# Exhibit H - STAR Health Scope of Work (SOW)
# RFP No. HHS0010427

## Table of Contents

ARTICLE 1 INTRODUCTION ....... 6
1.1 Overview of STAR Health ....... 6
1.2 Child Protective Services and Substitute Care in Texas ....... 6
1.3 Eligible Population ....... 8
1.4 Definitions and Exhibits ....... 8
1.5 Mission Statement ....... 31
1.6 Mission Objectives ....... 31
1.6.1 Network Adequacy and Access to Care ....... 31
1.6.2 Quality ....... 32
1.6.3 Timeliness and Accuracy of Claims Payment ....... 32
1.6.4 Service Coordination ....... 32
1.6.5 Medical Home ....... 32
1.6.6 Timeliness of Initial Texas Health Steps Checkups ....... 32
1.6.7 Health Passport ....... 33
1.6.8 Timeliness and Accuracy of Encounters Submission ....... 33
1.6.9 Behavioral Health Services ....... 33
1.6.10 Outpatient Pharmacy Services ....... 33
1.6.11 Delivery of Healthcare to Diverse Populations ....... 34
1.6.12 Continuity of Care ....... 34
1.6.13 Disease Management Requirements ....... 34
1.6.14 Fraud, Waste, and Abuse (FWA) Requirements ....... 34
1.6.15 Cost-Effective Provision of Services ....... 34
1.7 Service Area ....... 34
1.8 Authority ....... 34
ARTICLE 2 SCOPE OF WORK ....... 35
2.1 Required Federal and State Approval and Funding ....... 35
2.2 Remedies and Liquidated damages ....... 35
2.3 Antitrust ....... 36
2.4 Member Eligibility, Enrollment, and Disenrollment ....... 36

2.4.1 Eligibility determination and disenrollment ..... 36
2.4.2 Member Enrollment and Disenrollment ..... 36
2.4.3 Span of Coverage ..... **Error! Bookmark not defined.**
2.5 Transition Phase Scope ..... 40
2.5.1 Introduction ..... 40
2.5.2 Administration and Key Personnel ..... 41
2.5.3 Readiness Review ..... 43
2.5.4 Health Passport Readiness ..... 50
2.5.5 Texas Department of Insurance Licensure, Certification or Approval ..... 50
2.5.6 MCO Accreditation ..... 51
2.6 Operations Phase Scope ..... 51
2.6.1 Administrative Services ..... 51
2.6.2 Administration and Contract Management ..... 51
2.6.3 Operations Phase Readiness Review and Targeted Operational Reviews ..... 51
2.6.4 Future Initiatives ..... 53
2.6.5 HHSC Performance Review and Evaluation ..... 54
2.6.6 Provider Credentialing and Re-credentialing ..... 54
2.6.7 Provider Relations Including Manual, Materials, and Training ..... 57
2.6.8 Continuing Education credits ..... 61
2.6.9 Provider Hotline ..... 61
2.6.10 Provider Reimbursement ..... 62
2.6.11 Minimum Wage Requirements for Attendants ..... 67
2.6.12 Electronic Visit Verification ..... 67
2.6.13 Managed Care Organization Termination of Provider Contracts ..... 67
2.6.14 Provider Protection Plan ..... 68
2.6.15 Member Services ..... 69
2.6.16 Requirements Common to All Member-Facing Call Centers ..... 73
2.6.17 Member Education ..... 76
2.6.18 Managed Care Organization Website ..... 80
2.6.19 Smart Phone Application ..... 83
2.6.20 Marketing and Prohibited Practices ..... 83
2.6.21 Quality Improvement and Performance Evaluation ..... 84

2.6.22 Utilization Management (UM) ... 92
2.6.23 Special Supplemental Nutrition Program for Women, Infants, and Children ... 96
2.6.24 Health Passport ... 96
2.6.25 Coordination with Texas Department of Family and Protective Services ... 98
2.6.26 Financial Requirements for Covered Services ... 101
2.6.27 Reporting Requirements ... 103
2.6.28 Management Information System (MIS) Requirements ... 106
2.6.29 FWA ... 110
2.6.30 Complaints and Managed Care Organization Internal Appeals Process for Providers 116
2.6.31 Member Complaint and Appeal System ... 118
2.6.32 Covered Services ... 125
2.6.33 Access to Care ... 129
2.6.34 Telemedicine and Telehealth Access ... 136
2.6.35 Provider Network ... 137
2.6.36 Out-of-State Providers ... 147
2.6.37 Value-added Services ... 147
2.6.38 Case-by-case Services ... 148
2.6.39 Covered Community-Based Long-Term Services and Supports ... 148
2.6.40 Community First Choice Services ... 149
2.6.41 Personal Care Services ... 150
2.6.42 Service Delivery Options ... 151
2.6.43 Facility Based Care ... 153
2.6.44 Early Childhood Intervention ... 153
2.6.45 Members with Special Healthcare Needs ... 155
2.6.46 Screenings and Assessments ... 155
2.6.47 Service Coordination ... 159
2.6.48 Individual Service Plan Description ... 168
2.6.49 Disease Management ... 171
2.6.50 Behavioral Health Services ... 173
2.6.51 Continuity of Care ... 180
2.6.52 Vision Services and Vision Network ... 184

