Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

June, 2012

v1.0

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Application for Section 1915(b) (4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of Texas requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Non-Emergency Medical Transportation (NEMT) Region 4.
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
X an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
___ a renewal request

Section A is:
- ___ replaced in full
- ___ carried over with no changes
- ___ changes noted in **BOLD**.

Section B is:
- ___ replaced in full
- ___ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of 5 years beginning August 1, 2016 and ending July 31, 2021.

State Contact: The State contact person for this waiver is Kathi Montalbano and can be reached by telephone at (512) 730-7409 or fax at (512) 730-7477or e-mail at kathi.montalbano@hhsc.state.tx.us. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

HHSC has signed an agreement with the state's federally recognized tribes and tribal organizations describing the tribal consultation process. The agreement requires a request for feedback for waiver changes that have an impact on (1) client eligibility, (2) acute care services and (3) acute care providers. NEMT is not an acute care service and this amendment has no impact on client eligibility. However, in the interest of open communication with the tribes, HHSC sent a notification and request for feedback on March 4, 2016.. In addition, this item was discussed with the tribal contacts on a conference call held on March 15, 2016.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

This new waiver is intended to reflect the change in management in Region 4 from an MTO under the MTO NEMT waiver to management by HHSC. There are approximately 109,000 clients that reside in Region 4 that are elibilge for NEMT services.

November 2015, HHSC terminated its contract with the MTO in Region 4 (Texoma Area Paratransit System d/b/a/ TAPS (TAPS)) for cause and material breach of the contract. Due to the severity of the deficiencies in TAPS' performance, HHSC immediately assumed TAPS' duties under the contract and took all other steps necessary to ensure that public services continue to be provided without interruption. Pursuant to the terms of the contract between HHSC and the MTO, most of the subcontracts were assigned to HHSC in order to ensure continuity of service. The subcontracts affiliated with TAPS were terminated. Under HHSC's management, the scheduling, arranging and coordinating of trips for eligible clients that do not have any other means of transportation services to a Medicaid covered healthcare appointment are occurring without incident. The subcontractors and individual transportation participants are now being timely paid for their services and services continue to be provided to individuals without interruption. Participants are entitled to the same services they received under the MTO delivery model, the only difference is that HHSC has stepped into the MTO's position.

The original MTO contract with TAPS was procured through a competitive procurement process. Payment methodology was capitated - per member, per month. TAPS received capitated payments to provide all NEMT services to eligible clients in Region 4. TAPS contracted with subcontractors to provide demand response transportation services and the subcontracts that were assigned to HHSC were assigned at the rates agreed upon in the original contracts with TAPS. The subcontracts affiliated with TAPS were terminated.

HHSCs Primary Functions
- Operate call centers
- Manage provider network and monitor network providers
- Assure that all NEMT services are provided to eligible clients in Region 4
- Ensure all NEMT services provided are prior authorized
- Manage client and provider reimbursements for transportation services
- Handle and process client issues and complaints

Pursuant to the terms of the contract between HHSC and TAPS, the subcontracts assigned to HHSC were for the delivery of demand response services. MTP is now responsible for the provision of all other transportation services in Region 4.

HHSC directly reimburses performing providers for transportation services, including ITPs. HHSC only reimburses Individual Transportation Participants (ITPs) for transportation to and from a Medicaid-covered service; ITPs should not receive reimbursement for mileage incurred when the client is not in the vehicle (i.e., “unloaded miles” or “non-loaded trips”).

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver.

Transportation Services include:
- Demand Response transportation services- Transportation that involves using contractor dispatched vehicles in response to requests from individual or shared one-way trips;
- Mass Transit tickets - Fixed route, intercity, or intra city transportation systems;
- Mileage Reimbursement for Individual Transportation Participant (ITPs) services- reimbursement to a family member, friend or neighbor to drive a client to a health care service;
- Meals and Lodging services- provided for overnight or extended stays;
- Transportation to and from renal dialysis services;
- Advanced Funds - funds authorized by the MTO in advance of travel and provided to the client or attendant to cover authorized transportation services for travel to a medically necessary health care service;
- Out-of-State transporation;
- Commercial Airline transportation - service provided by a commercial airline for medical care that can't be provided in the client's service area; and
- Transportation of an attendant.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   X **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a._X__**Section 1902(a) (1) - Statewideness**
   b._X__**Section 1902(a) (10) (B) - Comparability of Services**
   c.__X_**Section 1902(a) (23) - Freedom of Choice**
   d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   __X_ the same as stipulated in the State Plan
   _ __ is different than stipulated in the State Plan (please describe)

