authorizations in the explanation of the drug authorization process.	3/15/2017	Completed	
20	Share draft document with TMA/TPS for feedback from the associations and a sampling of providers. This will be the draft revision of the PDL document incorporating links to clinical prior authorization criteria.	5/17/2017	Completed	
21	Fully launch revised PDL document incorporating links to clinical prior authorization criteria.	8/1/2017	Completed	Clinically-enhanced PDL posted to VDP website.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	11b
Recommendation:	Limit changing drugs from preferred to non-preferred status on the PDL to annual revisions.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with TMA and TPS on 8/10/2016, and it was clarified that drugs are only reviewed once per year but the review date is not clear to providers. It was agreed that providers would benefit from additional information about the date when the drug was reviewed and when it will be reviewed again. In addition, easier access to the review schedule would be helpful.				
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. HHSC staff agreed to revise the PDL to include the date of review, and date when the drug will be reviewed again, and to make the review schedule easier to locate on the website.				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Revise the PDL to include the date when a drug was last reviewed, and the date when it will be reviewed again.	2/1/2017	Completed	
2	Revise the PDL website to make the review schedule easier to find.	2/1/2017	Completed	
3	Review communications regarding the DUR meeting and related notices to improve clarity around the drug review schedule and review process.	2/1/2017	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Capture rationale at next DUR Board Meeting.	07/29/2016	Completed	
2	Develop sample document to share rationale for next meeting.	10/1/2016	Completed	
3	Share sample document with TMA and TPS, and obtain feedback from TMA and TPS.	11/15/2017	Completed	
4	If new descriptions are developed to explain the rationale for changes, the new descriptions will be included in the next PDL (effective January 2017).	2/1/2017	Completed	Note: The addition of the three-columns to the PDL recommendation document should meet this expectation. PDL Recommendations are published within 10 business days of every board meeting. Next meeting Jan. 27.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X (See explanation in HHSC Response)	**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 contacted its Prospective DUR vendor that manages the Texas Medicaid Epocrates contract. The Epocrates product will not be modified, but actions taken in response to recommendation 11a will provide this information in the PDL. Technical issues for users of the product through iPhone and other Apple products have been addressed.				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Consult with Epocrates regarding feasible options.	8/31/2016	Completed	
2	Develop scope of work and obtain high-level estimate from Prospective DUR vendor.	9/30/2016	NA	Epocrates declined our request to make these changes at this time.

3	Contact MCOs to find out if they are using Epocrates as required, and if not why.	10/31/2016	Completed	
4	Follow up with Epocrates regarding work around for broken links, and obtain an estimate on when this will be addressed.	11/30/2016	Completed	
5	Technical issues with Epocrates for iPhone users addressed.	11/30/2016	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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. This issue was discussed in a meeting with TMA and TPS on 8/10/2016, and it was clarified that this issue relates to specific situations where there are changes during a public health emergency or heavy flu season.				
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. HHSC will review this situation and determine changes needed based on the clarification received.				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Review this issue with the VDP Contractor Performance Management and Formulary teams to understand issue and identify what changes need to be made.	10/1/2016	Completed	
2	Develop internal process.	10/31/2016	Completed	
3	Share process with external stakeholders and seek feedback (include meeting, if needed).	3/01/2017	Completed	
4	Finalize and implement process.	3/01/2017	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**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. This item will be closed until further information is received.				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Schedule meeting with TMA/TPS to discuss this issue.	7/31/2016	Completed	
2	Obtain examples of this issue from TMA and TPS.	12/1/2016		TMA and TPS working with members to obtain examples.
3	Review examples to determine next steps.	2/1/2017		

Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**Number:**	13 / 41
Recommendation:	Eliminate recoupments when a patient is erroneously enrolled in a plan. Abide by Texas insurance requirements establishing that coordination of benefits is an insurance function, thus eliminating the need for costly Medicaid recoupments from providers when a Medicaid health plan discovers a patient was erroneously enrolled in the plan. Medicaid MCOs frequently recoup payments from providers as much as two years after a service was provided. The recoupments are triggered by various reasons, such as after the MCO is informed the patient was retroactively enrolled in Medicaid FFS or was mistakenly enrolled in two MCOs simultaneously. While the provider can subsequently bill Medicaid fee for service or the correct MCO for services, this process is time consuming and expensive for the practice. Since the patient did not lose Medicaid eligibility, the recoupment should be managed among the payers, which is how commercial carriers manage these types of recoupments. Additionally, we have received an increase in calls from providers reporting Medicaid is recouping payments when it identifies another insurer as the responsible party, such as an auto or home insurer. The recoupments often occur months to years after the service was provided and the family no longer carries insurance with that carrier, thus making it difficult for the physician to file a claim. These types of recoupments also should be handled between Medicaid and the insurer when a provider has provided the service in good faith and made reasonable attempt to determine if a party besides Medicaid was liable.				
Additional Stakeholder Background:	In further discussions with TMA, it was noted that this issue is also related to homeowner and auto insurance claims.				
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS /Coalition of Texans with Disabilities				
HHSC Response:	Medicaid CHIP Services (MCS) added information to the 834 Enrollment File and associated Capitation files in April, 2017 to confirm Managed Care Organizations (MCOs) are informed of members gained and lost (as well as of MCO enrollments gained and lost). Additionally, MCS instructed the Eligibility and Enrollment Workgroup to continue to evaluate cases to determine if ongoing systematic issues exist. Since the spring of 2017, MCS Program Enrollment and Support (PES) has worked with Access and Eligibility Services (AES) to				

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

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Provider Recoupment ongoing agenda item added to the Eligibility and Enrollment Workgroup	6/2018	Completed/ Other	
2	Add values to current interfaces to provide additional member information to MCOs.	4/2017	Complete	

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Agency/Division/Department:	HHSC FSD / CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X This recommendation is addressed through an existing process. See details below.	**Number:**	14
Recommendation:	Implement a provider type and specialty code for urgent care. Many PCPs cover urgent care centers in addition to operating their own practices. Without a separate provider type, it wreaks havoc with PCP assignments and makes it difficult to differentiate physician after-hours clinics from other facilities.				
Additional Stakeholder Background:					
Category:	Network adequacy / access to care				
Provided By:	TMA / TPS				
HHSC Response:	The Legislative Budget Board published a staff report on increasing access to urgent care providers and HHSC monitored to see if there would be legislative direction around this item. There was not legislative direction to add this new benefit. HHSC has an existing process for reviewing proposals for new or changes to existing Medicaid medical benefits. Stakeholders can submit a topic nomination form with evidence to support their request. Information about how to submit a topic nomination form can be found on the HHSC webpage: https://hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/medicaid-medical-dental-policies Once a topic nomination form is submitted, HHSC staff will research the request and present to a governance committee for review. The governance committee determines whether the proposal should be further reviewed to determine if it will become a Medicaid benefit. A fiscal estimate will need to be completed before a decision can be made to incorporate the proposal as a Medicaid benefit. If the fiscal estimate exceeds $500,000, the Legislative Budget Board will have to approve the funding associated with the policy proposal. Timeline is dependent upon prioritization within the medical policy review process.				
Date Last Updated:	12/12/2017				

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

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

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	15
Recommendation:	Add a feature to the TMHP and MCO fee schedules or policy manuals to determine any place of service or diagnosis restrictions (e.g., whether procedure can only be performed on an in-patient). Having a single place to look up such information will make it easier for physicians to abide by Medicaid utilization restrictions, which often vary from other payers.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	TMA / TPS				
HHSC Response:	HHSC researched options to provide the public with a more streamlined method for looking up FFS and MCO benefits and claims submissions. MCOs are required to disclose payment methodologies and fee schedules with contracted providers. Because MCOs may negotiate different rates with providers there is no standard fee schedule for each MCO. MCOs are required to post provider handbooks on their websites. For fee-for-service, providers can review the Texas Medicaid Provider Procedures Manual (TMPPM) for additional information on covered benefit. The FFS schedule is also available online at http://public.tmhp.com/FeeSchedules/.				
Date Last Updated:	12/12/2017				

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

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

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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 identify steps to be taken to encourage adoption of practices that reduce the administrative burden for, and encourage utilization of, providers that can show a history of proper utilization of medical services.				
Date Last Updated:	3/15/17				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Review contract and manual language to determine whether clarifications are needed to encourage this process.	9/30/2016	Completed	
2	Develop plan to address this recommendation.	3/1/2017	Completed	HHSC has developed new MCO contract language related to alternative payment models (APM) and APM targets for FY18. The new provisions categorize this kind of administrative relief (i.e. Gold Carding a provider) as an APM. This may have the effect of incentivizing more MCOs to explore this practice.

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Agency/Division/Department:	HHSC CPSCO MCS	**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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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, 2015 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 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 applied for a demonstration grant, but did not receive the grant. However, HHSC is exploring ways to leverage the processes and framework developed under the planning grant to potentially pilot innovative and effective care models (alternative payment model for integrated care (mental health, substance use disorder and primary care services), certification process for integrated care clinics, and use of measures and incentives to promote effective integrated care)

In 2014, HHSC initiated a contract provision into the managed care contracts that required MCOs to implement VBP models with providers and to submit to HHSC annual reports on their VBP activities. This began the process of "signaling" to the MCOs HHSC's interest in moving provider payments to VBP. This contract provision was augmented with one-on one "quality" meetings with MCOs. A priority topic for these web-based meetings was the identification of opportunity areas and barriers related to provider VBP. Data driven discussions related to MCO performance on key quality/efficiency metrics was woven into the discussions. If a MCO had positive trends for quality metrics, it led to discussion of clinical and/or payment models put in place which may have led to the positive trends. Conversely, if a MCO had negative trends on quality metrics, it became an opportunity to explore underlying reasons, and whether VBP could improve the trends. This framework, based on regular, *individual* interactions with MCOs centered on VBP and performance trends, leveraging existing publicly reported data, set expectations and provided a constructive forum for MCOs to more openly discuss their performance, as well as their VBP direction.

To continue this forward progress on MCO VBP efforts, HHSC is strengthening the 9/1/17 MCO contract requirements to include:

1. **Establishment of MCO VBP Targets:** Overall *and* Risk-Based VBP contractual targets based on MCO expenditures on VBP contracts relative to all medical expense. Each MCO's targets will begin for calendar year 2018, beginning at 25% of provider payments in Overall VBP and 10% of provider payments in Risk Based VBP. These targets will increase over four years to 50% overall VBP and 25% Risk-Based VBP in calendar year 2021. For Dental Managed Care Organizations (DMOs), these targets are set at 25% Overall VBP and 2% Risk Based VBP in 2018. The targets increase to 50% Overall VBP and 10% Risk Based VBP in 2021.