2.6.53 Pharmacy Services ..... 184
2.6.54 Dental Services and Dental Network ..... 195
2.6.55 Health Home Services ..... 198
2.6.56 Medicaid Wrap-Around Services ..... 199
2.6.57 Additional Requirements Regarding the Medically Dependent Children Program 200
2.6.58 Texas Health Steps ..... 206
2.6.59 Immunizations ..... 210
2.6.60 Provisions Related to Covered Services for Members ..... 210
2.7 Turnover Phase Scope ..... 223
2.7.1 Turnover Plan ..... 224
2.7.2 Transfer of Data and Information ..... 225
2.7.3 Post Turnover Services ..... 226
2.8 Terms of Payment ..... 226
2.8.1 Calculation of Monthly Capitation Payment ..... 226
2.8.2 Time and Manner of Payment ..... 227
2.8.3 Certification of Capitation Rates ..... 227
2.8.4 Modification of Capitation Rates ..... 228
2.8.5 Capitation Rate Structure ..... 228
2.8.6 MCO Input During Rate Setting Process ..... 228
2.8.7 Adjustments to Capitation Payments ..... 229
2.8.8 Experience Rebate ..... 229
2.8.9 Payment by Members ..... 236
2.8.10 Restriction on Assignment of Fees ..... 237
2.8.11 Liability for Taxes ..... 237
2.8.12 Liability for Employment Related Charges and Benefits ..... 237
2.8.13 No Additional Consideration ..... 237
2.8.14 Federal Disallowance ..... 238
2.8.15 Pass-through Payments for Provider Rate Increases ..... 238
2.8.16 Non-Risk Payments for Certain Drugs ..... 238
2.8.17 Supplemental Payments for Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products ..... 239

# ARTICLE 1 INTRODUCTION

## 1.1 OVERVIEW OF STAR HEALTH

On April 1, 2008, the Texas Health and Human Services Commission (HHSC) launched the STAR Health Program as the first comprehensive health and medical network for children and young adults who are in the State of Texas' foster care system. The goal of STAR Health is to give each of these children and young adults Covered Services that are coordinated, comprehensive, easy to access, and uninterrupted when the individual moves.

Children and young adults in foster care have significant healthcare needs: up to 80% of children come into foster care with at least one healthcare related problem; 33% of children come into foster care with a chronic medical condition; and up to 80% of children and young adults enter with a significant mental health condition. Members in the STAR Health Program may have health problems associated with poverty, such as low birth weight and malnutrition. They are also at risk for conditions associated with Caregiver neglect, physical or sexual abuse, Caregiver substance use or mental illness, and the separation and loss associated with out-of-home care.

The American Academy of Pediatrics recommends children and youth in conservatorship see medical professionals early and often. In 2017, the Texas Legislature required children in foster care to receive a medical screening exam within three Business Days of entering conservatorship.

While they may have multiple and complex medical, physical health, Behavioral Health (BH), and developmental needs, Members also have the typical health needs of all children. Such needs include routine well-child healthcare, immunizations, developmental surveillance, and the treatment of acute childhood illnesses.

The STAR Health Program addresses the healthcare needs of children and young adults in foster care and beyond by delivering integrated physical and BH Services, centralized Service Coordination and effectively managed healthcare data and information.

Information regarding HHSC and its programs is available online and can currently be accessed at https://hhs.texas.gov/.

## 1.2 CHILD PROTECTIVE SERVICES AND SUBSTITUTE CARE IN TEXAS

The Texas Department of Family and Protective Services (DFPS) is the agency granted authority to administer child protective services in the State of Texas. DFPS investigates reports of child abuse and neglect to protect children from harm now and in the future. DFPS works to strengthen and stabilize families so that they can safely care for their children at home. When that is not possible, DFPS works with the courts and communities to find permanent homes or other places for children to live. DFPS works to ensure appropriate placements for children and comprehensive services for families in an effort to stabilize and reunite families when possible.