2. **Procurement**. The State will select the contractor in the following manner:

   ___ **Competitive** procurement
   ___ **Open** cooperative procurement
   ___ **Sole source** procurement
   X **Other** (please describe)

- Demand response transportation services. Pursuant to the terms of the contract between HHSC and TAPS (the MTO) most of the subcontracts were assigned to HHSC. Subcontracts affiliated with TAPS were terminated. The subcontracts that TAPS had in place were for the delivery of demand response services (including transportation of an attendant, if necessary). The rates vary from subcontractor to subcontractor depending on the contract that TAPS had with the subcontractor.

  The remaining MTP services (mass transit tickets, mileage reimbursement for individual transportation participant (ITP) services, meals and lodging services, transportation to and from renal dialysis services, advance funds, out-of-state transport, commercial airline transportation services and transportation of an attendant, if necessary), which were provided by the TAPS in Region 4, are now being provided by HHSC.
- Mass transit tickets are purchased by MTP from the mass transit provider and provided to the client.
- Mileage reimbursement for ITP is being reimbursed at the State mileage reimbursement rate for State employees of .54¢ per mile (referenced on the Texas Comptroller of Public Accounts website). HHSC directly reimburses performing providers for transportation services, including ITPs. HHSC only reimburses ITPs for transportation to and from a Medicaid-covered service; ITPs should not receive reimbursement for mileage incurred when the client is not I the vehicle (i.e., "unloaded miles" or "non-loaded trips").

- Meals are being reimbursed at the rate of $25 per day per person pursuant to the *Frew v. Traylor* lawsuit.
- Lodging is being arranged by the State on a fee-for-service basis with the most cost effective lodging provider in the area.
- Transportation to and from renal dialysis services only for indidudals who reside in a nuring home. Tranportation is provided via one of the means of transportation available that is most cost effective.
- Advanced funds are being issued by the state for meals and for mileage when the client has no means or money to make the trip and receive mileage reimbursement.
- Out-of-state transport is being arranged via one of the means of transportation available that is most cost effective (ie Greyhound, demand response, commercial airline)availableat.
- Commercial airline transportation services is being paid by the state at the best price to the location traveled.
- Transportation of an attendant is provided via one of the means of tranpsoration available, if demand response there is no additional cost to the state.

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

   _X__ Beneficiaries will be limited to a single provider in their service area.
   ___ Beneficiaries will be given a choice of providers in their service area.

   (NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

   Region 4 which includes the following counties: Archer, Baylor, Clay, Collin, Cooke, Cottle, Fannin, Foard, Grayson, Hardeman, Jack, Montague, Wichita, Wilbarger, Wise, and Young.

2. **State Standards.**

   Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

Except for the rates currently in place for demand response services, there are no other differences between the state standards applied under this waiver and those detailed in the State Plan.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

   __X_Section 1931 Children and Related Populations
   __X_Section 1931 Adults and Related Populations
   __X_Blind/Disabled Adults and Related Populations

_X__Blind/Disabled Children and Related Populations
_X__Aged and Related Populations
__X_Foster Care Children
___ Title XXI CHIP Children

Other: Nursing facility residents may obtain NEMT services to/from dialysis treatment as a waiver benefit.

Former Foster Care Children described in 1902(a)(10)(A)(i)(IX) of the Social Security Act may receive NEMT services.

The 1931 group is made up of the following eligibility groups:

- other caretaker relatives specified at 435.110,
- pregnant women specified at 435.116, and
- children specified at 435.118

All Medicaid-eligible individuals under the age of 21 may obtain NEMT services, including transportation to EPSDT services.

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
___ Poverty Level Pregnant Women
___ Individuals with other insurance
__X_Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program
___ Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
__X_Individuals receiving retroactive eligibility
___XOther (Please define):

Exclude nursing facility residents, except for nursing facility residents needing NEMT to/from renal dialysis treatment.