	2. **Requirements for MCOs to adequately resource this activity:** MCOs must dedicate sufficient resources for provider outreach and negotiation, assistance with data and/or report interpretation, and other collaborative activities to support VBP and provider improvement. 3. **Requirements for MCOs to establish and maintain data sharing processes with providers:** Requires data/report sharing between MCOs and providers. 4. **Requirements for MCOs to have a process in place to evaluate VBP models:** Requires that the MCO dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment.
Date Last Updated:	03/13/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	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.	12/1/15	Completed	
2	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	Completed	
3	MCOs will begin reporting Quality Improvement Costs to HHSC on their FSRs.	9/1/2016	Completed	
4	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.	10/1/16	Completed	

	In addition, the tracking tool used to capture and monitor MCO use of value-based payment models is being reviewed for revision to capture additional information.			
5	Demonstration Grant application due to CMS.	10/2016	Completed	
6	CMS notification of award to states.	12/2016	Completed	
7	Implementation (if awarded)	8/2017	Completed (not awarded)	HHSC has formed an internal workgroup to pursue the model absent the grant award. Several meetings have been held and a decision on whether this is feasible is forthcoming.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	23
Recommendation:	Promote adoption of innovative Medicaid delivery models, such as physician-led accountable care organizations or patient-centered medical homes, as well as value based purchasing initiatives, such as gain sharing, to reward physicians for improving Medicaid quality and reducing costs. At the recent Texas Medicaid Congress facilitated by TMA, several physicians noted they were interested in partnering with health plans to test new models of care, but either had no interest from the MCO(s) in their region or were unsure how to initiate the discussion. HHSC should facilitate efforts by physicians and MCOs to test new delivery system and payment models.				
Additional Stakeholder Background:					
Category:	Alternative Payment Mechanisms				
Provided By:	TMA / TPS				
HHSC Response:	For the past three fiscal years HHSC has incorporated contract provisions requiring MCOs to move down the path of value-based contracting with providers. Each MCO submits to HHSC an annual inventory of their value-based contracting initiatives with providers. This effort is further reinforced during quarterly one-on-one web-based meetings with MCOs where value-based payments are a standing agenda item. MCOs are also strongly encouraged to seek ways to evaluate and, if feasible, integrate high-value DSRIP projects into their networks. Based on the MCO deliverables, and through HHSC discussions with MCOs, there are observable increases in the numbers of providers who are being paid via such value-based contracting arrangements. HHSC has observed MCOs often tend to adopt HHSC's Pay-for-Quality Program measures for their value-based contracting with providers. HHSC is continuing to work with the MCOs to encourage the use of value-based purchasing with providers and has changed the MCO contracts for 9/1/17. These contract changes are described in response to item 22. The deliverable associated with the contract provision (MCO submitted tracking tool and narrative description of their payment models) has been modified to help ensure accurate data collection. This will further enable HHSC to track MCO progress in this area.				

	The value based purchasing (VBP) summary document for 2015 is posted on the VBP webpage: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement/value-based-payments. HHSC met with representatives from TMA and other providers regarding their interest in entering into value-based contracting relationships with MCOs for Medicaid and CHIP services. To help ensure that value-based contracting is occurring where feasible, HHSC will create and send out a broadcast communication to stakeholders regarding HHSC's support and direction of value-based contracting. This communication will include a dedicated email for inquiries from stakeholders. If inquiries related to unresponsiveness come in through the email, HHSC will reach out to the appropriate parties to help connect individual MCOs with interested providers. HHSC is also exploring data that could be added to the "data and reports" subpage of the quality website (https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement/data-and-reports) to assist providers in understanding where opportunities may exist in terms of quality improvement. As described in response to recommendation 22, HHSC is exploring more effective ways to recognize medical costs when setting MCO rates. This is an activity driven in part by CMS policy changes on what counts as administrative vs. medical costs. HHSC has established a Quality Improvement Cost Allocation workgroup, which is working on a two-year project with Medicaid and CHIP MCOs to integrate the new CMS guidance. This effort could support greater payment innovation by MCOs and healthcare providers. MCO contracts have been amended for FY 2017 to allow quality improvement costs to be recorded as medical expense. HHSC received funding through CMS and SAMHSA for a planning grant to establish a certification process for integrated care clinics (mental health, substance use disorder, and limited primary care), and develop a prospective payment model (e.g. bundled payment) to support innovative and effective service provision. HHSC did not receive the planning grant. However, HHSC is exploring ways to leverage the processes and framework developed under the planning grant to potentially pilot innovative and effective care and payment models (i.e. alternative payment model for integrated care (mental health, substance use disorder and primary care services), certification process for integrated care clinics, and use of measures and incentives to promote effective integrated care) On August 30, 2016, HHSC hosted the DSRIP statewide learning collaborative. A major theme of this learning collaborative was value-based contracting. HHSC facilitated a panel discussion on value-based contracting. One of the desired outcomes of this meeting was to communicate the types of information MCOs need to receive in

	evaluating their willingness to consider value-based contracting. This should be helpful for providers in making future proposals to MCOs. HHSC also developed a value based purchasing roadmap, which will organize all value based purchasing efforts into one document. This document is posted on HHSC's website: https://hhs.texas.gov/sites/default/files//documents/about-hhs/process-improvement/quality-efficiency-improvement/draft-texas-vbp-apm-roadmap-august-2017.pdf HHSC will continue this important work to increase value-based purchasing and quality initiatives and further updates can be found on the website address listed above.
Date Last Updated:	11/1/2018

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Develop new tracking tool (for MCO annual submissions).	7/31/2016	Completed	
2	Submit new tracking tool through internal channels for distribution to MCOs.	7/31/2016	Completed	
3	Additional data to website (if determined to be useful).	7/31/2016	Completed	
4	Communication to stakeholder (to include link to data on quality webpage and dedicated email box).	7/31/2016	Completed	
5	MCO submit data via new tool.	11/30/2016	Completed	
6	Initiate contract with University of Texas-Dell Medical School to work on an ongoing basis to Identify and evaluate VBP models for cost and quality outcomes.	5/1/2018	Completed	HHSC has engaged University of Texas-Dell Medical School (with funding by Episcopal Health Foundation) to assist HHSC with the activities listed below.

				• Review care delivery and evaluation experiences in other states to inform Texas efforts • Focused analysis of HHSC data to inform and provide a baseline for reform initiatives. Analysis would confirm areas of greatest opportunity for improvement through value-based care reforms • Organize and moderate a symposium with key stakeholders to review initial findings and develop possible next steps to strengthen the Texas Medicaid program • Propose alternative care/payment models and tools to support program improvement for HHSC consideration

Executive Commissioner's Commitment to
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Agency/Division/Department:	HHSC Ombudsman	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	24
Recommendation:	Improve consumer protections, assistance and ombudsman services. SB760 includes improvements, though short of what was originally envisioned, including more in-person services. Consider opportunities to leverage consolidation with DADS and the DADS Ombudsman program. Funding by MCOs—could be Medicaid reimbursable expenses?				
Additional Stakeholder Background:					
Category:	Service Coordination / Member Assistance				
Provided By:	Coalition of Texans with Disabilities				
HHSC Response:	HHSC is committed to ensuring clients receive the services they need and will certainly consider opportunities to leverage consolidation with DADS and the DADS Ombudsman program, as well as other options to serve this population. The HHS Ombudsman Managed Care Assistance Team is available to assist all clients enrolled in managed care that may be experiencing barriers to care. The State Long-Term Care Ombudsman is available for all clients residing in nursing homes and assisted-living facilities. The Office of the State Long-term Care Ombudsman became part of the HHS Office of the Ombudsman on September 1, 2017. SB 760, 84th Legislature, Regular Session, 2015, directs the HHS Office of the Ombudsman to coordinate a network of entities to provide support and information services to Medicaid managed care consumers. The Office of the Ombudsman has held 11 meetings of the "Managed Care Support Network" which includes HHSC staff that work with Medicaid eligibility, enrollment, and operations, the Long-Term Care Ombudsman, the Department of Family and Protective Services, Aging and Disability Resource Centers, Area Agencies on Aging, enrollment broker (MAXIMUS), and other representatives who interact regularly with consumers and families. Meetings include discussions to determine how to improve consumer protections and ombudsman services as well as how to enhance communication and collaboration among HHS entities that work with or are impacted by managed care. Several participating organizations give presentations to the network to provide members				

	with a better understanding of the work and challenges involved in supporting the delivery of Medicaid managed care services. The network established a contact within the agency that works with Social Security Administration staff. Issues that the network has addressed in the last year include: DMOs not accessing the authorized representative information for their members, organizations obtaining client eligibility information or enhancements to what they already receive, clients losing waiver services when transitioning from nursing facilities to the community, and children's files coming from SSA with no address or authorized representative, bills passed in the 85th Texas Legislative Session impacting Medicaid and CHIP clients, expansion of MBCC and Adoption Assistance into Managed Care, and access to care issues as the result of Hurricane Harvey. Participating organizations benefited from the increase in collaboration and communication among members, especially when reaching out for assistance in resolving managed care client issues.
Date Last Updated:	11/17/2017

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

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

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	25 / 34c / 67
Recommendation:	Expand home-based care for ventilator-dependent consumers. People with ventilators are at elevated risk for institutionalization. A potential pilot—designed by a person with vent assistance—can improve cost-effective independent living.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/9/2016. The recommendation was further explained to include the following recommendations: • Address direct care staff training needs related to the care of clinically complex and ventilator dependent individuals. • Request revisions to the state plan to allow access to in-home respiratory therapy services. • Include home health agencies in the home-based care for ventilator-dependent consumer discussions.				
Category:	Network Adequacy / Access to Care				
Provided By:	Coalition of Texans with Disabilities/ EveryChild, Inc./Texas Council for Developmental Disabilities/Arc of Texas/Disability Rights Texas				
HHSC Response:	HHSC is committed to ensuring individuals with ventilators are able to remain in the community successfully or are able to transition to the community if in a nursing facility. On 2/23/2016, HHSC convened a ventilator services workgroup of stakeholders, agency staff, and MCOs to explore options for addressing the needs of individuals with ventilators receiving Medicaid services, including individuals who are at an elevated risk of institutionalization. The workgroup will collaboratively address barriers to transitioning institutionalized members on vents to the community, finding community providers who are trained and available to deliver these services to community-based members and educating these providers and MCO service coordinators on these specialized services. On 3/21/2016, HHSC and DADS staff met internally to discuss and review materials submitted by community advocates after the 2/23/16 meeting with stakeholders.				