As directed by Acts 2017, H.B. 5, 85th Leg., R.S., sec. 24(c) (effective September 1, 2017), DFPS established an Investigations division that oversees the Child Protective Investigations (CPI) and Special Investigations (SI) programs. The CPI and SI programs investigate reports of child abuse and neglect while the Child Protective Services (CPS) division of DFPS provides ongoing services beyond the investigation stage.

State law requires anyone who believes a child is being abused or neglected to report the situation to the DFPS abuse hotline so that the Investigations division of DFPS can investigate. Reports of abuse or neglect can be made to the DFPS statewide intake hotline at 1-800-252-5400 or www.txabusehotline.org. The CPI division investigates reports of child abuse and neglect that meet statutory definitions. The objectives of the investigation are to ensure child safety by:

1. Determining whether abuse or neglect occurred;
2. Assessing whether the child may be at risk of future abuse or neglect; and
3. Providing or referring the family or child to needed safety services, community services, or agency services which reduce the risk of abuse and neglect and enhance the well-being of the family.

If, during the course of an investigation, DFPS determines it is not safe for a child to live with his or her own family, DFPS petitions the court to remove the child from the home. Although DFPS is the entity given conservatorship of the child, it is CPS that provides the Substitute Care Services. CPS may temporarily place a child with relatives, a verified substitute family, an emergency shelter, a specialized group home, a residential treatment center, or another licensed residential child-care facility. CPS is required to ensure all medical, dental, and therapeutic services needed by the child are provided timely.

After DFPS removes children from their home and places the children in the State's conservatorship, CPS works with parents, Caregivers, and professionals to ensure that children live in a stable, nurturing environment and do not remain in Substitute Care. Whether the plan is for a child to return home, to be adopted, or to live independently, CPS works to avoid unnecessary delays in permanency. When it is not possible for a child to return home, the court may terminate the parent's rights and legally make the child available for adoption.

Although CPS tries to find a permanent home for every child, sometimes that is not possible. Older youth in foster care are informed about transitional living services, including the Preparation for Adult Living (PAL) program, the education and training voucher program, and the college tuition and fee waiver. These services help older youth prepare to transition to adulthood successfully. Supportive services and benefits are provided to eligible youth ages 16 to 23, to assist youth and young adults after they leave foster care.

As directed by Acts 2011, S.B. 218, 82nd Leg., R.S., sec. 11, DFPS was tasked with the redesign of the foster care system. DFPS, along with various child welfare stakeholders, developed a system that would address existing problems and improve permanency outcomes for children and young adults by ensuring:

1. Children are safe in their placements;

2. Children are placed in their home communities and with siblings, so that connections important to the children are maintained;
3. Children are appropriately served in the least restrictive environment that supports minimal moves for the children;
4. Substitute Care Services respect the child's culture;
5. Youth are provided opportunities, experiences, and activities that fully prepare them for successful adulthood; and
6. Children and youth are provided opportunities to participate in the decisions that impact their lives.

DFPS is in the process of transitioning to this redesigned system through contracts with Single Source Continuum Contractors (SSCCs) responsible for providing the full continuum of paid foster care placement and services for children and youth in DFPS conservatorship in the designated geographic catchment area. For additional information, see: http://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/default.asp.

## 1.3 ELIGIBLE POPULATION

The following categories, the Target Population, are eligible to enroll in STAR Health:

1. Children and young adults in DFPS conservatorship (Category 1);
2. Young adults aged 18 years of age through the month of their 22nd birthday, who voluntarily agree to continue in a foster care placement (Category 2);
3. Young adults from 18 years of age through the month of their 21st birthday, who are participating in the Former Foster Care Children (FFCC) program or are participating in the Medicaid for Transitioning Foster Care Youth (MTFCY) program (Category 3);
4. An infant born to a mother who is enrolled in STAR Health (Category 4); and
5. A child or young adult, from birth through the month of his or her 21st birthday, who is enrolled in the AA Program or the PCA Program and who:
    a. Receives Supplemental Security Income (SSI);
    b. Received SSI before becoming eligible for the AA Program or the PCA Program;
    c. Is enrolled in a Medicaid 1915(c) waiver; or
    d. Is enrolled in Medicare (Category 5).

