CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

March Children's Health Coverage Coalition Meeting
Friday, March 23rd
11:00 a.m. - 1:00 p.m.

Present:

Mimi Garcia, TACHC
Mary Allen, TACHC
Rey De La Garza, TNP
Aliyah Conley, CDF-TX
Laura-Guerra Cardus, CDF-TX
Christina Hoppe, CHAT
Christina Phamvu, MHM
Michelle Romero, TMA
Kaitlyn Doerge, TPS
Helen Kent Davis, TMA
Clayton Travis, TPS
Greg Hansch, NAMI TX
Anne Dunkelberg, CPPP
Jessica Giles, CPPP

On Conference Line:

Melinda Olivo, Maximus
Celia Kaye, League of Women Voters Texas
Cheasty Anderson, CDF
Melissa McChesney, CPPP
Sarah Gonzales, THA

Invited Guests:

Alan Pittman, HHSC
Kaitlyn Doerge, TPS

Meeting Chair: Greg Hansch, NAMI Texas
Meeting Scribe: Jessica Giles, CPPP

1. Introductions

2. Federal Updates

Anne Dunkelberg on Budget Bill:

- Congress passed a budget bill yesterday. The New York Times has an article that goes through all of the things that President Trump pushed for that didn't' make it into the budget. There isn't much in the way of cuts for anything. Most have some small

increases. There's a veto possibility. The people who objected to the passage of it were pretty ideological.

Anne Dunkelberg on proposed rule

- There is a proposed rule that any state with 85% or more of Medicaid participants won't have to do much about ensuring network adequacy. There are 15 or 16 other states that meet that threshold. Not sure of what the organized pushback will be, but definitely worth paying attention to.

Helen Kent Davis:

- 60-day comment period starts today.

Anne Dunkelberg on Public Charge Proposed Rule:

- A couple of updates concerning the leaked draft of a federal rule that would dramatically change the rules about getting a green card or visa into the US. No leaked draft to Office of Management and Budget, but that should be the next thing.
- The problem with it is that it previously it was only based on the individual and cash assistance. The proposed rule extends to food stamps, WIC, CHIP, Medicaid, and more. Even worse, it also extends potentially to the individual's family use even if their family members are US citizens.
- In Texas, 17-18% of children have both parents who are undocumented. ⅓ have at least one parent who is foreign born. Working on getting the number of kids who have at least 1 parents who isn't a US citizen. We know that the specific population is already scared of using those benefits. This is going to affect roughly ¼ Texas families with children. From everything that we hear about people who are delivering services, people are already concerned.

Laura Guerra-Cardus

- I know that part of the strategy will be to slow this down. There will be a comment period. Will be important for everyone to put in comments. Are there any other part of the strategy?

Anne Dunkelberg:

- It's possible that we could only have a 30-day comment on the rule, but it could be more like 60 days. Public statements, pushback, and a public profile could be very helpful on it. Food banks have already said that they're interested in doing a public statement. Healthcare providers may want to do this.

Melissa McChesney:

- Public Education is also very important for groups that interact with clients and consumers.We want to mitigate the damage as much as possible. Getting some clarifications out will be crucial, but first we have to see what the proposed rule is. Providers, enrollment assisters, etc.

Anne Dunkelberg:

- Story collection, even in an anonymous fashion, could be great. If ¼ of the children in Texas are affected, we either have to embrace them or turn our backs on them. This is a huge moment in children's advocacy.

Greg Hansch:

- There is a webinar on March 29th from Georgetown Center on Children and Families that will be presenting highlights from the budget.
- 85% or higher on managed care they won't have to do much about ensuring network adequacy. Will have to make sure that gets sent out.

Christina Hoppe:

- HHSC has posted the proposed rules for Healthy Texas Women. Haven't seen anything official that they got federal approval for the waiver, but they either have it or are close to getting it.

Helen Kent Davis:

- The preamble is written like it has been approved. They had a draft rules that they sent comments about requirements for providers. There were some problematic requirements for providers.

Anne Dunkelberg:

- Attorney General Paxton's letter was filled with a lot of inaccuracies about the issues. There will probably be a blog post about it soon.

3. Interim Charges

Mimi Garcia:

- Senate Finance committee hearing on Tuesday. Hurricane Harvey will have a significant demand that will impact healthcare and education. $4b shortfall, which will impact a lot of legislation in the next session.

Christina Hoppe on Appropriations Subcommittee:

- Pediatric therapy rates wasn't a charge, just a hearing topic.There are still problems with how HHSC is collecting complaints about the rates. Ombudsman isn't accurately depicting the number of complaints. We have these reference tracking numbers, we filed complaints, and they weren't represented in the complaint data.

Clayton Travis:

- Most feel pediatric therapy rates have been dealt with, with the 25% restoration. Not sure it's going anywhere after this.

Greg Hansch on Psych infrastructure issue:

- There were only a few people giving testimony on the psychiatric in-patient infrastructure. HHSC gave a plan on what the money will be used for- to rebuild the structure. HHSC has a report on the phases of their plan to see each local area. There are some specifics about what the local infrastructure will look like when the plan comes to fruition. It's a huge win in terms of building infrastructure. There are children's bed in various state hospitals. A small portion of the money has been dedicated for planning to rebuild Austin State Hospital.

Clayton Travis on Senate HHSC

- Hearing went well on Medicaid Managed Care side. Those who testified and weren't with the state agency were tasked with talking about how Medicaid is a good program. Caseload growth is the thing that's really exploding the numbers. Two contentious issues that will probably be coming up are competitive bidding and the role that community health programs play in the Medicaid Managed Care system.