	On 4/18/2016, HHSC held a meeting with MCO workgroup participants to get feedback on the proposal submitted by stakeholders, give an update on the status of transitioning nursing facility residents into the community, and request MCOs send relevant current policies and procedures to HHSC. In May 2016, HHSC Utilization Review nurses began a targeted review of service plans and service provision for ventilator dependent residents residing in the community. In June 2016, HHSC Utilization Review completed the targeted review of ventilator-dependent individuals and provided findings to each of the MCOs. On July 14, 2016, HHSC reconvened the interdisciplinary ventilator workgroup comprised of external stakeholders, state staff, and the managed care organizations (MCO). The MCOs reviewed portions of a combined ventilator PowerPoint presentation that provided high-level details on their processes for managing clinically complex individuals. On August 5, 2016, HHSC met with the Texas Association for Home Care and Hospice to discuss transitioning ventilator-dependent individuals to the community. On October 13, 2016 the MCOs provided an update on all ventilator-dependent members who transitioned from the nursing facility to the community in SFY 16. HHSC will continue to explore opportunities for improving and enhancing care for ventilator-dependent members.
Date Last Updated:	11/17/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Initial meeting of Ventilator Services Workgroup, (includes agency staff, MCOs, and external stakeholders).	2/23/16	Completed	

2	Internal agency workgroup meeting.	3/21/16	Completed	
3	Meeting with MCO Service Coordinators.	4/18/16	Completed	
4	Conference call with MCO Service Coordinators.	6/15/16	Completed	
5	Meeting with Ventilator Services Workgroup.	7/14/16	Completed	
6	Follow-Up conference call with MCOs.	9/19/16	Completed	
7	Quarterly Ventilator Services Workgroup.	10/13/16	Completed	
8	MCOs to provide a presentation on ventilator services to the Promoting Independence Advisory Council (PIAC).	1/19/2017	Postponed/ Completed	The meeting exceeded the scheduled time and concluded prior to the MCOs presentation.
9	Meeting with the Coalition of Texans with Disabilities and staffer from Rep. C. Turner's office	12/7/2016	Completed	
10	MCO Service Coordinator Quarterly Report of ventilator-dependent nursing facility members	1/13/2017	Cancelled	Stakeholders agreed to receive updated ventilator information during the PIAC meeting scheduled Jan 19.
11	MCO Service Coordinator Quarterly Report of ventilator-dependent nursing facility members	1/13/2017	Completed	
12	A copy of the MCO Ventilator Care Services PPT provided to the PIAC Stakeholders	1/1/2017	Completed	
13	Update to PIAC on the number of STAR+PLUS and nursing facility ventilator dependent members.	1/19/2017	Completed	
14	Meeting with Tennessee's TennCare Program Representatives	2/27/2017	Completed	
15	Review of the STAR+PLUS MCOs managing complex medical needs hospital transition team policies.	3/31/2017	Completed	
16	Quarterly Ventilator Services Workgroup	4/18/2017	Cancelled	No stakeholder updates; meeting cancelled
17	Update to PIAC on the number of STAR+PLUS community and nursing facility ventilator dependent members.	4/25/2017	Completed	
19	MCOs to provide updates on all NF ventilator dependent members.	7/17/2017	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**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:	Children's Hospital Association of Texas (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				

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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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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: https://hhs.texas.gov/services/health/medicaid-and-chip/about-medicaid/draft-medicaid-medical-and-dental-policies. HHSC received feedback from stakeholders on the proposed policy and reviewed all comments. Stakeholders requested that HHSC consider extending the delegation to include postdoctoral fellows, as this would align with the occupational code. This is part of the outpatient behavioral health policy that will be implemented January 2017. A rate hearing will be required to implement the policy changes.				
Date Last Updated:	02/02/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Finalize fiscal analysis.	TBD	Completed	
2	Schedule briefing with leadership.	TBD	Completed	
3	Conduct rate hearing.	11/16/2016	Completed	
4	Policy Implemented	01/01/17	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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: https://hhs.texas.gov/services/health/medicaid-and-chip/about-medicaid/draft-medicaid-medical-and-dental-policies. HHSC received feedback from stakeholders on the proposed policy and reviewed all comments. This is part of the outpatient behavioral health policy that will be implemented January 2017. A rate hearing will be required to implement the policy changes.				
Date Last Updated:	02/02/2017				

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

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

3	Conduct rate hearing.	11/16/2016	Complete	
4	Policy Implemented	01/01/17	Complete	

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Agency/Division/Department:	HHSC CPSCO MCS	**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.				

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	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/Department:	HHSC CPSCO MCS	**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				

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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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**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:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/9/2016. The representatives provided feedback that although the HHSC response is appreciated, it does not address the recommendation to implement peer support services as a Medicaid paid benefit for people with developmental disabilities.				
Category:	Benefits				
Provided By:	Disability Rights Texas/TMA/TPS/Hogg Mental Health Foundation				
HHSC Response:	HHSC and the Office of Mental Health Coordination staff, with input from stakeholders, drafted an exceptional item for leadership consideration that would add peer support services to the Medicaid program. Due to competing budgetary priorities and budget constraints facing the state at this time, peer support services was not included in the HHSC legislative appropriations request for fiscal years 2018-19. Staff will pursue the recommendation that peer support services be a Medicaid benefit if directed by the 85th legislature to do so.				
Date Last Updated:	03/08/2017				

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Improving Member and Provider Experience in Medicaid Managed Care

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.	9/30/2016	Completed	Completed as part of LAR process.
2	Review recommendation related to peer supports for individuals with developmental disabilities and consider next steps.	3/08/17	Completed	Staff will pursue the recommendation that peer support services be a Medicaid benefit if directed by the 85th legislature to do so.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	34a / 67
Recommendation:	Improve access to services in the community and MCO transition planning. HHSC and its managed care contractors must ensure individuals have the support needed to successfully plan and access services for individuals with complex medical, physical and psychiatric needs in the community. Early selection of an MCO and MCO involvement in service/discharge planning will ensure timely and successful transitions/diversions for those in or at risk of institutional placement and improve MCO enrollment of individuals with complex needs from the community interest lists. MEPD involvement and MCO enrollment and service planning will ensure that switching from institutional to community Medicaid and into managed care can be accomplished without delay or complexity.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, The Arc of Texas, and Disability Rights Texas on 8/12/2016. The representatives provided feedback that the response to this issue should go beyond the handbook, and that ongoing systematic training for services coordinators is needed. In addition, it was suggested that this training be developed outside of HHSC by individuals with experience helping children transition from nursing facilities.				
Category:	Service Coordination / Member Assistance				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas/ Disability Rights Texas				
HHSC Response:	HHSC is working to clarify and strengthen requirements of service coordinators, particularly in the transition to community. HHSC is updating the managed care requirements and improving language in the STAR+PLUS Handbook about the role and responsibilities of a service coordinator. All members enrolled in the STAR Kids managed care program have access to service coordination. The STAR Kids service coordinator is expected to assist the individual in locating and coordinating all Medicaid acute care and long term services and supports. This includes coordination to facilitate a smooth transition from an institutional setting to the community. The STAR Kids program also includes extensive requirements regarding transition planning for children aging out of STAR Kids into STAR+PLUS. The STAR+PLUS Handbook was revised to make HHSC expectations for MCO service coordinators and their responsibilities for members in a nursing facility and other programs (e.g., intellectual and developmental disability (IDD) waivers and 1915(i)) clear. STAR+PLUS contract changes effective 9/1/16 include additional required service coordination training and assessment requirements regarding a member's change in condition and MCO responsibilities for reassessment and authorization of additional services. The STAR Kids contract				

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

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	STAR+PLUS Handbook Update.	9/01/17	Completed	
2	STAR+PLUS Contract Changes.	9/01/2016	Completed	
3	Begin transition workgroup.	Fall 2016	Completed	
4	STAR Kids Handbook Published and Effective.	11/01/2016	Completed	
5	STAR Kids Contract Effective.	11/01/2016	Completed	

6	Ongoing workgroup	Continues until complete	Completed	HHSC is addressing systematic barriers faced by MCOs and their members. Following the clarification of expectations for transitions from facilities to the community, particularly transitions from a facility to a community in which the MCO does not operate, HHSC will address transitions from facilities other than nursing facilities and transitions to programs other than STAR+PLUS HCBS. This work is ongoing and includes MCOs, state staff, and community organizations.

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

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

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

	concept, draft proposal to estimate rates and other aspects of feasibility.			

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	34 d / 100 / 101
Recommendation:	Efforts to educate TMA and other organizations representing acute care providers regarding the transition of IDD services into the Texas Medicaid managed care system need to be initiated or, if already initiated, intensified. This includes ensuring: - Those organizations educate their respective members about the IDD population, - Acute care providers understand their respective responsibilities in providing medical and other health-related care and services under the Texas Medicaid Managed Care program, and - HHSC responds to acute care providers' concerns about the Texas Medicaid managed care system which many cite as their reasons for either refusing or terminating their 'relationships' with MCOs (concerns such as increased administrative requirements not experienced under 'traditional' Medicaid and reported billing and payment issues). Also conduct additional training for all affected stakeholders (MCOs, MCO SCs, LTSS IDD providers, and individuals with IDD receiving services (either acute care only or other services, specifically CFC) through STAR+PLUS and their LARs or families, Local IDD Authorities) to include: Further training related to the roles and responsibilities of the MCOs, LIDDAs and LTSS under managed care, and Communication of changes to processes to affected stakeholders. Note: Use of complaint data related to IDD service-related issues might be helpful in identifying topics that would be beneficial to include in any training as well as issues raised in various agency workgroup meetings in which IDD-related issues are discussed.				
Additional Background:					
Category:	Stakeholder engagement and feedback				
Provided By:	PPAT / EveryChild, Inc. / Texas Council for Developmental Disabilities / The Arc of Texas				
HHSC Response:	While HHSC makes every effort to inform and include organizations and providers on forums, councils and workgroups, we are always interested in ways we might enhance outreach and education.				

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

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Improving Member and Provider Experience in Medicaid Managed Care

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 requested feedback regarding survey criteria from Transition to Managed Care SRAC Subcommittee meeting in August 2016.	8/2/2017	Completed	
6	HHSC Quality Assurance will review the feedback from the subcommittee and develop possible solutions to survey individuals with IDD and family members.	10/3/17	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	34e / 67
Recommendation:	Enhance service coordination. Enhanced service coordination; enhanced medical/nurse coordination and supervision; and coordination and communication between acute and community care providers including transparency regarding assessments and authorization/denial of services. Identify, if needed, a complex care unit/swat (statewide or regional) team to best facilitate transitions between settings; between MCOs/MCO contract areas, or to address unusual chronic needs and prevent health care or other crises.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, The Arc of Texas, and Disability Rights Texas on 8/12/2016. The representatives provided feedback that stakeholders need to be more involved with this process, that transitions between settings are not adequately addressed, and that there needs to be greater transparency of assessments and denials based on assessments need review.				
Category:	Service Coordination / Member Assistance				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas/ Disability Rights Texas				
HHSC Response:	HHSC is working to clarify and strengthen requirements of service coordinators, particularly in the transition to community. HHSC is updating the managed care requirements and improving language in the STAR+PLUS Handbook about the role and responsibilities of a service coordinator. All members enrolled in the STAR Kids managed care program will have access to service coordination. The STAR Kids service coordinators are expected to assist the individual in locating and coordinating all Medicaid acute care and long term services and supports, which includes coordination to facilitate a smooth transition from an institutional setting to the community. The STAR Kids program will also include extensive requirements regarding transition planning for children aging out of STAR Kids into STAR+PLUS. The STAR+PLUS Handbook changes regarding expectations for members in a nursing facility and other programs (e.g. IDD waivers and 1915(i)) have been made. STAR+PLUS contract changes effective 9/1/16 included additional required service coordination training and assessment requirements regarding a member's change in condition. HHSC encourages contracted MCOs to develop innovative solutions to issues with care, such as transitions from facilities to the community or between MCOs. Requiring certain innovations, such as a complex care unit,				

