Health and Human Services

State Medicaid Managed Care Advisory Committee

Network Adequacy and Access to Care Subcommittee

February 11, 2026

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.

Network Adequacy and Access to Care Subcommittee Supports a comprehensive monitoring strategy to ensure members have timely access to the services they need. Objectives include accuracy of provider directories, incentivizing use of telehealth, telemedicine and telemonitoring services, reducing administrative burden related to network adequacy reporting and monitoring and integrating network adequacy reporting to include additional measures.

Members Present. Yolunda Haynes-Mims, Beth Hughes, Lindsey Vasquez, Neel Naik

1. Call to order, introductions and roll call. Yolunda Haynes-Mims convened the meeting. A quorum was present.

2. Consideration of November 5, 2025, draft meeting minutes (NAAC). The minutes were approved as drafted.

3. Discussion on the SMMCAC 2025 annual report and possible integration of various recommendations from the former STAR Kids Managed Care Advisory Committee 2023 report (NAAC). A handout was discussed that was not made available to the public.

Summary.

Members discussed formal STAR Kids Managed Care Advisory Committee recommendations for the annual report, using handouts with highlighted items and Subject matter expert (SME) Elizabeth Tucker provided context for several recommendations, focusing on:

- Challenges families face securing single case agreements for out-of-network care
- Cumbersome processes at managed care organizations (MCOs) and the need for improved access

Dr. Knight clarified that approved recommendations would move to the full committee for potential inclusion in the annual report

Dr. Lindsay Vasquez suggested reviewing all highlighted and non-highlighted items for completeness

Recommendations/Items discussed in detail included:

- Single case agreement process improvement

- Network adequacy standards for long-term services and supports (especially for in-home nursing and attendant care)
- Continuity of care for at least 90 days, especially when changing programs/providers
- Ensuring HHSC evaluates if individuals are being properly assessed for Community First Choice (CFC) and personal care services
- Tracking and standardizing assessment triggers for CFC and PCS across MCOs
- Alternative models to address nursing shortages, including higher pay for health aides and parental caregiver roles
- Incentivizing comprehensive service lines with FQHCs and supporting primary care for children with complex needs
- Promoting evidence generation through pilot projects to identify best service delivery practices
- Challenges in transition from pediatric to adult care, including poor coordination and communication between systems
- The need for MCOs to fully inform members about both preferred and non-preferred providers, ensuring members know their rights and options
- Families voiced that financial costs to MCOs must be balanced against the stress burden and convenience for families

The subcommittee agreed to vote on all highlighted items plus two additional recommendations (number nine on page two and number 18 on page three). All were approved.

Discussion. Highlighted items were open for discussion.

#	Status	Assessment and Service Delivery Subcommittee	Notes
1.	Assessing	Improve access to single-case agreements and make the process easier for families to access and physicians to accept.	
2.	Assessing	HHSC should work to develop a list of services that are rarely provided via commercial insurance and allow Medicaid managed care organizations (MCOs) to authorize services without waiting on Explanation of Benefit from a commercial carrier.	
3.	Assessing	Exempt the Medically Dependent Children Program (MDCP) population from any out of network utilization benchmarks placed on MCOs.	Texas Government Code § 540.0552, *Coordination of Benefits; Continuity of Special Care for Certain Recipients*, allows a single-case agreement to not be considered out-of-network for the purposes of network adequacy if it meets Texas Government Code requirements.
4.	Assessing	Consider allowing families who live on bordering regions to select the neighboring region if most of their health care providers are in that region.	If a member wants to receive a service from a provider who is out-of-network with the member's MCO, the member can ask their MCO to do a single-case agreement with the provider. See STAR Kids contract section 8.1.23.4, *Single Case Agreements with Out-of-Network Specialty Providers*.
5.	Assessing	HHSC should develop a document that can be sent from the MCO to the family 120 days prior to the annual assessment informing them: a. What to expect at the assessment b. What documents to have ready.	

The highlighted item (item 1) was presented for consideration after very brief discussion.