## 1.4 DEFINITIONS AND EXHIBITS

Defined terms have the meaning described in **Exhibit A**, **STAR Health Uniform Terms and Conditions**, and **Exhibit B, Texas Medicaid & Children's Health Insurance Program (CHIP) - Uniform Managed Care Manual (UMCM),** unless the context clearly indicates otherwise. Defined terms are capitalized, are proper nouns, or serve to define an acronym. Also, Services may not have been incorporated into **Exhibit B, UMCM,** at the time of the SOW's publication. In the event they have not been, such services will be added as part of the current HHSC UMCM change process, and the Contract will be amended as appropriate. Additionally, as used in this SOW, unless the

context clearly indicates otherwise, the following terms and conditions have the meanings assigned below:

**Abuse, Neglect, or Exploitation (ANE)** has the meaning assigned in Tex. Fam. Code 5, § 261.001(1), (3), and (4) (for Child Protective Services (CPS) provider investigations).

**Acute Care** means preventive care, primary care, specialty care, and other medical care provided under the direction of a provider for a condition having a relatively short duration.

**Acute Care Hospital** means a Hospital that provides Acute Care services. Acute Care Hospitals can be general hospitals as that term is defined in Tex. Health & Safety Code § 241.003(5).

**Adaptive Aid** means a device necessary to treat, rehabilitate, prevent, or compensate for a condition resulting in a Disability or a loss of function. An Adaptive Aid enables an individual to perform Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) or control the environment in which he or she lives.

**Adjudicate** means to deny or pay a Clean Claim.

**Adoption Assistance Program (AA Program)** is the program administered by DFPS under 40 Tex. Admin. Code pt. 19, ch. 700, subch. H. The AA Program provides Medicaid coverage for the adopted Member.

**Administrative Expense Cap** or **Admin Cap** is a calculated maximum amount of administrative expense dollars that can be deducted from Revenues for purposes of determining income subject to the Experience Rebate.

**Adverse Benefit Determination** means:

1. The denial or limited authorization of a Member or Provider requested services, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner, as determined by the State;
5. The failure of a Managed Care Organization (MCO) to act within the timeframes provided in the Contract and 42 C.F.R. § 438.408(b);
6. For a resident of a rural area with only one MCO, the denial of a Member's request to exercise his or her right, under 42 C.F.R § 438.52(b)(2)(ii), to obtain services outside of the Network; or
7. The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

**Affiliate** means any individual or entity that meets any of the following criteria:

1. Owns or holds a five percent (5%) or greater interest in the MCO (either directly or through one or more intermediaries);
2. In which the MCO owns or holds a five percent (5%) or greater interest (either directly or through one or more intermediaries);

3. Any parent entity or Subsidiary entity of the MCO, regardless of the organizational structure of the entity;
4. Any entity that has a common parent with the MCO (either directly or through one or more intermediaries);
5. Any entity that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the MCO; or
6. Any entity that would be considered to be an Affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

**Allowable Expenses** means all expenses related to the Contract between HHSC and the MCO that are incurred during the Contract Period, are not reimbursable or recovered from another source, and that conform with **Chapter 6 of UMCM, Exhibit B**.

**Approved Nonprofit Health Corporation (ANHC)** means an organization formed in compliance with Tex. Ins. Code ch. 844 and licensed by the Texas Department of Insurance (TDI) to provide services as a health plan.

**Authorized Representative** means any person or entity acting on behalf of the Member and with the Member's written consent in the Complaint and appeals process.

**Auxiliary Aids and Services** means an accommodation that ensures that no individual with a Disability is excluded, denied services, segregated or otherwise treated differently than other individuals that do not need such accommodations and includes:

1. Qualified interpreters or other effective methods of making aurally delivered materials understood by persons with hearing impairments;
2. Taped texts, large print, braille, or other effective methods to ensure visually delivered materials are available to individuals with visual impairments; and
3. Other effective methods to ensure that materials (delivered both aurally and visually) are available to those with cognitive or other Disabilities affecting communication.

Auxiliary Aids and Services are not Adaptive Aids described in the Medically Dependent Children Program (MDCP) 1915(c) waiver.

**Behavioral Health (BH) Crisis Services Hotline** means the toll-free number operated by the MCO to handle routine or emergency BH-related calls.

**Behavioral Health (BH) Services** means Covered Services for the treatment of mental, emotional, or Substance Use Disorders.