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

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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.	3/01/17	Completed	The STAR+PLUS Handbook moved to biannual updates. As a result, this item was not updated. HHSC is aiming for a 3/1 effective date.
2	STAR+PLUS Contract Changes.	9/01/2016	Completed	
3	Begin transition workgroup.	Fall 2016	Completed	
4	STAR Kids Handbook Published and Effective.	11/01/2016	Completed	
5	STAR Kids Contract Effective.	11/01/2016	Completed	
6	Ongoing workgroup		Completed	This work is ongoing and includes MCOs, state staff, and community organizations.
7	Transparency and access to assessments		Completed	Assessments range from 1 to up to 60 pages. Systems changes to post assessments to a portal or printing/faxing/emailing assessments have costs not currently included in MCO capitation. HHSC continues to work with MCOs to enhance MCO systems over time to address this concern without requiring additional appropriations. MCOs will identify changes that can be made at no cost to address this concern. HHSC continues to explore additional requirements related to service coordination.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**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. This item will be closed until further information is received.				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Obtain examples from TMA/TPS of this issue occurring.	8/1/2016	In Progress	TMA will revisit this issue and the others submitted at their annual meeting in the fall to determine if these issues have been resolved since they were originally submitted, and to identify the issues that are highest priority to address.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	39
Recommendation:	Ensure that Texas enforces mental health parity, allowing individuals receiving Medicaid managed care services to access needed mental health treatment. Initial steps could include increased monitoring of MCO activity, educating plan members on mental health parity, and ensuring parity complaints receive priority attention. Millions of Texans currently have private health insurance either through their employer or self-funded plans. According to the Mental Health Parity and Addictions Equity Act of 2008 (MHPAEA), these individuals are guaranteed access to the mental health and substance use disorder benefits at the same level as medical and surgical benefits. However, many individuals find themselves facing barriers to treatment including caps on the quantity of treatment, high copays, or separate deductibles for people seeking mental health treatment. According to the Department of Labor, to date, the U.S. government has not taken a single public enforcement action against an insurer or employer for violating the laws established through MHPAEA.				
Additional Stakeholder Background:					
Category:	Benefits				
Provided By:	Hogg Foundation for Mental Health				
HHSC Response:	The 2016 federal regulations require that mental health parity apply to Medicaid MCOs to ensure that financial requirements (such as co-pays and deductibles), non-quantitative limits (such as prior authorization), and quantitative treatment limitations (number of treatments allowed) for mental health or substance use disorder (MH/SUD) benefits are generally no more restrictive than requirements or limitations applied to medical and surgical benefits. Parity between MH/SUD and medical/surgical benefits occurs within each of the four classifications specified by CMS (inpatient, outpatient, emergency services, and pharmacy) and not at the individual benefit level. HHSC currently requires in its contract that all MCOs comply with all applicable parity regulations. CMS issued regulations on March 29, 2016, providing guidance to the Medicaid program about implementing and monitoring MHPAEA. The Centers for Medicare and Medicaid Services granted Texas an extension of its parity compliance to December 2, 2017. HHSC has conducted a full analysis its Medicaid and CHIP program for parity and as required by regulation, submitted documentation to CMS and posted on its state Medicaid website required information. HHSC has updated the managed care contracts requiring MCOs to comply with parity				

	requirements and to provide HHSC with all required information for it to conduct the parity analysis. HHSC continues to engage stakeholders updates regarding compliance with the federal rules.
Date Last Updated:	11/1/2018

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

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

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	40
Recommendation:	Ensure full access to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The EPSDT mandate ensures for the provision of screening, diagnosis, and treatment. While individual state Medicaid programs may place a limitation on the number of treatment sessions provided annually, they also include—for most part—exceptions processes to address those medically necessary services that require treatment beyond the stated limitation caps. HHSC should be sure to monitor such limits to ensure the children covered under MCOs have full access to EPSDT mandated services as stipulated in the Texas Medicaid Manual.				
Additional Stakeholder Background:	This issue was discussed in a meeting with TSHA on 8/16/2016, and it was clarified that this issue specifically relates to MCO compliance with HHSC medical policy regarding the amount, duration, and scope of treatment provided by the MCOs. TSHA believes some MCOs are not following the medical policy outlined in the Texas Medicaid Provider Procedure Manual.				
Category:	Benefits				
Provided By:	TSHA				
HHSC Response:	MCOs are required to provide EPSDT services (also known as THSteps in Texas) to all members 0 through 20 years of age, including all services in the TMPPM (See UMCC 8.1.3.2). EPSDT mandated services are stipulated in Medicaid policy and the Texas Medicaid Provider Procedures Manual. MCOs must provide services in the same amount, duration, and scope as those services are offered in Traditional Medicaid. To help address potential inconsistencies between MCOs, HHSC will issue policy guidance in the Uniform Managed Care Manual, effective 9/1/17, to provide additional definition and clarification around HHSC's expectations for amount, duration, and scope. HHSC will also continue to monitor and address provider and member complaints related to this issue through its established complaint resolution processes.				
Date Last Updated:	03/20/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HHSC will 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.	05/31/2017	On target	HHSC continues to review examples and working with MCOs to determine the processes they used and next steps.

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	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. If this is still an issue, please submit additional managed care examples to HPM_Complaints@hhsc.state.tx.us so that the issues can be tracked and HHSC can work with the appropriate MCO to resolve this issue.				
Date Last Updated:	11/1/2018				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Request examples from CHAT.	6/1/2016	Completed	
2	Review additional examples to determine issue.	4/1/2017	Completed	Staff continue to research examples provided. Most examples were fee-for- service and not Managed Care claims.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: X In Progress: 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, 2015 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. Examples were received and reviewed by staff. From the examples provided, it was seen in many cases the process took fewer than 30 days. This issue was reviewed and it was determined that the current requirement to process within 60 days would remain.				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Obtain examples from CHAT of this issue occurring.	7/31/2016	Completed	

2	HHSC review the examples, reach out to health plans to obtain additional information, and determine root cause of issue.	11/1/2016	Completed	
3	Develop recommended solution.	2/1/2017	NA	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: X In Progress: 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 coordinated with CHAT to understand the specifics of the reported issue. The examples provided by CHAT were reviewed and it was determined that there may be legitimate reasons for varying denials codes as there may be more than one denial code. It was determined that no change would be made for this item, and this item is now closed.				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Request examples from CHAT of this having occurred.	6/1/2016	Completed	
2	Review examples to determine issue.	11/1/2016	Completed	Examples received. Staff reviewed and determined no action will be taken.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**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, 2015 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. This item will be closed until further information is received.				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Reach out to TMA/TPS	8/1/2016	Completed	TMA will revisit this issue and the others submitted at their annual meeting in the fall to determine if these issues have been resolved since they were originally submitted, and to identify the issues that are highest priority to address.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**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. This item will be closed until further information is received.				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Request examples from TMA and TPS.	7/1/2016	Completed	
2	Obtain examples of this issue occurring.	TBD	Pending	TMA will revisit this issue and the others submitted at their annual meeting in the fall to determine if these issues have been resolved since they were originally submitted, and to identify the issues that are highest priority to address.

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Agency/Division/Department:	HHSC CPSCO MCS	**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.				

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	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

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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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.				

	Based on review of operational procedures for reporting missed appointments utilized by the DMOs and THSteps, it was determined that existing procedures are adequate to address this concern. Missed appointments are of concern to dental as well as medical providers. For members who miss appointments, often there are factors such as lack of transportation or child care that interfere with a member's ability to keep appointments. The responsibility to manage their personal medical appointments ultimately rests with the member. In lieu of implementing tracking and reporting that could represent an additional administrative burden on providers, HHSC recommends that providers actively utilize the following options to address this concern: • Notify the member's dental plan of members who regularly miss appointments. The dental plan's Member Services department can assist with member education and case management, including coordinating travel arrangements. • Notify the Texas Health Steps Outreach and Informing Unit of Texas Health Steps patients who miss appointments, need help scheduling appointments, or coordinating transportation. Providers can contact Texas Health Steps at 1-877-THSteps (847-8377) or submit a referral at this website: http://www.dshs.texas.gov/thsteps/POR.shtm • Promote awareness among patients of the Medicaid Transportation Program (MTP). This program provides free transportation for Texas Health Steps patients and most others who use Medicaid medical and dental services. Providers and patients can obtain information about MTP at 1-877-633-8747 or www.hhsc.state.tx.us/medicaid/mtp/. MTP also provides educational materials such as posters that providers can use in-office to promote patient awareness of the program. • Help patients understand the importance of keeping scheduled appointments, and send timely reminders of upcoming appointments.
Date Last Updated:	3/7/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Research THSteps Outreach & Informing Unit policies and procedures.	3/7/17	Completed	

2	Based on results of research, review DMO operational procedures by DMOs to determine if procedures can be refined further.	3/7/17	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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 staff reviewed this issue and determined that the authorized representative is currently shared with DMOs. HHSC will review the process of sharing names of authorized representatives to identify areas where changes can be made to improve the process. HHSC received feedback from the Texas Dental Association that there are not specific examples available, but that providers have given feedback that this issue is occurring. HHSC reviewed this issue and identified system changes that may be impacting the transfer of this information. These issues were addressed and resolved and this should improve the transfer of data. However, the SSI file will continue to override any information in the authorized user field as this is considered more accurate. This is the one situation in which the authorized representative designated in TIERS may not be transferred.				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Obtain examples from Texas Dental Association of this issue occurring.	8/1/2016	Complete	
2	Further explore system processes to confirm that information is transferring to DMOs as expected.	12/1/2016	Completed	
3	Develop recommended solution based on system information received.	1/1/2017	Completed	
4	Modify system to address issues of data transfer.	3/1/2017	Completed	

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

	portals to share assessment information outside of a request from a member will require additional funding in MCO rates.
Date Last Updated:	11/8/2017

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

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

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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:	5/4/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Develop and send survey to MCOs and TAHP.	12/1/2016	Completed	
2	Compile and follow-up as needed on survey responses.	2/1/2016	Completed	
3	Research possible solutions resulting from survey responses in consultation with TAHP.	3/31/2017	Completed	HHSC distributed a survey to MCOs, TAHP, and provider groups regarding value based purchasing and associated activities, to include data sharing. The survey closed 3/31/17 and the results are being collated. Prior to

				the survey, HHSC has been working on MCO contract language for value based contracting to include the activity of data sharing between MCOs and providers. See milestone #4 below.
4	Amend MCO contracts to include provisions for data sharing between MCOs and physicians (as well as other providers) that are operating under an alternative payment model	3/15/17	Complete	FY18 MCO contracts have been amended to include a requirement for MCOs to share data.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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 propose a contract amendment to address this recommendation.				
Date Last Updated:	03/12/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Develop a proposed amendment for the managed care contracts including the proposed requirement.	9/9/2016	Completed	
2	Contract change reviewed by MCOs.	10/4/2016	On Target	
3	Contract change submitted to CMS for review.	Winter 2016	On Target	
4	Contract change effective.	3/1/2017	Complete	The contract change requires any MCO to notify a provider in writing within five days of a change to a designated provider relations representative, including the name and contact information of the new representative.