#	Status	Assessment and Service Delivery Subcommittee	Notes
6.	Assessing	HHSC should require the MCOs to notify individuals via a text, email or call when a document has been uploaded to the member portal. Parent contact information including email addresses can be updated at every reassessment for accuracy.	
7.	Assessing	Require MCO service coordinators to contact families when an adverse determination is being sent and remind the family of their right to appeal the denial.	
8.	Assessing	HHSC should monitor the MCOs to ensure MCOs have provided access in the health portal for families to timely view: • STAR Kids Screening and Assessment Instrument (SK-SAI) • Individual Service Plan (ISP) • Authorizations, claims, information on the child's MDCP budget, and pending and final denials and reductions • Request an internal appeal	STAR Kids contract section 8.1.5.5.1, *Member Portal*, requires each MCO to maintain a member portal and upload required documents within seven days of receiving or finalizing a document.
9.	Assessing	HHSC should include a service fulfillment strategy as a measure of adequacy for long-term services and supports, i.e., hours authorized versus hours delivered.	
10.	Assessing	Ensure the continuity of care provision is a minimum of 90 days.	See STAR Kids contract sections 8.1.13.1, *Identification*, regarding continuity of care communication and 8.1.23.2, *Requirements for Individuals who become Members after the Operational Start Date*, regarding prior authorization transfers.
11.	Assessing	HHSC should closely evaluate through data collection whether individuals are being assessed for Community First Choice (CFC) and Personal Care Services (PCS).	
12.	Assessing	HHSC should closely evaluate through data collection whether individuals who are receiving CFC or PCS are receiving the number of hours they have been assessed as needing.	

It was mentioned that number 9 and 10 should be under consideration. There was mention that there should be several others highlighted for consideration as well Number 11 was briefly discussed.

It was suggested that the following link to the STAR Kids report could provide background for all recommendations under discussion. STAR Kids Final Report

#	Status	Assessment and Service Delivery Subcommittee	Notes
32.	Completed (ongoing)	Continue to work with knowledgeable stakeholders on improvements to the SK-SAI.	HHSC encourages members, families, providers, MCOs, and other stakeholders to provide feedback. HHSC encourages individuals to provide public comment and subject matter expert (SME) involvement at State Medicaid Managed Care Advisory Committee (SMMCAC) meetings. HHSC will continue consulting with stakeholders.
33.	Completed	Continue to assess if the reassessment tool limits questions based on no change in condition and which focuses on assessing for improved outcomes for children.	This recommendation was in relation to the STAR Kids Screening and Assessment Instrument (SK-SAI) optimization project required by Senate Bill 1207, 86th Legislature, Regular Session, 2019. The streamlined SK-SAI went into effect on September 1, 2022.
34.	Completed	The SK-SAI should account for medical intervention as a contributor to how one answers the questions. For example, is he in pain, no "because of medical intervention?" The same could be said for being "stable," due to medical intervention. The intervention must be accounted for because without it the child's condition could deteriorate. Families should be asked to what they attribute the change.	The SK-SAI has fields for service coordinators to add additional information.
35.	Completed	Evaluate and monitor the revised tool triggers for referrals for Community First Choice, durable medical equipment, Personal Care Services, and therapy are working.	This recommendation was in relation to the SK-SAI optimization project.
36.	Completed (ongoing)	SK-SAI feedback: Review feedback specifically, including children with medical complexities, children with intellectual and developmental disabilities (IDD) and children with significant mental health needs.	HHSC sought feedback when the SAI was originally developed and incorporated the feedback into the final version of the SAI. STAR Kids members and families are surveyed as part of HHSC's quality initiatives.
37.	Completed	SK-SAI feedback: Solicit family and Service Coordinator (MCO assessors) feedback from the new tool.	HHSC sought feedback when the SAI was originally developed and incorporated the feedback into the final version of the SAI.
38.	Mix: Completed or Assessing	HHSC should include the following recommendations as strategies for the recruitment, retention, and access to community attendants. a) Facilitate/incentivize the creation of community attendant registry to help families find direct service workers. b) Encourage value-based payment models that incentivize the development of specifically trained attendants to care for children who have medically complex conditions or who have behaviorally complex support needs by allowing for increased payment for individuals with more skills and certifications as well as increased administrative payments to home health agencies and ensuring that Managed Care Organizations who participate in such initiatives are not financially penalized including during capitation rate setting and procurement. c) Increase the Medicaid fee schedule for Personal Care Services and Community First Choice to a minimum of $15.00 per hour. d) Explore models that allow families to be providers of care such as Parents as Certified Nurse Assistants in Colorado and the Licensed Health Aide program in Arizona.	a) Completed. HHSC established a community attendant registry website, Direct Care Careers, in October 2023. b) Assessing. HHSC's managed care contracts include requirements to encourage value-based alternative payment models with providers. c) Completed. The 89th Texas Legislature, Regular Session, 2025, provided legislative direction and funding to HHSC to increase attendant rates. d) Assessing. HHSC is assessing other states' models.

Number 36, 37, and 38 were discussed. Only item 38 had been highlighted.