- Schwertner said, “Don’t we already have too many MCO’s in our Medicaid plan already?” Community health plans are typically the more expensive plans, but this is because they usually have the sicker patients. They think the way they can simplify that is through a competitive bidding process. Process of putting in a bidding number through HHSC and they usually take the lowest number possible, not taking much into account. The bidding process doesn’t take into consideration quality, nuance, low-balling numbers. There are some obvious concerns because the type of MCOs that can low-ball numbers the most are for-profit national ones, which are usually viewed as the most problematic to work with because there is less communication and strategy making with leadership. If Texas adopts a competitive bidding process, that is one way to limit the access that community health plans have.

Helen Kent Davis:

- There is criteria that the plans have to meet, but it is based on what is paid. The worry is if we focus exclusively on cost, no focus will be on value. Community health plans also serve the good neighbors. If they're doing a good job with their provider network, then it puts pressure on the for-profit plans to do better.

Clayton Travis:

- Limits competition to improve.

Anne Dunkelberg:

- The current system which is flawed already looks at the average spending in a particular type of medicaid client group and uses that to come up with a rate. That average is reflecting the additional expenditures and better benefits that some of the community based plans are offering. Basically community based plans are maintaining marginal profits. Whereas for-profits are taking back huge profits. We cannot drive how the community based health plans can advocate for themselves, but we may have to show that the costs are lower.

Clayton Travis:

- We also need to think about what we’re going to offer up instead. Schwertner's ultimate goal is to see cuts in Medicaid- we have to see other ways that can be done. Someone at the hearing hinted at how we could tweak the experience rebate. Besides the members, who else is advocating for this? All of the plans are against it.

Helen Kent Davis:

- What has happened in other states is the boomerang effect. Low-ball and then a couple years, later there’s a huge increase.

Michelle Romero:

- Look at what happened with ERS lowballing each other. How low can you go until you disrupt the system so much?

Helen Kent Davis:

- It is also very disruptive for employees.

Mimi Garcia:

- Reducing service regions: heard at one point from 13 to 11 service regions.

Clayton Travis

- Heard 5 recently.

Laura Guerra-Cardus

- Is there an argument that this may look like cost saving initially and later it won't be?

Clayton Travis

- Arizona data specifically shows this, but in several states.

Helen Kent Davis:

- There is some valid frustration with the different areas, specifically why is Dallas and Fort Worth different service areas.

Clayton Travis:

- Other states that are similar size have similar amounts.
- TPS submitted recommendations that there are some things that need to be changed with Medicaid Managed Care. Submitted to advisory committee. Stakeholder review period and comment period, requiring a sunset process for MCO vendor drug program and TMHP prior authorizations, allowing and specifically clarifying in statute the ability for MCO's to do innovative practices; eliminating certain provisions. Could maybe send that list around if it is okay with Helen.

Anne Dunkelberg:

- There's been movement from advisory committee to try and get HHSC to take it to the next level of creating a public facing matrix, but we are definitely not there yet.

Greg Hansch:

- One of the resources is an LBB staff report that has some pretty promising recommendations about increasing utilization of care coordination. As far as I know, none of those things were put into statute and some of those recommendations could be put into 2019.

Helen Kent Davis:

- On maternal health side, there were questions about data and accuracy. Questions about if substance use is really related to maternal death. The issue regarding whether Medicaid contributes to the opioid crisis and questioning whether covering more people contributed to more people getting prescription drugs and getting addicted. Pre-dating ACA, there was an opioid crisis and the opioid crisis isn't just prescription drugs. This is something that we have to be prepared to talk about.

Laura Guerra-Cardus:

- Kolkhorst saying that CMS data saying that more opioids for Medicaid, but we're going to follow up with that.

Sarah Gonzales:

- We rolled out opioid prescribing guidelines. Board adopted them in February. Our guidelines are specific to the emergency department. Schwertner was confused about the guideline asking about the payers requiring the pain scale. Witness had the guidance and read it to him. Acute pain and not chronic pain. In acute pain, this is a first step in trying to curb overprescribing in that initial setting.

Clayton Travis

- Much of the focus should be pointed to maternal health, child health, and foster care. Go check out Texans Care for Children brief with 10 recommendations.

Anne Dunkelberg:

- Lots of pushback on misinformation about Medicaid and its relationship with the opioid crisis. There is a piece by CBPP that debunks all of it and puts out the resources . Health affairs article that is also useful.

Laura Guerra-Cardus

- In my mind, I don't divide adult substance use issues from the child because many children are being affected by it because of their parents. Greg passed along recommendations from the behavioral health advisory committee under HHSC that has some child specific recommendations for substance abuse. Some are recommendations to include Medicaid coverage for parent peer support services for children, changing regulations so you can provide substance abuse services in school districts more easily, having more of the peer support system trained to assist youth, and having more younger folks who can be peer supports for younger folks. ⅔ of cps cases are parental substance use related. If we want to curb fatalities and children going into CPS, we have to get serious about substance abuse.

Mimi Garcia:

- Just had national conference. Something that is gaining more traction is early childhood trauma and it being a contributor to addiction. I'm just wondering if in any of these conversations that's coming up and making any traction.

Kaitlyn Doerge:

- There's some early policy conversations about how to integrate trauma informed services into our child welfare and health. There's a lot of different perspectives on how to achieve that. A lot for what is happening is at the community level, making sure that agencies are trauma informed. TPS and TMA both had an adverse childhood experience continuing education tracts. A lot of the education is happening, but not sure where the policy will go with it. Focus on ensuring that foster parents and child welfare workers have the right education.

Greg Hansch:

- Put out notice about collecting input on LAR. Deadline is April 23rd. Taking input directly to a particular email address.

Clayton Travis

- I will probably send something to this coalition about sending something in.

Greg Hansch:

- There is a hearing next week covering Medicaid Managed Care compliance, HHSC oversight, as well as ECI.