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Agency/Division/Department:	HHSC CPSCO MCS	**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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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. In addition, the Uniform Managed Care Contract was amended to make clear that the MCO must provide a provider portal that supports functionality to reduce administrative burden on Network Providers at no cost to the Providers and functionality must include the following: • Client eligibility verification • Submission of electronic claims • Prior Authorization requests • Claims appeals and reconsiderations • Exchange of clinical data and other documentation necessary for prior authorization and claim processing				
Date Last Updated:	3/9/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Schedule meeting with Acadian Ambulance Service of Texas.	8/1/2016	Complete	Meeting occurred on 9/28/2016.
2	Determine next steps.	12/1/2016	Complete	

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Agency/Division/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	55
Recommendation:	Require that the DMOs adhere to the main dentist model as defined in rule and in contract. Despite the clear definition and contract expectations for main dentists, the dental managed care organizations are allowing dentist providers to be credentialed an unlimited number of dental office locations thereby showing certain dentists credentialed at locations in which they have never stepped foot in the office. This out-of-control credentialing not only highly misleads clients searching for a main dentist, but corrupts the automated dental home assignment process used by the DMOs in situations where the client has not self-selected a main dentist. Certain dental practices receive an unfair advantage in the assignment process because it appears they have dentists practicing at locations in which those dentists are not really practicing.				
Additional Stakeholder Background:	In March 2012, the state began using the main dentist model for delivering dental care. Under this model, the main dental home provider supports the ongoing relationship with the client including all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. As the coordinator of a child's dental care, the main dental home provider also coordinates referrals to dental specialists. HHSC must require that the DMOs adhere to the main dentist model as defined in rule and in contract.				
Category:	Contract Provisions				
Provided By:	Texas Dental Association				
HHSC Response:	HHSC conducts provider directory verification for the DMOs on a quarterly basis to identify inaccurate directory listings. HHSC may review DMO directory listings and request additional information from DMOs regarding credentialing practices and network adequacy as needed. Additionally, both DMOs regularly monitor network rosters for accuracy, contact providers to validate provider network rosters, and monitor claims activity to identify inactive providers. Monitoring of provider networks and the accuracy of provider directories are also topics under active review with the SB 760 workgroup. HHSC convened a main dental home workgroup of dentists, the Texas Dental Association, and the DMOs to review HHSC's main dental home policy and related procedures. As a result of this workgroup, the current procedures for member assignment will remain in place. However, additional clarification of operational procedures will be added to the UMCM. HHSC has implemented, for a limited time, monitoring of main dental				

	home changes as reported by the DMOs to better identify trends and patterns that may require additional attention. Because TMHP does not limit the number of locations for which a dental practice can enroll in Medicaid, the DMOs may credential providers at those locations for which they are enrolled in Medicaid. Some providers have a need to be affiliated with multiple locations, such as traveling providers. Providers hold the ultimate responsibility for ensuring that their directory listings with TMHP and HHSC are accurate, and for notifying the DMOs if they are no longer active providers. In addition, DMOs actively review their rosters for inactive provider locations with no claims activity and follow up with providers to ensure rosters are as accurate as possible. Providers may be listed at four locations in the DMO provider directories.
Date Last Updated:	4/24/2019

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Main dental home workgroup meeting.	February 2016	Completed	
2	Implement monitoring tools for main dental home changes.	Spring 2016	Completed	
3	Complete monitoring of main dental home changes.	September 2017	Completed	
4	Clarification of main dental home operational procedures added to UMCM		Closed	Further research indicates that amending the UMCM is not the most appropriate format to address this concern about provider credentialing. In addition, there is a need to maintain provider access points for members to access care. HHSC will focus on increased oversight at this time.

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Agency/Division/Department:	HHSC CPSCO MCS	**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 Children's Health Insurance Program (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.				

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	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

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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	57
Recommendation:	Require that the dental maintenance organizations (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 fee-for-service (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/Department:	HHSC CPSCO MCS	**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

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/Department:	HHSC CPSCO MCS	**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 measures for 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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	61
Recommendation:	Improve accuracy of eligibility data communicated between TMHP and MCOs. More up to date eligibility determination between TMHP and Managed Care Plans. We encounter issues where Managed Care plans have delays in uploading the State eligibility files, which cause erroneous denials related to eligibility. If Managed Care Plans were capturing eligibility timely it would prevent delays in payment. This may also cause issues if a patient has switched plans and the possibility of their treatment not being reported timely could cause delays in the family receiving other benefits, such as TANF, etc.				
Additional Stakeholder Background:					
Category:	Claims				
Provided By:	CHAT				
HHSC Response:	MCOs are contractually required to upload eligibility files in a timely manner. HHSC requested examples of this occurring from CHAT and will work to address issues using these examples. In reviewing the examples provided, it was determined that one solution to address this issue would be to institute a daily transfer of information (daily file) from the enrollment broker to the MCO for all members. This is currently in place for members in STAR Kids, STAR+PLUS, STAR Health, and pregnant women and newborns within STAR. HHSC explored the feasibility of implementing this for the remaining members of the STAR program, and determined that this would be feasible. A plan to implement this in 2018 is underway. Providers can stay informed about further progress on this effort through communication with managed care organizations.				
Date Last Updated:	11/2/2017				

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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	Obtain examples from CHAT of this issue occurring.	8/1/2016	Completed	
2	HHSC review the examples, reach out to health plans to obtain additional information, and determine root cause of issue.	11/1/2016	Completed	Examples received and staff currently reviewing to determine next steps.
3	Develop recommended solution.	2/1/2017	Completed	
4	Determine feasibility of implementing daily file for remaining members of STAR program.	12/1/2017	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	62 a-c / 63 / 64
Recommendation:	Require (or strongly encourage) MCOs, LTSS providers and other persons/entities/organizations which interface with individuals (or their LAR, families, etc.) receiving care/services via the Medicaid managed care program to share and review the process for submitting a complaint with individuals, LARs and families and, perhaps on an annual basis, require MCOs to remind their members of the process. Although HHSC and DADS recently disseminated the process for submitting a complaint to those who receive DADS and HHSC communications, many stakeholders still do not subscribe to these communications or even know they can. Many also still have no access to a computer, and many do not feel comfortable asking the MCO how to submit a complaint or even filing one if they do know how to submit a complaint for fear of some form of retaliation. Clarify the differences between filing a complaint via the HPM Complaint email box, the Ombudsman or online form for reporting to the Ombudsman and sending an email to contact@hhsc.state.tx.us (an option noted when one clicks on the link to the ombudsman form) and inform stakeholders. Note: Some stakeholders have been told any of the 3 options can be used to submit a complaint about the Medicaid managed care program. Consider consolidating the 3 options if no distinct differences exist. Consider offering persons who access the HHSC complaint email box the option to either send their complaint via email or use a form similar to the Ombudsman online form. The form should be revised to include a question as to whether the issue pertains to an MCO, and if so, which one, as well as a question that asks the person to identify if the issue pertains to a person in a nursing facility, a person with IDD, etc.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with PPAT on 8/8/2016 and it was noted that families need more information about how to file a complaint and information provided should address family concerns about retaliation.				
Category:	Service Coordination / Member Assistance				
Provided By:	PPAT				
HHSC Response:	HHSC HPM realizes the importance of the services being provided to customers and is committed to providing as many options as possible to file complaints and inquiries regarding Medicaid Managed Care. HHSC HPM and the Office of the Ombudsman work closely to resolve all reported issues. Both areas receive inquiries from Medicaid members and contracted providers. However, the Office of the Ombudsman mainly receives member				

	initiated complaints, while HHSC HPM receives complaints from both members and providers. Member and Provider manuals include detailed information on how to file a complaint and appeal. Clients and providers can submit their complaints through all available avenues and should feel confident that their issue will be routed to the appropriate responder in a confidential and secure manner. Current processes include a tracking number, receive dates, due dates, resolved dates, trending and analysis for global and isolated issues, and collaboration with program staff. Complaint data is reported daily and analyzed quarterly unless otherwise specified by leadership or due to a project need. The HHS Ombudsman Managed Care Assistance Team coordinates resolution of managed care inquiries and complaints received by the Office of the Ombudsman. The Office of the Ombudsman has held 11 meetings of the "Managed Care Support Network" that includes HHSC, staff that work with Medicaid eligibility, enrollment, and operations, the Department of Family and Protective Services, Aging and Disability Resource Centers, Area Agency on Aging, enrollment broker (MAXIMUS), and other representatives who interact regularly with consumers and families to provide support and information services to Medicaid managed care consumers. HHSC HPM coordinates with members, providers, other internal staff, stakeholders, and MCOs to review trends, issues, and resolution of inquiries and complaints received. HHSC HPM also makes recommendations to the HHSC HPM Teams and management regarding remedies and corrective action for egregious cases. MCOs who retaliate against members are in violation of their contract (UMCC section 8.2.6.1) and HHSC HPM can place the MCO on Corrective Action Plans, as well as administer monetary sanctions for any violation of the contract. Allegations of any discriminatory or punitive action against a complainant are entered in the HHS Enterprise Administrative Reporting and Tracking system (HEART); and researched by HHSC HPM, HHSC Medicaid CHIP Policy and potentially HHSC Legal. The reference to the Contact@hhsc.state.tx.us" email address has been removed from the agency's website. To report complaints to HHSC, consumers should call the HHS Office of the Ombudsman or make an online submission at https://hhs.texas.gov/ombudsman . Providers can submit complaints to HPM_complaints@hhsc.state.tx.us The HHSC/DADS Long-Term Care Ombudsman has requested nursing facility specific data from the MCOs on a monthly basis to determine the types, as well as the volume, of complaints received related to nursing facility members.

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	HHSC/DADS/Office of Ombudsman coordinated with stakeholder groups to create flyers for clients that include a simple explanation of the complaint process and list the most critical numbers to call for health and emergencies. HHSC staff also participate in monthly coordination meetings with the Office of the Ombudsman to ensure member needs are met. HHSC HPM will determine the feasibility of implementing an electronic form for complaints submission.
Date Last Updated:	11/17/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HPM participate in quarterly IDD Quality Subcommittee.	4/11/2016	Completed	
2	HPM participate in quarterly IDD Quality Subcommittee.	9/29/2016	Ongoing	
3	HPM participate in Texas Consumer Direction committee	02/28/2017	Completed	HPM presented the complaints process to the group.
4	Host first meeting of Managed Care Support Network authorized by SB 760 SECTION 3 (including the Long-term Care Ombudsman, 17 other HHS offices and three other state agencies).	5/19/16	Completed	
5	Second meeting of the Network.	6/16/16	Completed	
6	Outreach meetings with community organizations assisting Medicaid managed care clients.	Ongoing	Ongoing	

7	Create consumer-friendly outreach materials that can be shared with Medicaid managed care clients.	7/1/16	Completed	
8	Update UMCM with related changes.	1/04/2017	Completed	
9	Internal document created identifying appropriate program areas to funnel complaints.	7/22/15	Completed	
10	Review of MCO complaint and appeals data from nursing facility residents.	10/15/2016	Completed	Webinar with the MCOs, to discuss the requirements of the data, was held on 09/07/2016. All appropriate MCOs were present.
11	Regular coordination meeting between MCS HPM staff and HHS Office of the Ombudsman.	Ongoing	Ongoing	
12	Meeting to review complaints reported to HPM teams on a quarterly basis, focusing on any specific trends that are noticed.	Next meeting March 2017	Completed and Ongoing	Detailed complaint trends were discussed with all internal areas in August 2016, for all MCOs and DMOs.
13	Hosted third meeting of the Managed Care Support Network	7/21/16	Completed	
14	Hosted fourth meeting of the Managed Care Support Network	8/25/16	Completed	
15	Hosted fifth meeting of the Managed Care Support Network	9/22/16	Completed	
16	Hosted sixth meeting of the Managed Care Support Network	10/20/16	Completed	
17	Hosted seventh meeting of the Managed Care Support Network	11/17/16	Completed	
18	Hosted eighth meeting of the Managed Care Support Network	12/29/16	Completed	
19	Continue to host ongoing meetings of the Managed Care Support Network		Completed	The network has been established and continues to meet on a regular basis.