**Benchmark** means a target or standard based on historical data or an objective/goal.

**Business Continuity Plan (BCP)** means a plan that provides for a quick and smooth restoration of Management Information System (MIS) operations after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

**Call Coverage** means arrangements made by a facility or attending physician with another appropriate Provider, who agrees to be available on an as-needed basis to provide medically appropriate services for Members with routine, high risk, Emergency Services

that present without an appointment at the facility or when the attending physician is unavailable.

**Capitation Payment** means the aggregate amount paid by HHSC to the MCO on a monthly basis for the provision of Covered Services to enrolled Members, including associated Administrative Services in accordance with the Capitation Rates in the Contract.

**Capitation Rate** means a fixed predetermined fee paid by HHSC to the MCO each month in accordance with the Contract, for each enrolled Member in exchange for the MCO arranging for or providing a defined set of Covered Services to such a Member, regardless of the amount of Covered Services used by the enrolled Member.

**Caregiver** means the DFPS-authorized caretaker for a Member, including the Member's foster parent(s), relative(s), or 24-hour child-care facility staff.

**Case-by-case Services** means additional services for coverage beyond those specified in the Contract. Services required by Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) are not considered Case-by-case Services.

**Case Management for Children and Pregnant Women** is a Medicaid program for children with a health condition/health risk, birth through 20 years of age and for women with high-risk pregnancies of all ages, that helps them gain access to medical, social, educational and other health-related services.

**Change in Condition** means a significant change in a Member's health or functional status that will not normally resolve itself without further intervention.

**Change Management Plan** means the written plan that documents the orderly and effective procedure for tracking the submission, coordination, review, evaluation, categorization, and approval for implementation for all changes to the systems production environment. This includes the governance process for controlling the priority, scope, schedule and quality requirements for all approved changes. The document should specify the methods to evaluate, track, and monitor changes as well as describe the process for reviewing and approving emergency changes to the production environment.

**Children's Hospital** means a Hospital that offers its services exclusively to children. Services provided at Children's Hospitals include clinical care, research, and pediatric medical education focused specifically on children.

**Chronic or Complex Condition** means a physical, behavioral, or developmental condition that may have no known cure or is progressive or can be debilitating or fatal if left untreated or under-treated.

**Clean Claim** means a claim submitted by a physician or provider for Healthcare Services rendered to a Member, with the data necessary for the MCO or subcontracted claims processor to Adjudicate and accurately report the claim. A Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate claim type encounter guides as follows:

1. 837 Professional Combined Implementation Guide;
2. 837 Institutional Combined Implementation Guide;
3. 837 Professional Companion Guide;

4. 837 Institutional Companion Guide; or
5. National Council for Prescription Drug Programs (NCPDP) Companion Guide.

**Clinical Prior Authorization or Clinical PA** means a drug review process authorized by HHSC that is conducted by a healthcare MCO prior to dispensing a drug. All HHSC authorized Clinical PAs are identified on the Medicaid Vendor Drug website located at: https://www.txvendordrug.com/. The Clinical PA is used for verifying that a Member's medical condition matches the clinical criteria for dispensing a requested drug.

**Community-Based Services** means services provided to Members in a home or other community-based setting. This term includes Specialty Therapy; Personal Care Services (PCS); PCS or acquisition, maintenance and enhancement of skills in Community First Choice; nursing services; and for MDCP Members, in-home or out of home Respite, Supported Employment, and Employment Assistance.

**Community First Choice (CFC)** means PCS or acquisition, maintenance and enhancement of skills; emergency response services and support management provided in a community setting for eligible Members who have received a level of care determination from an HHSC-authorized entity.

**Community Health Worker (or Promotora)** means a trusted member of the community who has a close understanding of the ethnicity, language, socio-economic status, and life experiences of the community served, and who helps Members gain access to needed services, increase health knowledge, and become self-sufficient through outreach and follow-up, informal counseling, social support, advocacy, and more.

**Community Resource Coordination Groups (CRCGs)** means a statewide system of local interagency groups, including both public and private providers, which coordinate services for "multi-need" children and young adults. CRCGs develop Service Plans for children and young adults whose needs can be met only through interagency cooperation. CRCGs address Complex Needs in a model that promotes local decision-making and ensures that children receive the integrated combination of social, medical, and other services needed to address their needs.

**Competent Interpreter** means a person who is proficient in both English and the other language being used and has had orientation or training in the ethics of interpreting, including accuracy and impartiality in interpretation.

**Complainant** means a Member or a treating provider or other individual designated to act on behalf of a Member in order to file a Complaint.