4. Foster Care and Health Care (Kaitlyn Clifton Doerke)

Kaitlyn Clifton Doerge

- Almost a year ago right after the legislative session, I came and talked about a broad overview of child welfare related legislation that could impact child health. Today will be about 2017 legislative session SB 11. The bill instituted foster care privatization, but it had other things in it, two specific pieces- one piece has been going through a pretty heavy lift in the implementation process. Now, primary care physicians and treating physicians receive a notice when a child changes foster care placements. They didn't know that a child had changed foster care placements until a child didn't show up to an

appointment or had a refill request from somewhere across the state. Now, Superior Health Plan has to be notified within 24 hours of a placement change.Superior has to notify the primary care physician of record, which each child should have in their health passport, within two days of their change. Superior also has to notify any treating specialist of records and has to coordinate transition between the new and old team, which has no timeline.

- The other piece of SB 11 is the initial medical exam of children entering foster care. Children should be put in front of a medical professional within 72 hours and have a more comprehensive follow-up visit within 30 days according to the American Academy of Pediatrics. Previously, there was no initial, just the 30 day and the state was having trouble complying with that timeline. One of the theories was that seeing a medical provider wasn't put at the top of the list, it really was a low priority to get children seen within 30 days. Timeline got pushed to 3 business days. Another important thing is how the initial medical exam was piloted. Piloted in Dallas and Lubbock for all children entering into foster care, which yielded positive results, such as increased compliance. One of the more problematic amendments that played out was the vaccine amendment. A provider cannot administer a vaccination, except for tetanus at the 3-day medical exam without consent.
- [see attachment]
- 3-in-30 initiative between HHSC, DFPS, and Superior Health Plan that does some education about the exams and assessments that need to happen. 3-day medical exam is on there: purpose is to assess urgent medical needs. CANS assessment. Texas Health Steps well child visit: developmental screenings, more thorough. One thing that the department has been trying to drive home is the importance of receiving these within the 30 days so that a complete picture is painted of the child as the department creates the service plan, which happens on by the 45th day.
- Rollout of the initial health exam: has to rollout statewide by December of 2018. Report on how rollout went has to be submitted by December of 2019. [see other attachment] Start date for first rollout region is April 1st.
- Superior Health Plan will be conducting webinars for health providers regarding 3-in-30.

5. SB 760 Update

Allen Pittman:

- [see powerpoint]

Anne Dunkelberg:

- Have additional standards been made public yet?

Allen Pittman

- There will be a rulemaking process- still internal communication at HHSC. Incorporating stakeholder feedback through in-person workgroups to develop initial standards Can send out the attendees and invitees who were involved in stakeholder feedback.
- Slide 4: travel time, set types of providers. By Sept. 2018, we'll be in full compliance with those standards. Page 4 on handout: Every county in Texas has an associated designation based on population and density.

- Limitations: critical piece of information is if they're taking new patients and there's not a quick way to get that data.

Helen Kent Davis:

- One of the recommendations that we made is HHSC should also be looking at providers who are not taking Medicaid but are in the area. There may be possibilities to reach out to them.How often does designations get updated?

Allen Pittman

- We probably can't do it annually because we're trying to do trending data. It's probably pretty static though.

Greg Hansch:

- Are there opportunities to see corrective action plans?

Allen Pittman

- Each file per MCOs has millions of variables. We have excel sheet and baseline reports will all of this data available, but we're trying to do some summary tables.

Clayton Travis

- That data basically summaries every quarter should be presented to advisory committee. All corrective action plans should be summarized or provided as well. Public needs a forum to monitor updates and see any trends.

Helen Kent Davis:

- It would also be really helpful to know when a plan asks for an exception and it is granted.

Clayton Travis

- Those who are in rate discussion, this is our window into whether or not managed care companies are providing the rates to attract provider types to all sorts of programs. This is the way that we understand quality access into this program.

Allen Pittman

- Page 9: corrective action plans only- correcting a lot of what is in their networks and fixing their data issues. This should include a very accurate view of what the provider network looks like should be more representative of their provider network.
- Additional questions can be answered by: **MedicaidCHIP_Network_Adequacy@hhsc.state.tx.us**
- Michelle Long is the new subject matter expert.

3-Day Exam Rollout Schedule

April 1, 2018:

Regions 1, 7, 9 and 10

June 1, 2018:

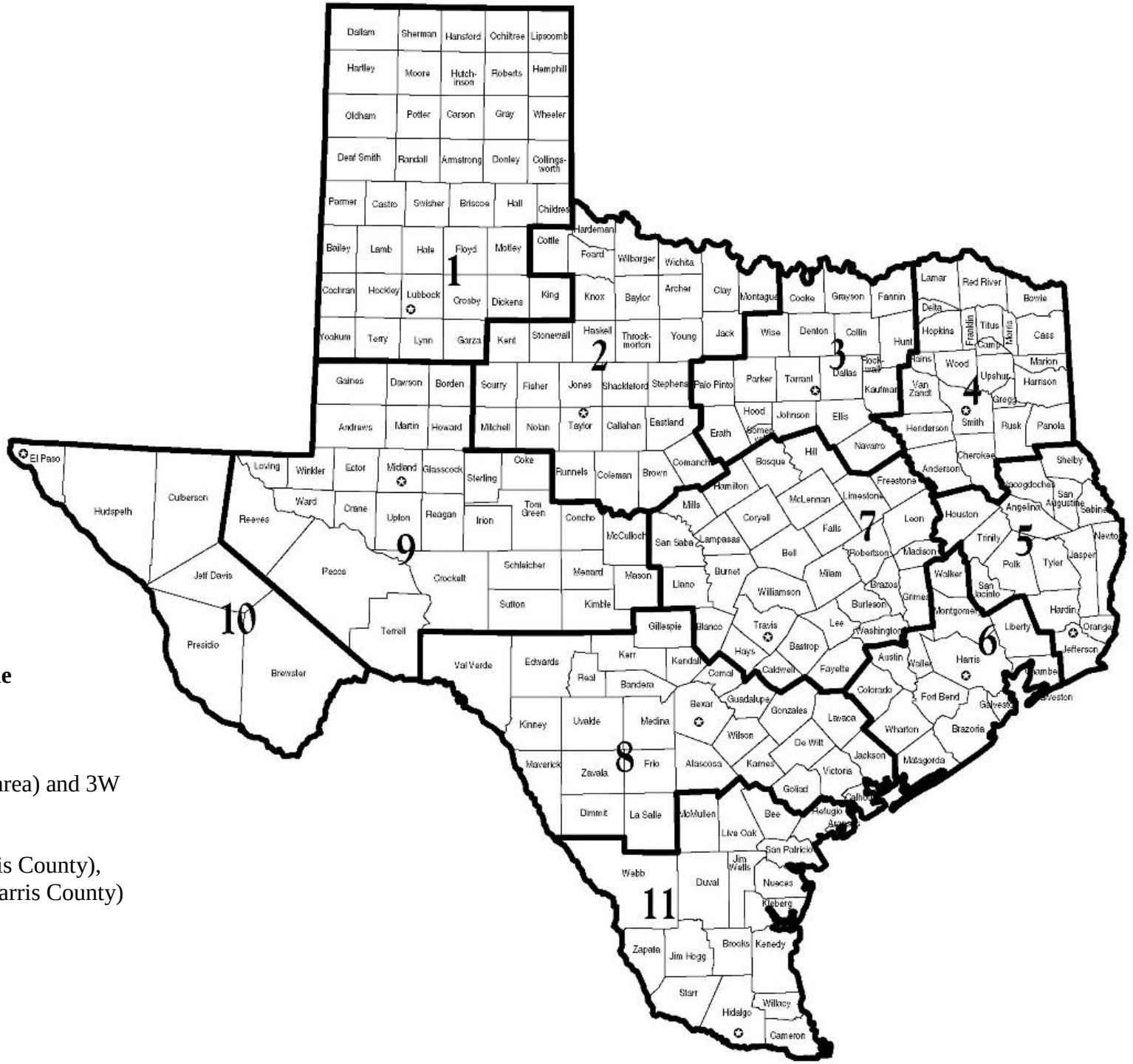
Regions 2, 3E (Dallas area) and 3W (Fort Worth area)

August 1, 2018:

Regions 4, 5, 6A (Harris County), and 6B (surrounding Harris County)

October 1, 2018:

Regions 8 and 11



3 IN 30

A Complete Approach to Better Care for Children

1 3-Day Initial Medical Exam

In 3 business days, children entering DFPS care must see a doctor to be checked for injuries or illnesses and get any treatments they need.

2 CANS Assessment

In 30 days, children (ages 3-17) must get a CANS assessment. This review helps us understand how trauma is affecting a child, and how the child is doing. CANS tells us which services may help the child, such as counseling. It also shows strengths we can build on, like good relationships.

3 Texas Health Steps Medical Check-Up

In 30 days, each child must see a doctor for a complete check-up with lab work.
This makes sure:

- We address medical issues early.
- Kids grow and develop as expected.
- Caregivers know how to help the child grow and develop.

SB760 Update
Network Adequacy

Allen Pittman, MSSW

Texas Health and Human Services Commission

TEXAS
Health and Human
Services

SB 760 Background

- Requires HHSC to establish minimum access standards for managed care organization (MCO) provider networks for specific provider types
- Requires MCOs to create an expedited credentialing process for specific provider types identified by HHSC
- Requires MCOs to regularly update and publish provider directories on their websites

TEXAS Health and Human Services

Revision of Network Standards

- HHSC received feedback during stakeholder meetings and written feedback throughout implementation.
- Initial standards were revised based on stakeholder and MCO feedback and included in March 2017 managed care contract amendments.
- Additional standards for LTSS, Pharmacy, TCM / Rehab, Texas Health Steps, Audiology will be implemented September

TEXAS Health and Human Services

CMS Network Adequacy Rules

- Center for Medicare and Medicaid Services (CMS) rules require Texas to develop network standards for managed care
- Standards must include distance and travel time and be based on analysis of Medicaid program characteristics (i.e., anticipated enrollment, utilization, member characteristics) and must include network standards for Long Term Services and Supports (LTSS)
- Contract changes for CMS will be effective for 9/1/2018