SCHIP Title XXI Children

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

Timely access is ensured by the following process:

A request for routine medical transportation must be received at least two working days in advance of the client's health care service appointment, unless the request is urgent in nature.. This gives the provider time to allocate resources that are adequate for the client's needs. A request for a long distance trip must be received at least five working days in advance of the client's health care service appointment. Exceptions are granted when circumstances have been determined to be beyond the client's control and are documented in the client's record.

The performing provider is required to call the client the night before to notify them of a pickup time. Once the driver arrives at the scheduled pickup time, they are the required to wait time is 10 minutes following the scheduled pickup time. Following this 10-minute wait, if the client does not board the vehicle, the client may be declared a no-show for the transportation service. If a client misses a scheduled ride, it may be possible for HHSC to schedule a same day urgent trip to provide the client with transportation to their healthcare appointment. When a client is ready for the return trip, the client calls the contracted transportation provider'sprovider toll-free number and requests the return trip. The transportation providers areprovider contractually obligated to pick-up a client no later than one hour from the time the client requested the return trip.

Additionally, the Health and Human Services Commission has adopted rules (Texas Administrative Code Title 1 Part 15 §380 to ensure the quality, efficient and economic provision of covered transportation services.

<u>Quality</u>

- Specifically, these rules addresses quality through the establishment of standards for motor vehicles. Adherence to the motor vehicle standards are monitored closely by the Contracted provider and also by MTP staff.
- Quality measures are also integrated into contracts by defining driver responsibilities and requirements, including satisfactory completion of numerous training requirements in order to qualify to transport Medicaid eligible clients.
- Key Performance Requirements are included as part of the contract. These standards stipulate the level of expected conformance and performance of services with penalties (Liquidated damages) associated with failure to adequately perform.

<u>Efficiency</u>

- Efficiency of operations may be addressed through a number of variables:

- Adequacy of transportation network – to ensure that a network of providers are available across a region to limit the amount of time that a client has to remain in the vehicle while being transported to their Medicaid-covered healthcare appointment.
- Diversification of transportation methods – HHSC utilizes and has implemented the use of diversified transportation services beyond the most commonly used transportation method, demand response. HHSC evaluates the clients' needs and provides alternative and more cost effective means of transport that may include mass transit, commercial airlines, fixed routes and the use of Individual Transportation Participants (ITPs).

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

The level of transportation capacity is reviewed by MTP for services in Region 4 and is adjusted accordingly to ensure clients are receiving timely and safe transportation services. Monitoring is ongoing and additional monitoring will be done principally through monitoring of complaints.

Timely access is ensured by the following process:

A request for routine medical transportation must be received at least two working days in advance of the client's health care service appointment, unless the request is urgent in nature. This gives the provider time to allocate resources that are adequate for the client's needs. A request for a long distance trip must be received at least five working days in advance of the client's health care service appointment. Exceptions are granted when circumstances have been determined to be beyond the client's control and are documented in the client's record.

The performing provider is required to call the client the night before to notify them of a pickup time. Once the driver arrives at the scheduled pickup time, they are required to wait time is 10 minutes following the scheduled pickup time. Following this 10-minute wait, if the client does not board the vehicle, the client may be declared a no-show for the transportation service. If a client misses a scheduled ride, it may be possible for HHSC to schedule a same day urgent trip to provide the client with transportation to their healthcare appointment. When a client is ready for the return trip, the client calls the contracted transportation provider's toll-free number and requests the return trip. The transportation providers are contractually obligated to pick-up a client no later than one hour from the time the client requested the return trip.

Additonally, Key Performance Requirements are included as part of the contract. These standards stipulate the level of expected conformance, quality, timliness and performance of services with penalties (Liquidated damages) associated with failure to adequately perform. HHSC will assess liquidated damages for the failure to adhere to the prescribed standtards.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

The performing provider must ensure that demand response transportation services are provided to all clients in the transportation service areas as authorized by HHSC and in compliance with contract requirements to meet the client's needs. The contractor is monitored for compliance. If the contractor does not meet the terms of the contract, remedies include placing the contractor on a corrective action plan, assessing liquidated damages, and contract termination.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

Subcontractor	# of Vehicles	County(ies) Served
Real Time Transport	88	Collin
LeFleur Transportation of Texas	26	Clay, Montague, Cooke, Fannin, Grayson, Wise
Rolling Plains Management Corp	67	Archer, Baylor, Cottle, Foard, Hardeman, Jack, Wichita, Wilbarger, and Young