#	Status	Health Homes and Quality Measures Subcommittee	Notes
1.	Assessing	HHSC should incentivize systems of care that allow for a coordinated review of needs at specified time points to streamline the approval and delivery of supplies and medications. Currently most authorizations for supplies, equipment and medications occur at desperate times in a very uncoordinated and haphazard manner. It is not unusual for a family to make a trip to the pharmacy every other day.	
2.	Assessing	Incentivize the development of dedicated comprehensive service lines within FQHCs and large primary care practices and their collaboration with centers of excellence.	
3.	Assessing	HHSC should promote evidence generation as to the best approach to service delivery by sponsoring and incentivizing statewide and national pilot projects to identify best practices.	
4.	Assessing	HHSC should pay particular attention to include outcome measures that directly measure the capability/comfort/calm of members – in the next iteration of the SK-SAI.	
5.	Completed	HHSC, MCOs and Providers should review and revise prior authorization requirements for appropriateness for this population. Example: An MCO requires a hearing test and developmental screens before authorizing for speech therapy. This may be a reasonable requirement for the typical STAR population but for children who already have a diagnosis of moderate to severe cognitive impairment the screening is unnecessary. This recommendation is supported by SB 1207 which requires an annual review of prior authorization processes.	Texas Government Code § 540.0304, *Annual Review Of Prior Authorization Requirements*, requires MCOs to work with the MCO's provider advisory group to conduct an annual review of the MCO's prior authorization requirements.

Numbers 2 and 3 were briefly discussed

STAR Kids Managed Care Advisory Committee (SKMCAC) 2023 Report Recommendations

#	Status	Transition from Pediatric System to Adult System Subcommittee	Notes
16.	Requires legislative directive	Design, pilot, and evaluate innovative value-based transition payment pilots to: 1) Increase the availability of participating adult physicians in the geographic areas of concern; 2) Strengthen the coordination and communication between pediatric-sending and adult- receiving practices; 3) Expand the level of health care transition support available to medically complex youth and young adults and their caregivers in both pediatric and adult sites; and 4) Improve appropriate use of health care among this vulnerable population.	

There was brief discussion on number 16. This area should be considered carefully. There is no transition occurring. "It is like dropping off a cliff". This should be considered in a stand-alone committee. This recommendation was ultimately approved

18.	Completed)	HHSC should require in contract that MCO call center staff inform members of non-preferred providers along with preferred providers available in the network, to enable members to choose the most appropriate services, providers, and equipment.	See STAR Kids contract section 8.1.7.9.3, *Non-Pharmacy Preferred Provider Arrangement.*

The above recommendation was suggested to be included, though it had not been highlighted by the subcommittee. An example of preferred providers was given when

an MCO required a family to change pharmacies, and this put a huge burden on the caregivers. This recommendation was ultimately approved.

MOTION: Approve all highlighted items and numbers 9, 18 above prevailed.
(This was a very chaotic motion)

4. Update on the Rural Health Transformation Program (Public Law No. 119-21 (07/04/2025), Chapter 4, Sec. 71401)

Summary. Claire Steeg (HHSC) presented an update on the Rural Texas Strong program, part of the Federal Rural Health Transformation Program. Texas was awarded $281.3 million for budget period one, with a potential for $1.4 billion over five years She outlined six initiatives outlined:

- Community-based prevention, wellness, and nutrition programs
- Patient portal and health technology investments for rural providers
- AI and telehealth tools for reducing administrative burden and improving care
- Provider workforce recruitment/retention and local career path development
- Cybersecurity infrastructure for rural healthcare organizations
- Infrastructure/capital improvements within CMS guidelines

There are restrictions to the funding: new construction capped is at 20%. There are also limitations on certain tech purchases and five-year workforce commitments were required

Stakeholders are encouraged to follow updates via the dedicated website and email list

Dr. Knight asked about sustaining rural provider workforce; Ms. Steeg emphasized incentives targeting local talent and five-year commitments.