TEXAS Health and Human Services

County Level Designations

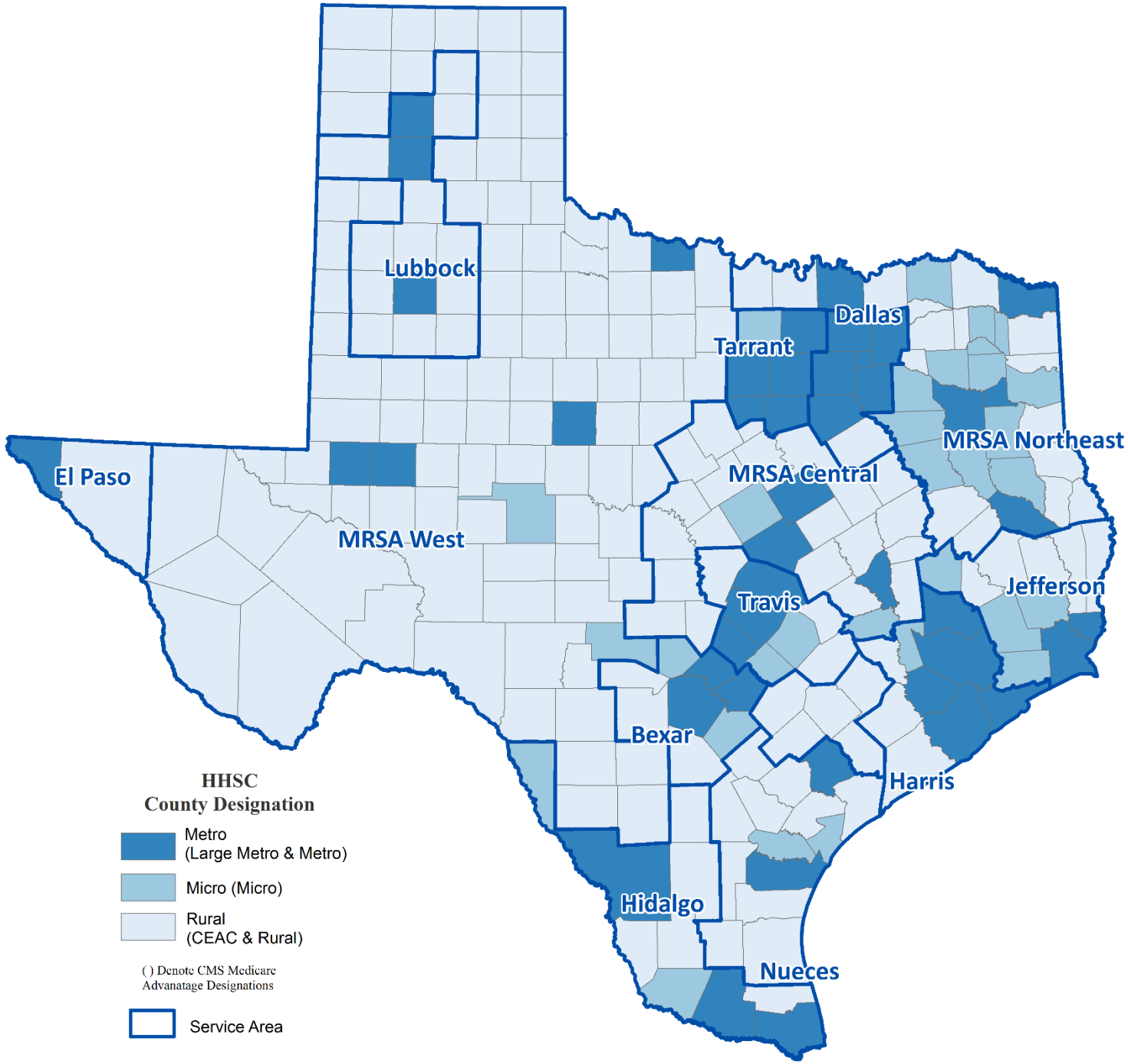
- Standards will vary based on county designation as metro, micro, and rural
- Each provider type will have a mileage and distance standard for one of three county designations
- Designations derived from Medicare Advantage (MA) standards
  - Large Metro and Metro were combined
  - Rural and Counties with Extreme Access Considerations (CAEC) were combined
  - Based on population and density

TEXAS Health and Human Services

County Level Designations

HHSC County Type	MA County Type	Population	Density
Metro	*Large Metro*	> 1,000,000	> 1,000/mi²
---	---	500,000 – 999,999	≥ 1,500/mi²
---	---	Any	≥ 5,000/mi²
---	*Metro*	≥ 1,000,000	10 999.9/mi²
---	---	500,000 – 999,999	10 – 1,499.9/mi²
---	---	200,000 – 499,999	10 – 4,999.9/mi²
---	---	50,000 199,999	100 4,999.9/mi²
---	---	10,000 – 49,999	1,000 – 4,999.9/mi²
Micro	*Micro*	50,000 – 199,999	10 – 99.9 /mi²
---	---	10,000 – 49,999	50 – 999.9/mi²
Rural	*Rural*	10,000 – 49,999	10 – 49.9/mi²
---	---	<10,000	10 – 4,999.9/mi²
---	*CEAC*	Any	<10mi²

TEXAS Health and Human Services


Lubbock
Dallas
Tarrant
MRSA Northeast
El Paso
MRSA Central
MRSA West
Travis
Jefferson
Bexar
Harris
Hidalgo
Nueces
HHSC
County Designation
Metro
(Large Metro & Metro)
Micro (Micro)
Rural
(CEAC & Rural)
( ) Denote CMS Medicare
Advanatage Designations
Service Area

Significant Changes in March 2017

- MCOs no longer submit Geo-Access Reports
- Reports will be generated at HHSC and sent to MCOs (in house analysis vs. self-reported data)
- Compliance will be assessed for provider type meeting travel time or distance standards
- Exceptions considered on a limited basis

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Provider Types Monitored

- Dental Specialists
- Hospital- Acute Care
- Main Dentist
- Nursing Facility
- Occupational, Physical, or Speech Therapy
- Prenatal
- Primary Care Provider
- Specialty Care Provider

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Provider Types Monitored (Physician Specialty Care)

- Cardiovascular Disease
- ENT (otolaryngology)
- General Surgeon
- OB/GYN
- Ophthalmologist
- Orthopedist
- Pediatrician
- Psychiatrist
- Urologist

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Provider Types Monitored (Dental Specialty Care)

- Endodontist, Periodontist, or Prosthodontist
- Orthodontist
- Oral Surgeons
- Pediatric Dental

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Provider Types Monitored (September 2018)

- In-Home LTSS
  - CFC Habilitation Services
  - Personal Care Services
  - Attendant Care
  - Private Duty Nursing
  - Occupational, Physical and Speech Therapies
  - Financial Management Service Organizations
- Pharmacy
- Targeted Case Management / Mental Health Rehabilitation (TCM / Rehab)
- Audiology
- Texas Health Steps Providers

TEXAS Health and Human Services

Monitoring Timeline

- **March 2017:** Monitoring began using new standards (baseline information only)
- **September 2017:** 75% Standard Established; MCOs subject to Corrective Action Plans (CAPs)
- **September 2018:** Full Compliance Begins; MCOs subject to CAPs and Liquidated Damages (LDs). New standards added.

TEXAS Health and Human Services

Reporting Frequency

- Full baseline report completed once each year for travel time and distance analysis.
- Quarterly Monitoring: Distance only analysis that occurs in intervening quarters. Includes analysis of all provider types all programs and all counties.