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

Currently, there are sixteen counties within Region 4. Nonemergency Medical Transportation (NEMT) services are provided by three contracted vendors that offer transportation through demand response. Each of the three contractors have offices that are strategically located in different areas of the region. MTP staff carefully worked with each vendor to ensure that specific counties were assigned within close proximity to their headquarters' offices. All understood that while the county assignments were approved based on their selections, all understood that the transport of these clients beyond these respective counties is necessary. To date, this agreement of county assignments has worked well. Additionally, MTP has registered over 700 Individual Transportation Participants (ITPs) who use their personal vehicles to transport family members, friends or neighbors to covered healthcare services. MTP is alos continually adding new ITPs who express interest in providing transportation for family members, friends or neighbors to covered healthcare servies. MTP will initially evaluate the effectiveness by reviewing encounter data and complaints.

HHSC arranges NEMT services through performing providers (e.g. former TAPS subcontractors providing demand response services). TAPS had four subcontractors covering the Region. Three of those subcontractors have been assigned to HHSC. One subcontractor was terminated due to its affiliation with TAPS.

HHSC uses an accelerated monitoring activity when complaint information analysis suggests that an insufficient number of service vehicles are available. HHSC performs monitoring of vehicles, ride-alongs, and on-site observations to ensure that clients are transported safely, comfortably, and in a manner that best suits their medical needs. The performing provider is responsible for ensuring a sufficient capacity of vehicles and adjusting their resources accordingly to maintain compliance with contract requirements. When necessary, HHSC requires performing providers to increase the number of their fleet, use back-up resources (e.g., fleet and drivers), and engage in subcontracting activities, if necessary, to increase the number of qualified and competent performing providers. HHSC also monitors timely receipt of services by reviewing driver logs and reviwing complaint informationcomplaints.

If the performing provider fails to meet contract requirements, the performing provider is issued a letter indicating it is necessary to submit a corrective action plan. The corrective action plan requires the performing provider to outline the necessary steps to address any specific contract issues. If the provider fails to follow the corrective action plan or address deficiencies identified by HHSC, HHSC may assess liquidated damages and/or terminate the contract.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

   MTP monitors Demand Response utilization three ways:
   - Historical utilization data is retrieved from another server that contains trip and client data. Although the data relates to the previous fee-for-service model, MTP is able to examine the client count by specifying the specific utilization according to the sixteen (16) counties within the region. Using this data, MTP staff can then compare with the current client count. However, MTP staff understands that this method of calculation is not an exact science, but it allows staff to gage the utilization.
   - The second method is to compare the number of calls requesting service against the number of validated trips performed as evidenced by the trip data submitted by the subcontractors for payment.
   - Examining the encounter data submitted by the terminated contracted vendor to determine if their reported numbers are in alignment with numbers from other sources.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

   The contract for performing providers currently has provisions to levy liquidated damages for any area of performance that is not up to standards, including utilization. MTP considers utilization as a key element to successful performance.

   If the performing provider fails to meet contract requirements, the performing provider is issued a letter indicating it is necessary to submit a corrective action plan. The corrective action plan requires the performing provider to outline the necessary steps to address any specific contract issues. If the provider fails to follow the corrective action plan or address deficiencies identified by HHSC, HHSC may assess liquidated damages and/or terminate the contract.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

   a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

      i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

         Beginning in November 2015, the State began conducting several monitoring activities to determine a subcontractor's compliance with contract requirements, including their adherence to the contract provsions that relate to quality and service standards which include at minimum:

         • Field audits that take place on annual basis or at random intervals
         • Targeted field and desk audits in response to client complaints, complaint trends, and number or gravity of incidents/accidents reported on quarterly basis
         • Monthly desk reviews on vehicle credentialing
         • Monthly desk reviews on driver records and training requirements
         • Monthly review and reconciliation of payment requests to include review of prior authorization for submitted trips, pick-up and drop-off location as well as a review of corresponding driver's logs and matching to a covered healthcare service
         • Auditing Performance Improvement Plans initiated in response to Corrective Action Plans put in place to address performance deficiencies.

Monitoring activities are guided by a risk-based monitoring plan that is developed using key requirements of the contract, agency rules, and state and federal laws. Each element is weighted based on the level of risk posed that may impact effective program operations, agency business needs, and cost containment strategies.