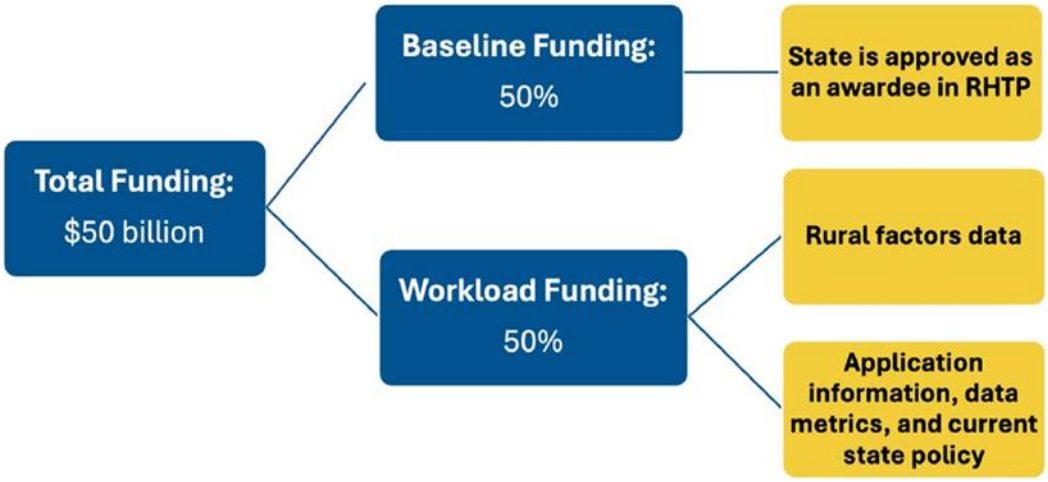
Presentation

Stevens Amendment: Texas' Rural Health Transformation Program, Rural Texas Strong, is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $281,319,361 in budget period 1 with 100 percent funded by CMS/HHS. The

contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Disclaimer: At this time, HHSC is not meeting with potential vendors or applicants so that we can maintain fairness for all interested participants and protect future procurements related to the federal Rural Health Transformation (RHT) Program. Actual eligible participants, including the definitions that will be used to evaluate eligibility, and a final determination of who is eligible will be a contracting and procurement function. Procurement details will be finalized as we work through the approval processes for our project design with CMS and then ultimately the internal procurement and contracting processes. We are unable to discuss or answer questions related to procurement and eligibility information. Please see the "How to Stay in Touch" slide for additional information on how to sign up for updates as they are released.

RHT Program Funding Distribution



Use of Funds

1. Prevention and chronic disease: Promoting evidence-based, measurable interventions
2. Provider payments: Payments to health care providers for the provision of health care items or services.
3. Consumer tech solutions: Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.

4. Training and technical assistance: Providing training and TA to improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.
5. Workforce: Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years.
6. IT advances: Providing technical assistance, software, and hardware.
7. Appropriate care availability: Assisting rural communities to right size their health care delivery systems.
8. Behavioral health: Supporting access to opioid use disorder treatment services, other substance use disorder treatment services, and mental health services.
9. Innovative care: Support innovative models of care that include value-based care arrangements and alternative payment models.
10. Capital expenditures and infrastructure: Investing in existing rural health care facility buildings and infrastructure, including minor building alterations or renovations and equipment upgrades.
11. Fostering collaboration: Initiating, fostering, and strengthening local and regional strategic partnerships between rural facilities and other health care providers

**Note: Additional details on the use of funds can be found in the CMS Notice of Funding Opportunity*.

Funding Limitations and Unallowable Costs

- New construction is unallowable. Minor renovations or alterations are allowed if clearly linked to program goals; funding cannot exceed 20% of the total funding CMS awards States in budget period.
- Limits on using funding for EMR systems. No more than 5% of total funding CMS awards to a state in budget period.
- Purchase of covered telecommunications and video surveillance equipment for households.
- Limits on provider payments. Cannot use funds to replace payment for clinical services that could be reimbursed by insurance.
- Clinician salaries or wage supports for facilities that subject clinicians to non-compete contractual limitations.

**Note: This is not an exhaustive list of restrictions. Additional details can be found in the CMS Notice of Funding Opportunity and on the CMS RHT website.*

Rural Texas Strong Update

- HHSC submitted its Rural Texas Strong application for the RHT Program to CMS on November 3, 2025. The submitted application and other materials are posted to HHSC's Rural Health Transformation Program website. Rural Health Transformation Program | Provider Finance Department
- CMS requested additional budget information in December, before announcing awards on December 29, 2025.
- Texas was awarded $281.3 million for budget period 1 of the program. An approximate $1.4 billion over five years. All future funding figures are estimates as CMS has not issued final budget awards for the remaining budget years of the program.
- HHSC must provide an updated budget to CMS since every state was required to draft an application using a hypothetical $200 million per year. Revisions were due to CMS on January 30, 2026.
- CMS will take up to 30 days to review the updated information, ask questions, and provide additional guidance on the terms and conditions of the award.

Initiative 1 Make Rural Texans Healthy Again

- **Eligibility**: Rural hospital districts.
- **Procurement process**: Direct awards.
- **Description:** Funding will be used to enhance or create community-based prevention, wellness and nutrition programs, or services aimed at improving chronic disease conditions (diabetes, cardiovascular disease, chronic respiratory disease or obesity).