**Complaint** means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Adverse Benefit Determination. See also "grievance" as defined by 42 C.F.R. § 438.400(b). Possible subjects for Complaints include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Complaint includes the Member's right to dispute an extension of time, if authorized by law, proposed by the MCO to make an authorization decision. There is no exception for an Initial Contact Complaint.

A Complainant's oral or written dissatisfaction with an Adverse Benefit Determination is considered a request for an MCO appeal.

**Complex Needs** means a condition or situation resulting in a need for coordination or access to services beyond what a Primary Care Provider (PCP) would normally provide, triggering the MCO's determination that Service Coordination is required.

**Comprehensive Care Program (CCP)** see Texas Health Steps.

**Comprehensive Provider Agency(ies)** means an entity that provides or subcontracts for the delivery of the full array of Mental Health TCM and Mental Health Rehabilitative Services, as defined in 1 Tex. Admin. Code pt.15, ch. 353, subch. P, § 353.1403.

**Consolidated FSR Report** or **Consolidated Basis** means FSR reporting results for all Programs and all Service Areas (SAs) operated by the MCO or its Affiliates, including those under separate Contracts between the MCO or its Affiliates and HHSC, with the exception of the Dual Demonstration. Consolidated FSR Reporting does not include any of the MCO's or its Affiliate's business outside of the HHSC Programs. Not all FSR Reporting Periods have utilized this methodology.

**Continuity of Care** means care provided to a Member by the same PCP or specialty Provider to ensure that the delivery of care to the Member remains stable, and services are consistent and unduplicated.

**Contract Year** means one complete State Fiscal Year (SFY) under the Contract.

**Court Order** means an order entered by a court of continuing jurisdiction placing a child or young adult under DFPS conservatorship.

**Court-ordered Commitment** means a commitment of a Member to an inpatient mental health facility for treatment ordered by a court of law including orders pursuant to the Tex. Health & Safety Code, chs. 573 or 574, or Tex. Code of Crim. Proc. ch. 46B.

**Covered Service(s)** means all Medicaid services the MCO must arrange to provide to Members, including all services required by the Contract, State and federal law, and all Value-added Services negotiated by the Parties. Covered Services does not include Administrative Services.

**Credentialing** means the process of collecting, assessing, and validating qualifications and other relevant information pertaining to a healthcare provider to determine eligibility and to deliver Covered Services.

**Critical Event or Incident** means an event or incident that may harm or create the potential for harm to a Member. Critical Events or Incidents include:

1. ANE;
2. The unauthorized use of restraint, seclusion, or restrictive interventions;
3. Serious injuries that require medical intervention or result in hospitalization;
4. Criminal victimization;
5. Unexplained Death;
6. Medication errors; and
7. Other incidents or events that involve harm or risk of harm to a Member.

**Cultural Competency** means the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves their dignity.

**Daily Notification File (DNF)** means the file used to provide notification on a daily basis to the MCO concerning each new Member taken into DFPS conservatorship (i.e., Category 1 and 2 of the Target Population), and to provide changes to demographic information for each Member. The DNF is not an official eligibility file and does not contain information concerning Members in Category 3, 4, or 5 of the Target Population.

**Date of Disenrollment** means the last day of the month in which the Member loses STAR Health Program eligibility.

**Delivery Supplemental Payment** means a one-time per pregnancy supplemental payment for STAR and CHIP MCOs.

**Dental Home**, see Main Dental Home Provider.

**DFPS** means the Texas Department of Family and Protective Services or its successor agency.

**DFPS Staff** means the administrators and employees of DFPS.

**Disabled Person** or **Person with Disability** means a person who qualifies for Medicaid services because of a Disability.

**Disability (Disabilities)** means a physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working.

**Disability-related Access** means that facilities are accessible to and usable by individuals with Disabilities, and that Auxiliary Aids and Services are provided to ensure effective communication in compliance with Title III of the Americans with Disabilities Act, 42 U.S.C. § 12182.

**Disaster Recovery Plan** means the document developed by the MCO that outlines details for the restoration of the Management Information System (MIS) in the event of an emergency or disaster.

**Discharge** means a formal release of a Member from an Inpatient Stay when the need for continued care at an inpatient level has concluded. Movement or Transfer from one Acute Care Hospital or long-term care Hospital or facility and readmission to another within 24 hours for continued treatment is not a Discharge under this Contract.