TEXAS Health and Human Services

Questions

- Please send questions to

  MedicaidCHIP_Network_Adequacy@hhsc.state.tx.us

TEXAS Health and Human Services

Reporting / Monitoring Frequency

HHSC will pilot network adequacy analysis and report delivery during quarter 3, Fiscal Year 2017. This analysis will include time and distance for PCPs and Main Dentists and will be delivered to MCOs in July 2017. Please see timeline on page 8 for additional information.

HHSC will conduct a full baseline report for travel time every three years, and a full baseline report for distance analysis every year. The first reports, including both travel time and distance analysis will be measured during Quarter 4, Fiscal Year 2017 and Quarter 1, Fiscal Year 2018 and will be sent to the MCOs by October 31, 2017 (for measurement occurring Q4 FY2017) and January 31, 2018 (for measurement occurring Q1 FY2018). Please see timeline on page 8 for additional information. Each baseline report will include all programs and plans serving each county, and will analyze provider types outlined in the chart entitled "Provider Types and Corresponding Standards."

On a quarterly basis when baseline analysis is not conducted, HHSC will implement a quarterly monitoring process. Prior to implementing this monitoring process, HHSC will work with MCOs to detail the parameters and technical specifications of the quarterly monitoring effort.

Network Adequacy Analysis Data Sources

Effective Q3 FY 2017, HHSC will begin conducting network adequacy analysis and geo-mapping for all programs. The provider data sources HHSC will use to conduct analysis are the P84, P88, and P023 provider files which are created from the MCO P92, P94, and P020 provider files.

Network adequacy reporting will be derived from the 2nd provider reconciliation file from the first month of the quarter analysis is conducted. For example, for the distance and travel time baseline analysis that occurs in Q4 FY 2017, HHSC will use the 2nd provider file from June 2017. Network adequacy analysis is a point in time analysis that includes a cross-sectional “snapshot” of the MCO network at the time of data collection.

MCOs should ensure provider files are submitted on time and consistent with the EB CHIP JIP. MCOs must ensure that provider response file issues are resolved timely to ensure accurate provider representation. As noted in managed care contracts, MCOs are subject to HHSC remedies should they not submit provider files on time and in accordance with the EB CHIP JIP.

The below chart notes the MCO provider file, provider response file and final file used for HHSC network adequacy analysis.

Program	Provider Network File (MCO / DMO Submitted)	Provider Response File	Provider File Used for Network Adequacy Analysis
MMC	P92 PCP Network File	P85 PCP Network Error Response File	P84 PCP Reconcile File
MMC	P94 Specialist Network File	P86 Specialist Network Error Response File	P88 Specialist Reconcile File
CHIP	P020 Monthly Provider File	P022 Provider Error Response File	P023 Provider Reconcile File

In addition, HHSC will utilize the MED ID, P010 with Dental, and P010 Perinate for CHIP enrollment files for member information.

File Delivery Logistics

MCO files will be posted to the XXXNETAD folders in TexMedCentral. Initial files will be created in Microsoft Excel and will be delivered within two months after the close of the quarter in which analysis occurs. Please see the column entitled "HHSC Generated Report Due Date" in below timeline for additional information. For example, baseline reports analysis conducted during Quarter 4, Fiscal Year 2017 will be delivered to MCOs by October 31, 2017.

Software Used for Analysis

HHSC is using the below software programs to develop geo-mapping reports:

1. StreetMap Premium for ArcGIS. This product works within the ArcGIS Desktop program and is the tool used for geo-coding addresses.

2. ArcGIS Desktop, including the Spatial Analyst and Network Analyst extensions. These extensions support geo-distance and travel time analysis, respectively.

   ESRI is the company that produces the ArcGIS products.

3. 'R'. This is an open-source statistical analysis program available without charge. The geosphere package developed for 'R' is used for conducting geo-distance analysis. This program runs the same geo-distance functions utilized in ArcGIS to calculate distance between geographical points.

4. MatchMaker SDK Pro. This program is also used for geo-coding addresses. Please note the company that develops this software will soon discontinue it, at which point HHSC will use StreetMap Premium for ArcGIS for geo-coding addresses.

Provider Types and Corresponding Standards for Distance and Travel Time Analysis

Provider Type		Current Managed Care Contracts		March 2017 Contract Standards					
		Distance in Miles	Travel Time	Distance in Miles			Travel Time in Minutes		
				Metro	Micro	Rural	Metro	Micro	Rural
Behavioral Health-outpatient		30 urban 75 rural	none	30	30	75	45	45	80
Hospital- Acute Care		30	none	30	30	30	45	45	45
Prenatal		none	none	10	20	30	15	30	40
Primary Care Provider[1]		30	none	10	20	30	15	30	40
Specialty Care Provider[2]	Cardiovascular Disease	75	none	20	35	60	30	50	75
	ENT (otolaryngology)	75	none	30	60	75	45	80	90
	General Surgeon	75	none	20	35	60	30	50	75
	OB/GYN	75	none	30	60	75	45	80	90
	Ophthalmologist	75	none	20	35	60	30	50	75
	Orthopedist	75	none	20	35	60	30	50	75
	Pediatric Sub-Specialists (Informational Only)	75	none	20	35	60	30	50	75
	Psychiatrist	75	none	30	45	60	45	60	75
	Urologist	75	none	30	45	60	45	60	75
Occupational, Physical, or Speech Therapy		75	none	30	60	60	45	80	75
Nursing Facility		75	none	75	75	75	N/A	N/A	N/A
Main Dentist (general or pediatric)		30 urban 75 rural	none	30	30	75	45	45	90
Dental Specialists	Pediatric Dental	75	none	30	30	75	45	45	90
	Endodontist, Periodontist, or Prosthodontist	75	none	75	75	75	90	90	90
	Orthodontist	75	none	75	75	75	90	90	90
	Oral Surgeons	75	none	75	75	75	90	90	90

[1] Primary care provider services include acute, chronic, preventive, routine, or urgent care for adults and children.
[2] Specialty care provider services include acute, chronic, preventive, routine, or urgent care for adults and children.