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Agency/Division/Department:	HHSC Ombudsman / CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	65 / 66
Recommendation:	Ensure independent ombudsmen are available for people experiencing barriers to accessing managed care services. The complaint system should be improved to ensure consumer complaints are documented and addressed timely and appropriately. Consumers and representatives have many ongoing burdens which preclude them from repeatedly seeking responses to complaints. The complaint system should funnel complaints to a proper channel so consumers and representatives do not have to repeatedly seek help for specific issues.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/9/2016. These representatives suggested that the ombudsman consider hiring an individual with a developmental disability to help present the material to individuals with DD and to test materials in an effort to improve communication. There were concerns shared about the service coordination workgroup activities and inclusion of DD advocates in those meetings.				
Category:	Service Coordination / Member Assistance				
Provided By:	Disability Rights Texas/ EveryChild, Inc./Texas Council for Developmental Disabilities/The Arc of Texas				
HHSC Response:	The HHS Ombudsman Managed Care Assistance Team is available to assist all clients enrolled in managed care that may be experiencing barriers to care. The State Long-Term Care Ombudsman is available for all clients residing in nursing homes and assisted living facilities. The Office of the State Long-term Care Ombudsman became part of the HHS Office of the Ombudsman on September 1, 2017. Any trends or global issues identified through complaints initiate a deeper HHSC review of the MCO or provider and their processes either by a desk review, onsite review, or secret shopper call. SB 760, 84th Legislature, Regular Session, 2015, directs the HHS Office of the Ombudsman to coordinate a network of entities to provide support and information services to Medicaid managed care consumers. The Office of the Ombudsman has held 11 meetings of the "Managed Care Support Network" that includes HHSC staff that work with Medicaid eligibility, enrollment, and operations, the Long Term Care Ombudsman, the Department of Family and Protective Services, Aging and Disability Resource Centers, Area Agency on Aging, enrollment broker (MAXIMUS), and other representatives who interact regularly with consumers and families.				

	The HHSC/DADS Long-Term Care Ombudsman has requested nursing facility specific data from the MCOs on a monthly basis to determine the types, as well as the volume, of complaints received related to nursing facility members. HHSC/DADS/Office of Ombudsman coordinated with stakeholder groups to create flyers for clients that include a simple explanation of the complaint process and list the most critical numbers to call for health and emergencies. The Office of the Ombudsman worked with HHS programs areas and community organizations to develop IDD consumer friendly outreach material. HHSC is currently looking at the roles of service coordinators and ways to strengthen the roles of the MCO provider relations teams, especially when serving IDD populations. Additional information about these activities can be found in the response to recommendation 34e / 67.
Date Last Updated:	11/17/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Host first meeting of Managed Care Support Network authorized by SB 760 SECTION 3 (including the Long-term Care Ombudsman, 17 other HHS offices and three other state agencies).	5/19/16	Completed	
2	Second meeting of the Network.	6/16/16	Completed	
3	Outreach meetings with community organizations assisting Medicaid managed care clients.	Ongoing	Ongoing	HHSC held a managed care stakeholder meeting on 07/26/2016 to discuss various topics, including the number/types of complaints received by HPM, for every program type, since January 1, 2016; including the time to resolve complaints. Additionally, stakeholders were educated on how to file member and provider complaints. HHSC will continue to hold these forums in the future.

4	Regular coordination meeting between MCS HPM staff and HHS Office of the Ombudsman	Ongoing	Ongoing	
5	Hosted third meeting of the Managed Care Support Network	7/21/16	Completed	
6	Hosted fourth meeting of the Managed Care Support Network	8/25/16	Completed	
7	HHS Office of Ombudsman is developing presentation and outreach material that will provide STAR Kids families with an overview of the Ombudsman Office. The office will offer organizations that work with STAR Kids clients the opportunity to present feedback during the production of this material.	10/31/16	Completed	
8	Continued to host monthly meetings of the Managed Care Support Network		Completed	The network has been established and continues to meet on a regular basis.
9	HHS Office of Ombudsman is developing presentation and outreach material that will provide clients with a developmental disability with an overview of the Ombudsman Office. The office will offer organizations that work with IDD clients the opportunity to present feedback during the production of this material.	5/31/17	Completed	

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

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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	Anesthesia Workgroup Meetings.	1/1/2017	Completed	Meeting held 11/9/2016. No additional meetings are scheduled at this time.
2	Implement Interim Anesthesia Policy.	7/1/2017	Completed	Interim Anesthesia policy implemented.
3	Long-term Anesthesia Policy Completion and revision of Criteria for Dental Therapy Under General Anesthesia Form.	7/1/2017	Completed	HHSC has determined that the long-term anesthesia policy, consisting of proposed revisions to the "Criteria for Dental Therapy Under General Anesthesia" form, is not an appropriate action at this time. HHSC will evaluate the impact of the interim anesthesia policy as data becomes available to determine if additional changes to the Criteria form would facilitate improved service delivery to Medicaid clients.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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 D~~i~~rectories. 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: 1-866-566-8989 Online: https://hhs.texas.gov/ombudsman HHSC HPM Email: HPM_complaints@hhsc.state.tx.us
Date Last Updated:	3/10/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HHSC 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	Completed	
4	Obtain SB 760 workgroup agreement on the draft provider directory standards prior to submitting the new critical elements through the UMCM amendment process.	9/1/2016	Completed	

5	Submit HHSC new critical elements for MCO Provider Directories through UMCM amendment process.	10/1/2016	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	70
Recommendation:	Outreach to physicians/office managers/specialists for additional stakeholder input on barriers that discourage or prevent them from enrolling as a Medicaid managed care provider and conduct ongoing outreach to medical and other professional schools. a) Outreach to physicians/office managers/specialists for additional stakeholder input on barriers that discourage or prevent them from enrolling as a Medicaid managed care provider from their perspective. b) On-going outreach to medical schools and other professional schools such as psychiatry, dental, nursing, occupational therapy, physical therapy. Work with professional schools to provide curriculum on community-based services, special needs populations and Medicaid. c) Work with health-related institutions and allied health professional schools with on-site clinics that might not currently accept Medicaid to begin accepting Medicaid patients.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	PACSTX				
HHSC Response:	HHSC coordinates with provider associations and collects feedback on strengths and challenges within the Medicaid program. In addition, HHSC reviewed information related to this issue as part of the process to develop network adequacy standards to implement SB760. There was a public forum on June 6, 2016 to discuss related proposals. In addition, TMHP conducts presentations at health-related institutions related to Medicaid State Programs (e.g. THSteps Medical and Dental, Children with Special Health Care Needs, Case Management for Children and Pregnant Women, etc. to recruit new Medicaid providers. HHSC staff will meet with TMHP to discuss additional information that may be included in these presentations in the future. HHSC will continue to coordinate and work with provider associations and advocates to collect feedback on strengths, challenges, and possible solutions to provider participation in the Medicaid program.				

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	The TMHP contract includes outreach to providers. HHSC met with TMHP recently about outreach for CHIP and new requirements on outreach.
Date Last Updated:	12/4/2017

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

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

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	71 / 74 a-e / 74 g / 74 j / 74 l-m
Recommendation:	HHSC should adopt additional standards regarding network adequacy, including: • Requiring MCOs to ensure availability and access to all medical assistance benefits to meet the health care needs individuals with disabilities. • Requiring MCOs to ensure continuity of providers by allowing the ability to maintain relationships with specialists after an individual is enrolled into a managed care plan. Continuity of care for individuals with long-term disabilities greatly contributes to preventing complications and promotes long-term stability, which in turn reduces the incidence of higher acute care costs. • Regularly assessing networks to identify gaps in access to care, accompanied by a plan to remedy those gaps and monitor access to care in those areas. • Ensuring the state's network adequacy standards, assessment procedures and data documenting compliance is clear and transparent to public. • Strong legal protections are needed to ensure that enrollees have access to high quality, medically necessary services. • Plans must monitor the number of network providers not accepting new Medicaid patients as a way to ensure sufficient in-network providers are available. • Plans should timely report if there has been any "significant change" in health status to LTSS providers and with permission and as requested by the member. • MCO members' should have access to services within time frames that account for differences in urban and rural areas: o Hospital services and emergency care with a 30 minute drive of or 15 miles from home or workplace. o Urgent care where no pre-authorization is required: within 24 hours of request. o Urgent care where prior authorization is required: within 48 hours of request. o All other requests: within 10 days, but no later than 15 days. o Allow for enrollees to access out-of-network providers without prior authorization if there is not a provider within timeframes or 10 miles from their home and/or if a request from a service coordinator does not get a response within 24 business hours.				

	○ If a grievance is reported, plans should resolve this grievance within 10 days, unless the grievance concerns potential loss of life or limb, severe pain, or imminent and serious threat to health, the plan must resolve it within 2 days.
Additional Stakeholder Background:	
Category:	Network Adequacy / Access to Care
Provided By:	Disability Rights Texas/Every Child, Inc./Texas Council for Developmental Disabilities/The Arc of Texas
HHSC Response:	SB 760 requires HHSC to publish network adequacy standards. SB 760 also requires HHSC to implement different mileage standards for urban and rural areas if feasible. Currently, HHSC contractually requires MCOs to comply with various network adequacy metrics including but not limited to: wait times for appointments, mileage standards, and out-of-network utilization. MCOs that are not in compliance are required to develop a corrective action plan to improve access SB 760 and rules issued by the CMS require HHSC to establish minimum access standards, including time and distance, for MCO provider networks for certain provider types. HHSC staff developed a draft proposal for revising existing distance and appointment availability standards as well as creating new travel time standards. The proposal was shared at the SB 760 stakeholder forum on June 6, 2016 and has been refined through subsequent meetings with stakeholders. HHSC has reviewed stakeholder input, analyzed the impact these new standards would have on existing MCO networks, compared the proposed standards to standards for commercial insurance, and identified all contract provisions and rules that would need to be amended to implement the proposed access standards. Changes to contracts related to access standards were effective March 1, 2017. Any access standards not included in the March 1, 2017 contract amendment will be included in subsequent amendments. This will likely include access standards for urgent care and long-term services and supports. In regards to monitoring, the S.B. 760 workgroup will establish a process to ensure MCOs comply with contractual standards. Once standards are established, HHSC will submit to the Legislature and make available to the public a report containing information on Medicaid members' access to healthcare services in managed care. Remaining activities are related to the milestones also reported on in item 1c, so future updates to these action items will be reported in item 1c.
Date Last Updated:	10/26/2017

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	Develop provider access standards for MCO provider networks.	6/1/2016	Completed	
2	Conduct stakeholder forum to receive feedback on implementing SB 760.	6/6/2016	Completed	
3	Reassess and revise proposed provider access standards based on stakeholder feedback.	8/15/2016	Completed	
4	Submit proposed access standards to MCOs as part of March 2017 contract amendment	10/1/2016	Completed	
5	Amend managed care contracts as necessary to include initial access standards.	3/1/2017	Completed	
6	Amend managed care contracts as necessary to include long term services and supports and other network adequacy standards to meet requirements of CMS rules.	9/1/2018	On Target	
7	Amend agency rules as necessary to include revised access standards.		Ongoing	See item 1c for further updates.