**Disease Management (DM)** means a system of coordinated healthcare interventions and communications for populations with conditions in which Member self-care efforts are significant.

**Disproportionate Share Hospital (DSH)** means a Hospital that serves a higher than average number of Medicaid and other low-income Members and receives additional reimbursement from the State.

**DSM** means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, which is the American Psychiatric Association's official classification of BH disorders, or its replacement.

**Dual Demonstration** means the Texas Dual Eligibles integrated care demonstration project, which uses a service delivery model for Dual Eligibles that combines Medicare and Medicaid services under the same health plan.

**Dual Eligibles** means Medicaid recipients who are also eligible for Medicare.

**Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT)** means the federally-mandated Early and Periodic Screening, Diagnostic, and Treatment Program contained at 42 U.S.C. § 1396d(r). Texas Health Steps is the name used for EPSDT in the State of Texas

**Early Childhood Intervention (ECI)** means a federally-mandated program for infants and toddlers under the age of three with developmental delays or Disabilities. See 34 C.F.R. pt. 303 and 26 Tex. Admin. Code pt.1, ch. 350, subch. A for further clarification.

**Effective Date of Coverage** means:

1. The date the Member enters into DFPS conservatorship for Members in Category1 of the Target Population; and
2. The first day of the month that a Member is enrolled in the STAR Health Program for Members in Categories 2, 3, and 5 of the Target Population who are re-enrolling due to a break in coverage. For Members in categories 2, 3, and 5 of the Target Population who are re-enrolling due to a break in coverage, HHSC will follow prospective enrollment procedures.
3. For infants born to mothers enrolled in STAR Health, coverage starts on the date of birth.

**Electronic Visit Verification (EVV)** is the electronic verification and documentation of visit data, such as the date and time the provider begins and ends the delivery of services, the identity of the attendant and recipient, and the location of services provided.

**Eligibles** means individuals eligible to enroll in the Program.

**Emergency Behavioral Health (BH) Condition** means any BH condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

1. Requires immediate intervention or medical attention without which a Member would present an immediate danger to the Member or others; or
2. That renders a Member incapable of controlling, knowing, or understanding the consequences of the Member's actions.

**Emergency Services** means covered inpatient and outpatient services furnished by a provider that is qualified to furnish these Services under the Contract and that are needed to evaluate or Stabilize an Emergency Medical Condition or an Emergency BH Condition, including Post-stabilization Care Services.

**Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity, including severe pain, such that a prudent

layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

1. Placing the Member's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. Serious jeopardy to the health of a pregnant woman or her unborn child.

**Employment Assistance** means assistance provided to an MDCP enrolled Member to help the Member locate paid employment in the community.

**Encounter** means a Covered Service or group of Covered Services delivered by a Provider to a Member during a visit between the Member and Provider.

**Encounter Data** means a representation of a claim received and adjudicated by an MCO without alteration or omission, unless specifically directed by HHSC. The data must include information on receipt of items or services including billing and rendering provider.

**Enrollment Report or Enrollment File** means the daily or monthly list of Eligibles enrolled with an MCO as Members on the day or for the month the report is issued.

**Experience Rebate** means the portion of the MCO's Net Income Before Taxes that is returned to the State in accordance with **Section 2.8.8 of Exhibit H, SOW** (Experience Rebate).

**Expedited MCO Internal Appeal** means an appeal to the MCO in which the decision is required quickly based on the Member's health status, and the amount of time necessary to participate in a standard appeal could jeopardize the Member's life, physical or mental health or ability to attain, maintain, or regain maximum function.

**External Medical Review (EMR)** is an independent review of the relevant information the MCO used related to an Adverse Benefit Determination based on functional necessity or medical necessity. EMRs are conducted by third party organizations, known as Independent Review Organizations (IROs), contracted by HHSC.

**External Quality Review Organization (EQRO)** means the entity that contracts with HHSC to provide external review of access to and quality of healthcare provided to Members of HHSC's Medicaid and CHIP programs.

**Family Strengths and Needs Assessment (FSNA)** means a comprehensive assessment of the strengths and needs of the Member's parent(s) that is completed by DFPS and assists with case planning. This assessment also assists BH Providers with the completion of the Texas Comprehensive Child and Adolescent Needs and Strengths (Texas CANS 2.0).

**Federal Poverty Level (FPL)** means the Federal poverty level updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. § 9902(2), (4) and in effect for the applicable budget period used to determine an individual's eligibility in accordance with 42 C.F.R. § 435.603(h).