County Designations[3]

Metro:

1. Angelina
2. Bell
3. Bexar
4. Bowie
5. Brazoria
6. Brazos
7. Cameron
8. Collin
9. Comal
10. Dallas
11. Denton
12. Ector
13. El Paso
14. Ellis
15. Fort Bend
16. Galveston
17. Grayson
18. Gregg
19. Guadalupe
20. Harris
21. Hays
22. Hidalgo
23. Hood
24. Hunt
25. Jefferson
26. Johnson
27. Kaufman
28. Lubbock
29. McLennan
30. Midland
31. Montgomery
32. Nueces
33. Orange
34. Parker
35. Potter
36. Randall
37. Rockwall
38. Smith
39. Tarrant
40. Taylor
41. Travis
42. Victoria
43. Webb
44. Wichita
45. Williamson

Micro:

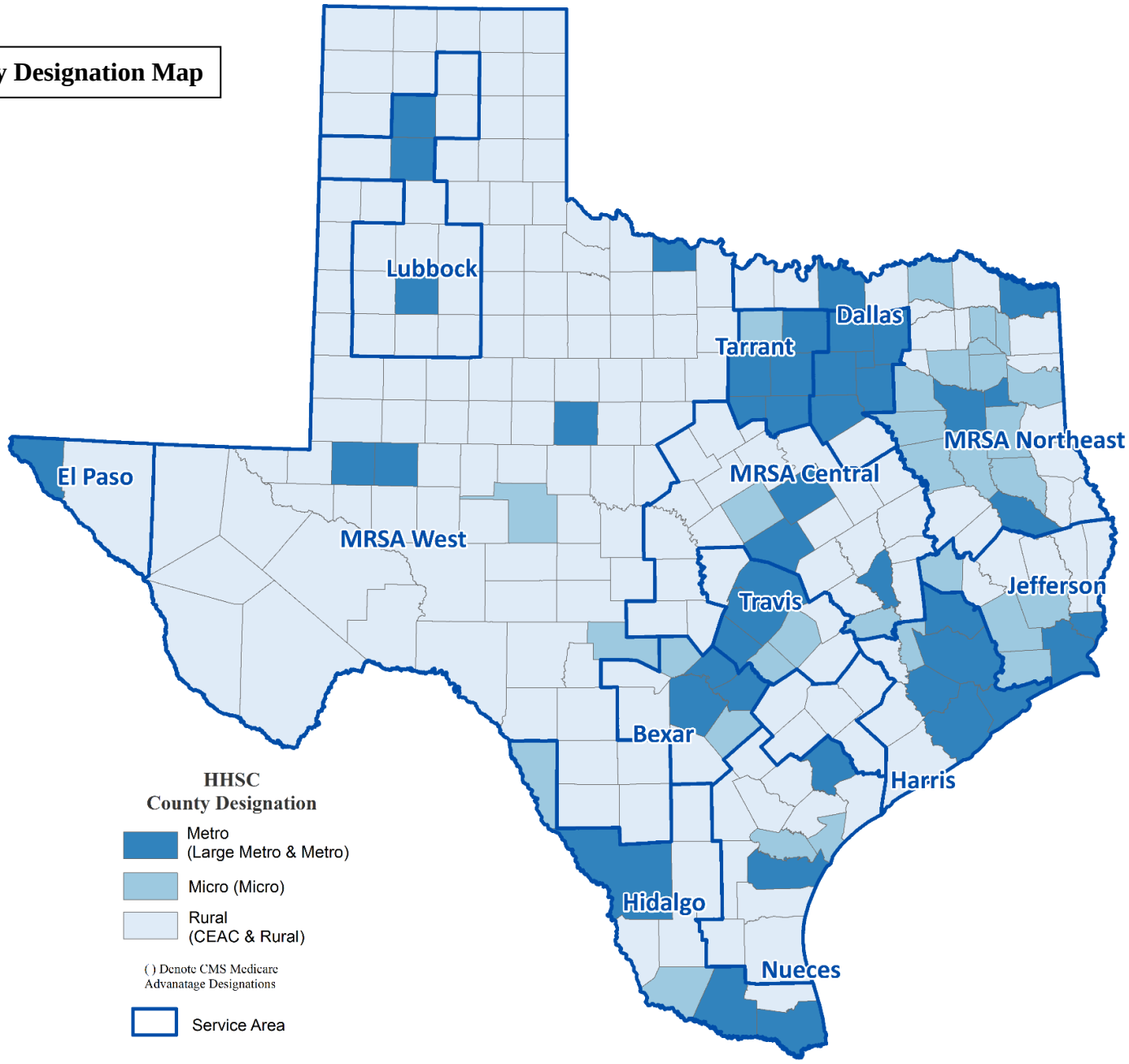
1. Anderson
2. Aransas
3. Bastrop
4. Caldwell
5. Camp
6. Chambers
7. Cherokee
8. Coryell
9. Hardin
10. Harrison
11. Henderson
12. Kendall
13. Kerr
14. Lamar
15. Liberty
16. Maverick
17. Morris
18. Nacogdoches
19. Rusk
20. San Patricio
21. Starr
22. Titus
23. Tom Green
24. Upshur
25. Van Zandt
26. Walker
27. Waller
28. Washington
29. Wilson
30. Wise
31. Wood

[3] County designation methodology is based on Medicare Advantage designations developed by CMS. Medicare designations include Large Metro, Metro, Micro, Rural, or CEAC (counties with extreme access considerations). For the purposes of access standards outlined in this proposal, HHSC has combined Large Metro and Metro into a single designation (Metro) and has combined Rural and CEAC designations into a single designation (Rural).