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Agency/Division/Department:	HHSC CPSCO MCS	**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

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

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Develop provider access standards for MCO provider networks.	6/1/2016	Completed	
2	Conduct stakeholder forum to receive feedback on implementing SB 760.	6/6/2016	Completed	

3	Reassess and revise proposed provider access standards based on stakeholder feedback.	8/15/2016	Completed	
4	Amend managed care contracts as necessary to include long term services and supports and other network adequacy standards to meet requirements of CMS rules.	9/1/2018	On Target	
5	Amend agency rules as necessary to include revised access standards.		Ongoing	See item 1c for further updates.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	74k
Recommendation:	If a member makes a request of their service coordinator for help with things like finding a provider or getting them information about their plan, they should respond within 24 hours.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	EveryChild, Inc./ Texas Council for Developmental Disabilities/ The Arc of Texas				
HHSC Response:	HHSC is committed to providing access to quality, cost-effective care. Imposing a 24-hour turnaround time for service coordinators would require round-the-clock service and expecting a registered nurse service coordinator to be available on evening and weekends would have a significant fiscal impact and require legislative appropriation.				
Date Last Updated:	12/7/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	HHSC research what timeframe to require MCOs to respond to a member request.	11/30/2016	Complete	Need more time to consider the best approach for implementing a specified timeframe for service coordinators to respond. HHSC implemented contract changes as listed in the milestones below to address this concern.
2	HHSC now has a contract provision requiring the MCO's Member Services Hotline to assist a Member to find a provider and schedule an appointment while on the phone with the Member.	3/1/17	Complete	

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3	HHSC is evaluating a potential change to MCO contracts related to timeframes in which a MCO service coordinator must return a call.	9/1/17	Complete	HHSC has determined that at the current time it is the "warm transfer" requirement in milestone number 2 is an adequate solution to the problem.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X 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:	3/13/2017				

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

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

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Agency/Division/Department:	HHSC FSD	**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/Department:	HHSC CPSCO MCS	**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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**Number:**	76
Recommendation:	Ensure that the MCOs are ready, willing and able to provide mental health services to individuals with IDD. Develop trauma-informed systems of care for individuals with IDD. Network adequacy for this population in general can be challenging – network adequacy for mental health services for this population can be even more difficult. Comprehensive assessments in the managed care programs should include mental health screening and evaluations for individuals with IDD.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Hogg Foundation for Mental Health				
HHSC Response:	HHSC acknowledges this issue and appreciates continued stakeholder feedback. Texas is a large state that includes rural counties where there are few primary care, specialty, or behavioral health providers. Also, Texas and the nation are experiencing a shortage of mental health providers and the extent of the mental health shortage is expected to worsen as the workforce continues to age (Hogg Foundation for Mental Health, 2011). To ensure access to Medicaid providers, HHSC expects its contracted Medicaid MCOs and DMOs to ensure access to primary care, specialty, and behavioral health providers within a certain distance of an individual's home, as defined by the state. However, MCOs and DMOs can only meet this standard when the provider base exists and the providers are also contracted with the state Medicaid program. MCOs and DMOs that do not meet these standards are subject to remedies, including liquidated damages, and must maintain an adequate provider network as a condition of contract retention and renewal. HHSC will explore the feasibility of developing trauma informed systems of care for individuals with IDD as well as comprehensive assessments in managed care that include mental health screening and evaluations. HHSC and the Hogg Foundation hosted a Medicaid Brainstorming Session on September 29, 2016 to address service gaps and solutions for individuals dually diagnosed with IDD and behavioral health conditions. Part of the summit discussion included provider shortages and gaps in service provision that members with IDD experience.				

	DADS released a free online training in June 2016 for people who care for, support, or advocate for people with IDD. This 6-part e-learning training series was developed by DADS and DSHS to educate direct service workers and others about behavioral health needs of people who have an IDD and a co-occurring behavioral health condition. This training looks at challenging behavior in a new way, emphasizes the importance of supporting mental wellness in individuals with an IDD, and includes a module for trauma-informed care for individuals with IDD. HHSC notified all MCOs of the training on June 10, 2016. The **Mental Health Wellness for Individuals with an Intellectual or Developmental Disability** training can be **accessed online at** http://www.mhwidd.com/**.** **This item is moved to the IDD SRAC transition to managed care subcommittee. Stakeholder may identify opportunities to engage in future discussion through the IDD SRAC. HHSC in collaboration with the IDD SRAC will identify opportunities during the system redesign to incorporate MH-IDD recommendations or reconvene the MH-IDD workgroup on an ad hoc basis.**
Date Last Updated:	11/13/17

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

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

5	Identify opportunities in the IDD System Redesign for MH-IDD recommendations discussed during the brainstorming session to be utilized	9/01/2021	Ongoing	

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Agency/Division/Department:	HHSC CPSCO MCS	**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/Department:	HHSC CPSCO MCS	**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 significant traditional providers (STPs) who have been delivering benefits to individuals who will be served in STAR Kids. As in previous managed care expansions, STAR Kids MCOs are required to offer contracts to STPs who have been actively serving children and young adults eligible for the STAR Kids program.				
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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X (Response and Milestone consolidated to 1C)	**Number:**	80
Recommendation:	Identify accurate and comprehensive methods for tracking and proving network adequacy, particularly for pediatric services and LTSS. Network Adequacy – As you know, this has been an ongoing concern for our organization and other stakeholders, particularly when it comes to establishing network adequacy for specialty services and long term services and supports (LTSS). Because home care agencies are by nature mobile, the current geo tracking system is inadequate for establishing network adequacy for home and community based services. We would like to work closely with your staff on the implementation of SB 760 and identify accurate and comprehensive methods for tracking and proving network adequacy, particularly for pediatric services and LTSS. We have provided recommendations to your staff in the past, such as measuring start-of-care timeframes, and would appreciate the opportunity to refresh those conversations.				
Additional Stakeholder Background:					
Category:	Network Adequacy / Access to Care				
Provided By:	Texas Association for Home Care & Hospice				
HHSC Response:	HHSC has developed an implementation plan for SB 760. Based on input HHSC received at the SB 760 Stakeholder Forum that was held on June 2016, staff will develop access standards for LTSS providers as well as monitoring mechanisms to ensure MCOs comply with established standards. HHSC will continue to work with stakeholder groups when developing provider access standards. Remaining activities are related to the milestones also reported on in item 1c, so future updates to these action items will be reported in item 1c.				
Date Last Updated:	10/26/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Review and incorporate feedback from stakeholder forum.	7/12/2016	Completed	
2	Develop additional access standards for other provider types, including LTSS.	9/1/2017	Ongoing	Initial standards for several LTSS provider types has been developed and will be included in September 2018 contract amendments consistent with the added milestone.
3	Implement contract revisions for provider access standards.	9/1/2018	On Target	HHSC included several contract revisions for provider access standards effective 3/1/2017. Standards for LTSS will be included for the 9/1/2018 contract amendment. See item 1c for further updates.

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	81
Recommendation:	Ensure access to providers of pediatric and adult services. While an MCO might employ or contract with a specific number of providers based on the number of beneficiaries in their network, the providers may be trained or limited in the ages of the people they treat. Ensuring access to providers of pediatric and adult services, as appropriate, would address this concern while strengthening provider networks and promoting beneficiary access. Additionally, fee schedules should be set in accordance with the current Medicaid fee schedule so that providers are not discouraged from accepting patients enrolled through MCOs.				
Additional Stakeholder Background:	On 8/16/2016 HHSC met with the TSHA and representatives confirmed that the recommendation was specifically addressing concerns with speech language pathologies rather than all providers.				
Category:	Network Adequacy / Access to Care				
Provided By:	TSHA				
HHSC Response:	Current network adequacy standards require MCOs to ensure that all members have access to age-appropriate primary care providers. Additionally, HHSC is working with our EQRO to survey primary care providers (PCPs) about their experience in obtaining specialist referrals. The current PCP referral study survey examines referring children and adults separately. In addition, there is room for an open response for providers to report their experiences with any specialty (in addition to those explicitly listed in the survey). HHSC does not set rates for services reimbursed by MCOs. MCOs are delegated the responsibility of managing a network and setting rates.				
Date Last Updated:	11/17/2017				

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.

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1	PCP Referral Study Phase 1 Summary of Results.	8/31/2016	Completed	
2	PCP Referral Study Report.	5/31/ 2018	In Progress	In order to improve on the initial low response rate of less than 12%, additional time is needed to ensure the provider directories are accurate. Toward that goal, the EQRO is contracting with a vendor to call each clinic and validate: 1) up to five names per clinic, 2) address accuracy, 3) plans the provider accepts (CHIP/Medicaid), and 4) provider type. They also ask providers whether they would like to have the survey mailed, faxed, emailed, or completed online. Data collection will be complete in November with a final report slated for spring 2018. The completed report will be shared with IDD SRAC at this time. Ongoing work on this topic will be facilitated through IDD SRAC Since this is also a milestone for item 3c, this item will be closed. Please see item 3c for future updates on this item.
3	UMCC amendment effective for new online provider directory standards effective 3/1/2017.	9/1/2017	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**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/Department:	HHSC FSD	**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				

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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	N/A			

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Agency/Division/Department:	HHSC FSD	**Status:**	Under Consideration: No Action to be Taken: X In Progress: Complete: Other:	**Number:**	85
Recommendation:	More adequately support people with complex medical and physical support needs to achieve community integration in the least restrictive setting to meet their needs.				
Additional Stakeholder Background:					
Category:	Rates				
Provided By:	EveryChild, Inc. / Texas Council for Developmental Disabilities / The Arc of Texas				
HHSC Response:	HHSC and DADS have developed a high medical needs add-on for its Intermediate Care Facilities for Persons with Intellectual and/or Developmental Disabilities and is currently working on developing such an add-on for the Home and Community-based Services (HCS) Program. There was a decision to put the high medical needs project for HCS on hold pending the outcome of session due to concerns about availability of funding. Following session, we will make a determination regarding if/when we can initiate benefits.				
Date Last Updated:	03/20/2017				

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

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

				Legislative Session. HHSC will not pursue the addition of high medical needs services to the HCS waiver at this time.
3	Rate for HCS high medical needs add-on effective, pending appropriation.	TBD	Pending	NA

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Agency/Division/Department:	HHSC FSD	**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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**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 is 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. HHSC's contract with STAR+PLUS MCOs allows MCOs to employ this model of service coordination, although it is not as explicit as the STAR Kids Contract. HHSC will evaluate the effectiveness and feasibility of this model in STAR Kids and determine whether explicit direction to STAR+PLUS MCOs is appropriate.				
Date Last Updated:	03/12/2017				