Monitoring activities are guided by the level of risk. Examples of strategies used are noted below:

- Validation of transportation services will be conducted through quarterly matching of transportation claims against a Medicaid covered healthcare event. MTP staff worked collaboratively with the Claims Administrator to establish a matching logic.
- Driver standards are monitored through the validation of driver's license, training, driver records, drug and substance abuse checks, and criminal history checks.
- Vehicles are checked for updated annual inspections and vehicle registrations.
- Call center metrics are reviewed monthly to ensure compliance with Frew measures.
- The level of transportation capacity was reviewed by MTP for services in Region 4 and is adjusted accordingly to ensure clients are receiving timely and safe transportation services. Monitoring is ongoing and additional monitoring will be done principally through monitoring of complaints.
- Creation of a Quality Assurance Team to review delivery of services in Region 4 by MTP staff to ensure appropriateness, adherence to policies and procedures, and accuracy and timeliness of payment.

HHSC uses an accelerated monitoring activity when complaint information analysis suggests that there is a decrease in the quality of service provided to eligible clients. HHSC performs monitoring of vehicles, ride-alongs, and on-site observations to ensure that clients are transported safely, comfortably, and in a manner that best suits their medical needs. HHSC also monitors quality of services including timely service delivery by reviewing vehicles, driver logs and reviwing complaints.

ii. Take(s) corrective action if there is a failure to comply.

The contractor is monitored for compliance. If the contractor does not meet the terms of the contract, remedies include placing the contractor on a corrective action plan, assessing liquidated damages, and contract termination.
The contract currently has provisions to levy liquidated damages for any area of performance that is not up to standards. If the performing provider fails to meet contract requirements, the performing provider is issued a letter indicating it is necessary to submit a corrective action plan. The corrective action plan requires the performing provider to outline the necessary steps to address any specific contract issues. If the provider fails to follow the corrective action plan or address deficiencies

identified by HHSC, HHSC may assess liquidated damages and/or terminate the contract.

2. Describe the State's contract monitoring process specific to the selective contracting program.

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.
        Beginning in November 2015, the State began conducting several monitoring activities to determine a subcontractor's compliance with contract requirements, which include at minimum:
        • Field audits that take place on annual basis or at random intervals
        • Targeted field and desk audits in response to client complaints, complaint trends, and number or gravity of incidents/accidents reported on quarterly basis
        • Monthly desk reviews on vehicle credentialing
        • Monthly desk reviews on driver records and training requirements
        • Monthly review and reconciliation of payment requests to include review of prior authorization for submitted trips, pick-up and drop-off location as well as a review of corresponding driver's logs and matching to a covered healthcare service
        • Auditing Performance Improvement Plans initiated in response to Corrective Action Plans put in place to address performance deficiencies.
        Monitoring activities are guided by a risk-based monitoring plan that is developed using key requirements of the contract, agency rules, and state and federal laws. Each element is weighted based on the level of risk posed that may impact effective program operations, agency business needs, and cost containment strategies.
        Organizationally, the Contract Management Operations Unit serves as the hub for four other functional areas in MTP. The unit is led by a contract administrator and varied levels of contract staff that are responsible for ensuring transportation providers adhere to the terms and condition of their contract, this includes the subcontractors who provide transportation services in Region 4. Monitoring activities are guided by the level of risk. Examples of strategies used are noted below:
        • Validation of transportation services will be conducted through quarterly matching of transportation claims against a Medicaid covered healthcare event. MTP staff worked collaboratively with the Claims Administrator to establish a matching logic.
        • Driver standards are monitored through the validation of driver's license, training, driver records, drug and substance abuse checks, and criminal history checks.
        • Vehicles are checked for updated annual inspections and vehicle registrations.

- Call center metrics are reviewed monthly to ensure compliance with Frew measures.
- The level of transportation capacity was reviewed by MTP for services in Region 4 and is adjusted accordingly to ensure clients are receiving timely and safe transportation services. Monitoring is ongoing and additional monitoring will be done principally through monitoring of complaints.
- Creation of a Quality Assurance Team to review delivery of services in Region 4 by MTP staff to ensure appropriateness, adherence to policies and procedures, and accuracy and timeliness of payment.

ii. Take(s) corrective action if there is a failure to comply.