Table 1: Implementation Options

Community wellness center (exercise, nutrition classes, etc.)	Non-emergent transportation support to improve access to pharmacies (to improve medication adherence), grocery stores, and primary or preventive healthcare appointments
Grocery stores, farmer's markets, or local food pantries to increase access to fresh U.S.-grown produce, dairy, and meat (Funds cannot be spent on meals themselves, per CMS)	Active remote monitoring for high acuity patients
After-hours primary care clinic to reduce non-emergent emergency department visits	Support and technology for enrolling individuals who are dually eligible for Medicare and Medicaid in care plans that include local behavioral and preventative care providers
Low or no-cost chronic disease screenings (prevention) and low or no-cost primary care visits	Other strategies, as approved by HHSC

Initiative 2 Rural Texas Patients in the Driver's Seat

- **Eligibility**: Two or more clinically integrated networks, accountable care organizations, or similar cooperatives supporting hospitals, clinics/physicians, and behavioral health providers
- **Procurement Process:** Request for Proposal, Competitive Procurement.
- **Description**: Funds will be used for patient portal creation, health information exchange (HIE) compatibility and advancement, and other consumer-facing-facing health technology equipment and applications.

Initiative 3 Lone Star Advanced AI and Telehealth

- **Eligibility**: Two or more clinically integrated networks, accountable care organizations or similar cooperatives.
- **Procurement Process**: Request for Proposal, Competitive Procurement.
- **Description**: Fund HIE and electronic medical record compatible artificial intelligence tools, including ambient listening, to improve patient record keeping, correct coding, and streamline medical administrative costs; support creation and establishment of telehealth networks for specialty and behavioral health services.

Initiative 4. The Next Generation of the Small Town Doctor and Team

- **Eligibility**: Rural health care providers, with at least one award per rural county.
- **Procurement Process**: Request for application.
- **Description:** Funding will support locally driven efforts with a focus on at least one of four approaches, described on the next slide.

Locally driven efforts will focus on at least one of four approaches:

1. Developing career paths for local high school students.
2. Providing scholarships for recent high school graduates.
3. Offering relocation or signing bonuses for early, mid, or late career professionals.
4. Creating a new residency training program, fellowship or combination program, including partnering with academic institutions or an existing teaching hospital.

Initiative 5. Unified Care Infrastructure and Rural Cyber Protection

- **Eligibility**: Vendors listed as a Managed Security Services Provider with the Texas Department of Information Resources.
- **Procurement Process:** Request for offer.

- **Description**: Funding will be used to establish a unified care infrastructure and bolster cybersecurity defenses across rural providers. By deploying a managed security solution
    - — including endpoint detection and response; comprehensive, all-time security operations center monitoring, and comprehensive user training
    - — risk can be significantly reduced, ensuring the security of sensitive patient data, and enhancing the overall security of an organization

Initiative 6. Infrastructure and Capital Improvement for Rural Texas

- **Eligibility**: Rural hospitals, rural health clinics, behavioral health providers, opioid and substance abuse programs, emergency medical services (EMS), pharmacies, public health offices and other eligible providers.
- **Procurement Process**: Request for Application.
- **Description**: Provide funding for providers to add and replace the equipment they need to improve patient care, within the required limitations on new construction and remodel projects.

The HHSC Rural Health Transformation Program website has been established and will be updated with new opportunities and information about the program.

New email: RuralTexasStrong@HHS.Texas.gov . . Rural Health Transformation Program | Provider Finance Department

HHSC is actively working on hiring a new dedicated team, with postings available online at Jobs at HHS
Jobs at HHS | Texas Health and Human Services

Stakeholders, applicants, and vendors are encouraged to sign up for the new Rural Texas Strong Gov Delivery , where HHSC will issue public notices and announce procurement opportunities. Texas Health and Human Services Commission

Procurement opportunities will also be posted to the Electronic State Business Daily website. ESBD Solicitations

Discussion.

Rural health has problems with provider access. There is a new residency program in the proposal but that may not address the problem. We need to have a way to make the provider stay in the rural area once they get there. Staff stated that there is a 5 year time commitment and it focuses on the emphasis on community programs to incentivize them to stay.

5. Review of action items and agenda items for next meeting.

Future Meetings.

- May 13, 2026
- Aug. 12, 2026
- Nov. 4, 2026

Action and Agenda Items

Condensed list of the recommendations that the subcommittee met on today

6. Adjourn. There being no further business, the meeting was adjourned.