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Implement STAR Kids	11/1/16	Completed	
2	Evaluate the use, effectiveness, and outcomes of third party service coordination in STAR Kids	12/1/2017	On Target	Managed care contracts allow MCOs to contract care coordination to health homes. HHSC will continue to

				evaluate the efficacy of health homes in all programs and make systematic improvements based on the evaluation.
3	Determine if appropriate and necessary to make changes to the STAR+PLUS contract	3/1/2018	On Target	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	92
Recommendation:	Improve understanding and effectiveness of care coordination within the Medicaid managed care model. a) Increase provider education on (1) populations that receive automatic care coordination, (2) how to best utilize this automatic care coordination and (3) how to request care coordination on behalf of a patient that does not automatically receive it. b) Include a patient's care coordinator name and phone number on the patient's Medicaid card and in the patient's electronic portal c) Care coordinators should be held responsible for helping a transition age youth find adult providers d) Billable care coordination by both the physician and a social worker/nurse coordinator in the provider setting should be streamlined and MCOs should clearly outline for all medical homes how to take advantage of this service e) Educate providers on the unique care coordination model STAR Kids MCOs will be responsible for implementing f) Encourage MCOs to provide a capitated care coordination PMPM to practices able to demonstrate high quality outcomes with internal care coordination efforts.				
Additional Stakeholder Background:					
Category:	Service Coordination / Member Assistance				
Provided By:	TMA / TPS				
HHSC Response:	Like STAR+PLUS, STAR Kids has a service coordinator hotline number that is on a STAR Kids member ID card, which will be an easy way for families or providers to reach a service coordinator. In addition, MCOs must provide a named service coordinator to any member who requests one, even if they are not in the groups that get one automatically (levels 1 and 2). Everyone in STAR Kids also has access to transition planning beginning at age 15. A transition specialist at the MCO, working closely with the service coordinator, will help the family with transition planning. This includes activities like assisting members to find adult providers and preparing members for transitioning to STAR+PLUS when appropriate.				

	HHSC has added a requirement to the managed care contracts, effective 9/1/16, which will require the STAR+PLUS MCOs to notify a STAR+PLUS member in writing (or the member's preferred communication method) within 5 days, if their service coordinator changes and provide updated contact information. In addition, each MCO has a service coordination hotline providers can call to receive the contact information for a member's care coordinator. STAR Kids definitions and requirements around care coordination and MCO standards were operational effective 11/1/16. If a provider needs to contact an MCO service coordinator, many MCOs post the information in the provider portal. In the event the MCO does not, the provider should call the MCO service coordination line. These phone numbers are in each provider handbook, on the MCO's website, and HHSC posts STAR+PLUS service coordination phone numbers in Appendix VI, STAR+PLUS Inquiries Chart, in the STAR+PLUS Handbook. HHSC is developing something similar for the STAR Kids Handbook. HHSC has several quality initiatives, among them is a move toward value-based purchasing for long term services and supports. In addition, HHSC encourages stakeholders to provide recommendations for program improvements through a variety of mechanisms, including requests for information and model requests for proposal for future contracts. HHSC will take the feedback provided through the Executive Commissioner's Commitment to Improving Member and Provider Experience in Medicaid Managed Care into account when developing future contracts as well as continue through various mechanisms to collect and use valuable stakeholder input.
Date Last Updated:	03/12/2017

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

	Milestone	Targeted Completion Date	On Target / Completed / Ongoing	If not on target, explain variance(s)/challenge(s) in achieving successful milestone completion by the targeted date.
1	Adopt STAR+PLUS contract changes.	9/1/16	Completed	
2	Conduct STAR Kids Information Sessions.	10/1/16	Completed	
3	Implement STAR Kids.	11/1/16	Completed	

4	Ask for stakeholder input around care coordination, including Health Homes, in a Request for Information (RFI) for new STAR+PLUS contracts	1/30/2017	Completed	
5	Continue to evaluate stakeholder requests around improving care coordination and implement requests, as appropriate		Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**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 Intellectual and Developmental Disabilities (IDD) System Redesign Advisory Committee (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/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: Other: X	**Number:**	95
Recommendation:	Conduct satisfaction surveys from individuals with IDD who have had their acute care services transitioned to managed care. The recommendation includes development of a questions that are relevant to persons with IDD, hence sent separately from any questionnaire sent to others enrolled in the Texas Medicaid managed care program. Note: The introductory information sent to persons with IDD prior to the 9/1/14 transition contained STAR+PLUS Health Plan Report Cards. The purpose of such was to offer individuals and families' information about the MCOs as reported or rated by others using the MCOs. The information was not relevant to assist persons in making an informed MCO selection for a host of reasons. One reason is that persons enrolled in an IDD waiver whose acute care services were transitioned to managed care in the Medicaid Rural Service Areas in 2012 were not sent the questionnaire that served as the basis for the Health Plan Report cards sent to individuals and families prior to the 9/1/14 transition. Even if the questionnaire had been sent to the 2012 IDD MRSA transition group, many of the items to be rated were not items of most importance to persons with IDD.				
Additional Stakeholder Background:	This recommendation was discussed in a meeting with PPAT on 8/8/2016 and in a meeting with EveryChild, Inc., Texas Council for Developmental Disabilities, Arc of Texas, and Disability Rights Texas on 8/9/2016. In both meetings feedback was provided emphasizing the importance of having information about MCOs specific to individuals with IDD. It was specifically noted that an individual with IDD currently has little information with which to determine which plans may best meet their needs.				
Category:	Stakeholder engagement and feedback				
Provided By:	PPAT				
HHSC Response:	HHSC will discuss the feasibility of a satisfaction survey for this population, seeking input from our IDD SRAC as well as the MCOs. This item was added to the July 28, 2016 IDD SRAC Meeting agenda. HHSC shared a copy of the existing CAHPS survey with the IDD SRAC and attended the 10/3/2016 meeting to discuss further the survey and its applicability to the IDD population. In October, IDD SRAC members decided that obtaining specific HEDIS results for individuals with IDD would be more useful. EQRO is running the analysis which should be ready for the December SRAC meeting. See recommendation 3C for information on the STAR Kids focus study as it relates to members with IDD. Additionally, as part of the focus study Texas's External Quality Review Organization is testing additional questions to determine their feasibility and applicability to the STAR Kids population.				

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	Since the remaining milestones are also part of item 3c, this item will be closed. Please see item 3c for future updates on this item.
Date Last Updated:	12/7/2017

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

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

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Agency/Division/Department:	HHSC CPSCO MCS	**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 Local Intellectual and Developmental Disability Authorities (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 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 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			

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Agency/Division/Department:	HHSC CPSCO MCS	**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/Department:	HHSC CPSCO MCS	**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/Department:	HHSC MSS MCS Department	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	103
Recommendation:	Conduct data analysis to support incentive payments. Conduct an analysis to compare and compute: A. Hospital outpatient out-of-network rates of contracted services: B. Dollar impact of high utilization of outpatient and ER services; and C. Development of potential incentive payments to MCOs that control outpatient rates of utilization. The expanded analysis can be used to confirm or refute the correlations between high rates of outpatient utilization and high rates of non-contracted network providers. In addition, the agency can use the expanded analysis to measure the fiscal impact that high utilization rates have on managed care costs. The agency can use this data to consider providing incentive payments to high performing MCOs. HHSC can use this analysis to get a better understanding of the out-of-network activity. The current out-of-network rules tie the hands of providers and give a big advantage to Medicaid MCOs.				
Additional Stakeholder Background:					
Category:	Alternative Payment Mechanisms				
Provided By:	THA				
HHSC Response:	HHSC collects information vital to monitoring utilization rates in the program. HHSC met with THA to discuss this recommendation, and provided initial information. THA indicated that no further information is needed at this time, and this will be revisited if THA determines that additional information needed in the future.				
Date Last Updated:	11/1/2018				

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

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

2	Initial data and information provided to THA for review and consideration.	4/1/2018	Completed	

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Agency/Division/Department:	HHSC CPSCO MCS	**Status:**	Under Consideration: No Action to be Taken: In Progress: Complete: X Other:	**Number:**	104
Recommendation:	Implement accountability measures linked to reimbursement It is important that HMOs have accountability measures so advocates can monitor what they are doing. These accountability measures should be in the contract linked to reimbursement so the HMO's have an economic incentive to perform in a way that benefits the people receiving services. ADAPT of Texas has drafted what we are calling Community Integration Performance Indicators. Community Integration Performance Indicators: 1. # of people out of nursing facilities/institutions; 2. # of people going into nursing facilities/institutions; 3. # of people getting face to face service coordination; 4. # of people getting phone service coordination; 5. # of people offered consumer directed services; 6. # of people selecting consumer directed services; 7. # of people living in their own home or apartment; 8. # of people living in assisted living; 9. # of people in adult foster care; 10. # of people living in group homes; 11. Availability/use of architectural barrier modifications; 12. Length of time receiving services; 13. Length of time keeping an attendant; 14. System of back up for attendants; 15. Pay wages $8.00 to $9.00; 16. Pay wages $9.00 to $10.00; 17. Pay wages above $10.00; 18. Access to durable medical equipment; 19. Access to Assistive Technology such as communication devices; 20. Nurse delegation of health maintenance task to unlicensed Direct Care Attendants; 21. Advisory Committee made up of at least 50% of people using the services and supports.				
Additional Stakeholder Background:					
Category:	Contract Provisions				
Provided By:	ADAPT Texas				
HHSC Response:	HHSC appreciates this information and the recommendation for measures. Currently, there are no national standards or nationally comparable measures for LTSS, which is an important component of Texas' quality assurance program. CMS has begun testing some LTSS measures. This testing will hopefully result in nationally comparable, valid, and reliable measures Texas could adopt. A number of Texas-specific measures have now been developed, but implementation of payment incentives for these measures is on hold due to the need for standardized, nationally recognized measures. LTSS will be included in the value-based payment program when such measures become available. HHSC will take the stakeholder suggested performance indicators into consideration if national measures are developed, and when coordinating with the National Association of States United for Aging and Disabilities (NASUAD) and Human Services Research Institute (HSRI). Note: HHSC would need legislative direction and appropriation to increase the attendant wages, as suggested in this recommendation.				

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	HHSC is currently focusing attention on its participation in the NASUAD and HSRI National Core Indicators - Aging and Disabilities (NCI-AD) survey. The NCI-AD survey is intended to collect data that will allow the state to understand, from the member's perspective, how their LTSS impact their quality of life and health outcomes. The survey is conducted biannually through in-person member surveys administered by EQRO. Included in the survey sample are STAR+PLUS members receiving LTSS through STAR+PLUS HCBS. The first year of surveys were completed in May 2016, and HHSC intends to participate on a biannual basis. The 2015-2016 survey domains are: • Community Participation • Choice and Decision-Making • Relationships • Satisfaction • Service/Care Coordination • Access • Safety • Health care • Wellness • Medication • Rights and Respect • Self-Direction • Work • Everyday Living • Affordability • Planning for Future • Functional Competence
Date Last Updated:	11/17/2017

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

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

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Agency/Division/Department:	HHSC FSD	**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			