The contractor is monitored for compliance. If the contractor does not meet the terms of the contract, remedies include placing the contractor on a corrective action plan, assessing liquidated damages, and contract termination.

The contract currently has provisions to levy liquidated damages for any area of performance that is not up to standards. If the performing provider fails to meet contract requirements, the performing provider is issued a letter indicating it is necessary to submit a corrective action plan. The corrective action plan requires the performing provider to outline the necessary steps to address any specific contract issues. If the provider fails to follow the corrective action plan or address deficiencies identified by HHSC, HHSC may assess liquidated damages and/or terminate the contract.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

Contract requirements require performing providers to coordinate with licensed, qualified and competent drivers. This allows HHSC to continue to use and encourage coordination with local service delivery providers to include local transit authorities and cab companies. This service delivery model supports the use of direct service delivery providers and existing networks of transportation providers. This approach offers an efficient and effective model for meeting client transportation needs.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

Methods of outreach materials for beneficiaries include:
-Posters
-Brochures

-Outreach and informing on available NEMT services through mail-outs or flyers
-Desk reference

In addition to these materials, several other State programs provide information regarding NEMT:

-Other State program areas or vendors that work with the eligible population.
-2-1-1 Texas provides information on NEMT whether by phone or internet.
-Texas Department of State Health Services offers a link to the NEMT materials used by outreach staff.
-NEMT information is distributed to eligible clients with eligibility information.

The State translates all client materials to Spanish. HHSC uses a language translation vendor for the translation services whenever necessary. The vendor offers translation services in 170 different languages. Additionally, HHSC allows the client's attendant to travel with them to offer translation services during their health care appointments when requested by the client.

B. Individuals with Special Needs.

___ The State has special processes in place for persons with special needs (Please provide detail).

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

In November 2015, the Texas Health and Services Commission (HHSC) terminated its contract with the managed transportation organization (MTO) in Region 4 (Texoma Area Paratransit System d/b/a TAPS (TAPS)) of the current 1915(b) NEMT waiver for cause and material breach of the contract. Due to the severity of the deficiencies in TAPS' performance, HHSC immediately assumed TAPS' duties under the contract and took all other steps necessary to ensure that public services continue to be provided without interruption. The utilization of selective contracts under specific circumstances affords HHSC the ability to continue the uninterrupted delivery NEMT services to eligible recipients and their attendant. NEMT services become more efficient and economic with the assignment of subcontractors to HHSC as it eliminates any administrative cost and/or operational startup cost on willing providers and reduces time associated with the renegotiation of rates or waiving certain contract requirements a provider may seek in light of the urgent need to setup operations in a new Region. Additionally, a willing provider may not necessarily be familiar with the geographic area, available transportation resources, and/or recipient transportation needs and may encounter considerable

resistance from transportation entities that may not be familiar with a transportation broker from another Region, leading to potential interruption of service and increase in service complaints. HHSC on the other hand has the infrastructure (staff and resources) in place and is acutely aware of recipient transportation needs as HHSC previously managed NEMT in Region 4. The oversight and monitoring become less programmatic with the assignment of subcontractors as it allows time for HHSC to evaluate and identify next steps to fold FFS back to broker services in a structured procurement process.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: _8_/_1_/_2016___ to _7_/_31_/_2017___

Trend rate from current expenditures (or historical figures): __5.0_____%

Projected pre-waiver cost ____$5,095,000 _____
Projected Waiver cost ____$4,633,000_____
Difference: __ $462,000 _____

Year 2 from: 8_/_1_/_2017___ to _7_/_31_/_2018___

Trend rate from current expenditures (or historical figures): _5.0_____%

Projected pre-waiver cost ____$5,603,000_____
Projected Waiver cost ____$5,092,000_____
Difference: __ _$511,000_____

Year 3 (if applicable) from: 8__/_1_/2018____ to _7_/31__/_2019___
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost _$6,060,000_____
Projected Waiver cost _$5,507,000_____
Difference: _$553,000_____

Year 4 (if applicable) from: _8_/1__/_2019___ to _7_/_31_/2020____
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _$6,554,000_____
Projected Waiver cost _$5,956,000_____
Difference: _$598,000_____

Year 5 (if applicable) from: _8_/_1_/2021____ to _7_/31__/_2021___
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _$7,088,000_____
Projected Waiver cost _$6,441,000_____
Difference: _$647,000_____