Rural:

1. Andrews
2. Archer
3. Armstrong
4. Atascosa
5. Austin
6. Bailey
7. Bandera
8. Baylor
9. Bee
10. Blanco
11. Borden
12. Bosque
13. Brewster
14. Briscoe
15. Brooks
16. Brown
17. Burleson
18. Burnet
19. Calhoun
20. Callahan
21. Carson
22. Cass
23. Castro
24. Childress
25. Clay
26. Cochran
27. Coke
28. Coleman
29. Collingsworth
30. Colorado
31. Comanche
32. Concho
33. Cooke
34. Cottle
35. Crane
36. Crockett
37. Crosby
38. Culberson
39. Dallam
40. Dawson
41. Deaf Smith
42. Delta
43. DeWitt
44. Dickens
45. Dimmit
46. Donley
47. Duval
48. Eastland
49. Edwards
50. Erath
51. Falls
52. Fannin
53. Fayette
54. Fisher
55. Floyd
56. Foard
57. Franklin
58. Freestone
59. Frio
60. Gaines
61. Garza
62. Gillespie
63. Glasscock
64. Goliad
65. Gonzales
66. Gray
67. Grimes
68. Hale
69. Hall
70. Hamilton
71. Hansford
72. Hardeman
73. Hartley
74. Haskell
75. Hemphill
76. Hill
77. Hockley
78. Hopkins
79. Houston
80. Howard
81. Hudspeth
82. Hutchinson
83. Irion
84. Jack
85. Jackson
86. Jasper
87. Jeff Davis
88. Jim Hogg
89. Jim Wells
90. Jones
91. Karnes
92. Kenedy
93. Kent
94. Kimble
95. King
96. Kinney
97. Kleberg
98. Knox
99. La Salle
100. Lamb
101. Lampasas
102. Lavaca
103. Lee
104. Leon
105. Limestone
106. Lipscomb
107. Live Oak
108. Llano
109. Loving
110. Lynn
111. Madison
112. Marion
113. Martin
114. Mason
115. Matagorda
116. McCulloch
117. McMullen
118. Medina
119. Menard
120. Milam
121. Mills
122. Mitchell
123. Montague
124. Moore
125. Motley
126. Navarro
127. Newton
128. Nolan
129. Ochiltree
130. Oldham
131. Palo Pinto
132. Panola
133. Parmer
134. Pecos
135. Polk
136. Presidio
137. Rains
138. Reagan
139. Real
140. Red River
141. Reeves
142. Refugio
143. Roberts
144. Robertson
145. Runnels
146. Sabine
147. San Augustine
148. San Jacinto
149. San Saba
150. Schleicher
151. Scurry
152. Shackelford
153. Shelby
154. Sherman
155. Somervell
156. Stephens
157. Sterling
158. Stonewall
159. Sutton
160. Swisher
161. Terrell
162. Terry
163. Throckmorton
164. Trinity
165. Tyler
166. Upton
167. Uvalde
168. Val Verde
169. Ward
170. Wharton
171. Wheeler
172. Wilbarger
173. Willacy
174. Winkler
175. Yoakum
176. Young
177. Zapata
178. Zavala

County Designation Map



	Fiscal Quarter	Quarter Months			Quarterly Monitoring	Baseline Report	HHSC Generated Report Due Date (New)	Milestone / Health Plan Remedies
2017	Q3	MAR*	APR	MAY	Pilot Testing (PCP / Main Dentist)		July 2017	• Mar 2017 Contract effective • PCP and Main Dentist Analysis Complete
	Q4	JUN*	JUL	AUG		X	Nov 14, 2017	• **Phase 1: Distance and Travel Time Baseline Complete (selected Provider Types, excluding STAR+PLUS) ****
2018	Q1	SEPT*	OCT	NOV		X	Jan 2018	• **Phase 2: Distance and Travel Time Baseline Complete (selected Provider Types*****
	Q2	DEC*	JAN	FEB	X		April 2018	• 75% Standard (CAP Only)
	Q3	MAR*	APR	MAY	X		July 2018	• 75% Standard (CAP Only)
	Q4	JUN*	JUL	AUG		X	Oct 2018	• 75% Standard (CAP Only) • **Distance Baseline Complete ******
2019	Q1	SEPT*	OCT	NOV	X		Jan 2019	• 90% Standard (CAP and LD) • LTSS and Pharmacy Services Added
	Q2	DEC*	JAN	FEB	X		April 2019	• 90% Standard (CAP and LD)
	Q3	MAR*	APR	MAY	X		July 2019	• 90% Standard (CAP and LD)
	Q4	JUN*	JUL	AUG		X	Oct 2019	• 90% Standard (CAP and LD) • **Distance Baseline Complete ******
2020	Q1	SEPT*	OCT	NOV	X		Jan 2020	• 90% Standard (CAP and LD)
	Q2	DEC*	JAN	FEB	X		April 2020	• 90% Standard (CAP and LD)
	Q3	MAR*	APR	MAY	X		July 2020	• 90% Standard (CAP and LD)
	Q4	JUN*	JUL	AUG		X	Oct 2020	• 90% Standard (CAP and LD) • **Distance and Travel Time Baseline Complete ******

* Network adequacy analysis will be derived from the 2nd provider reconciliation file from the first month of the quarter analysis is conducted, and Member eligibility file for the same month.

** Provider types analyzed for FY2017 Q4 include Cardiovascular Disease, ENT, Occupational, Physical, or Speech Therapy, Hospital - Acute Care, Psychiatrist, Nursing Facility, Prenatal, OB/GYN, Dental - all specialist. STAR+PLUS reports for FY2017 Q4 will be delivered prior to FY2018 Q1 reports.

*** Provider types analyzed for FY2018 Q1 include Behavioral Health - outpatient, Prenatal, General Surgeon, Ophthalmologist, Orthopedist, Pediatric Sub-Specialists, and Urologist.

**** Analysis will include all provider types