**Federally Qualified Health Center (FQHC)** means a center certified by the Centers for Medicare and Medicaid Services (CMS) to meet the requirements of 42 U.S.C. §

1395x(aa)(3) and (4) as a federally qualified health center that is enrolled as a provider in the Texas Medicaid program.

**Fee-for-Service (FFS)** means the traditional Medicaid Healthcare Services payment system under which providers receive a payment for each unit of service, after the service is provided, according to rules adopted under Tex. Hum. Res. Code ch. 32.

**Financial Management Services** means assistance provided to Members, Caregivers, and Medical Consenters who manage funds associated with self-directed service delivery options. The services include initial orientation and ongoing training for Members, Caregivers, and Medical Consenters related to responsibilities of being an employer and adhering to legal requirements for employers.

**Financial Management Services Agency (FMSA)** means an entity that contracts with HHSC or an MCO to provide Financial Management Services as described in 40 Tex. Admin. Code pt.1, ch. 41, subch. C, § 41.309(a) to an employer or designated representative.

**Financial Statistical Report (FSR)** means a report designed by HHSC and submitted to HHSC by the MCO in accordance with this Contract. The FSR is a form of modified income statement, subject to audit, and contains revenue, cost, and other data, as defined by the Contract. Not all incurred expenses may be included in the FSR.

**First Dental Home** means an initiative designed to establish a Dental Home, provide preventive care, identify oral health problems, and provide treatment and oral health instructions to Caregivers and Medical Consenters as early as possible.

**Former Foster Care Child (FFCC) Member** means a young adult who has aged out of the foster care system and has previously received Medicaid while in foster care, and who is eligible for STAR Health through the month of his or her 21st birthday.

**FSR Reporting Period** is the period of months that are measured on a given FSR. Generally, the FSR Reporting Period is a twelve-calendar-month period corresponding to the SFY, but it can vary by Contract and by year. If an FSR Reporting Period is not defined in the Contract, then it will be deemed to be the twelve months following the end of the prior FSR Reporting Period.

**Habilitation** has the meaning assigned in 1 Tex. Admin. Code pt.15, ch.353, subch. A, § 353.2. This service is provided to allow an individual to reside successfully in a community setting by assisting the individual to acquire, retain, and improve self-help, socialization, and daily living skills or assisting with and training the individual on ADLs and IADLs.

**Health Home** means a designated Provider, including a Provider that operates in coordination with a team of health care professionals, or a heath team selected by a Member with chronic conditions to provide Health Home Services.

**Health Home Services** means comprehensive and timely high-quality services that are provided by a designated Provider, a team of healthcare professionals operating with such a Provider, or a Health Team. Health Home Services include:

1. Comprehensive care management;
2. Care coordination and health promotion;

3. Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
4. Member and family support (including authorized representatives);
5. Referral to community and social support services, if relevant; and
6. Use of health information technology to link services, as feasible and appropriate.

**Health Passport** means an electronic health record system used to document information regarding Healthcare Services provided to a Member.

**Health-related Materials** are materials developed by the MCO or obtained from a third party relating to the prevention, diagnosis, or treatment of a medical condition.

**Health Team** has the same meaning as term as described in 42 U.S.C. § 256a-1.

**Healthcare Effectiveness Data and Information Set (HEDIS)** is a registered trademark of the National Committee for Quality Assurance (NCQA) and is a set of standardized performance measures designed to reliably compare the performance of managed healthcare plans. NCQA sponsors, supports, and maintains the HEDIS.

**Healthcare Service Plan** see Individual Service Plan.

**HHSC Administrative Services Contractor (ASC)** means an entity performing Medicaid managed care Administrative Services functions, including enrollment or claims payment functions, under contract with HHSC.

**Home and Community Support Services Agency (HCSSA)** means an entity licensed by HHSC to provide home health, hospice, MDCP services, CFC services, and PCS provided to individuals in a home or independent living environment.

**Hospital** means a licensed public or private institution as defined by Tex. Health & Safety Code chs. 241 and 571-578.

**Independent Review Organization (IRO)** is a third-party organization contracted by HHSC that conducts an EMR during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity.

**Indian** has the meaning assigned to it in 42 C.F.R. § 438.14(a).

**Indian Health Care Provider (IHCP)** has the meaning assigned to it in 42 C.F.R. § 438.14(a), and “means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. [§] 1603).”

**Initial Contact Complaint** means a Complaint that is resolved within one Business Day.

**Individual Family Service Plan (IFSP)** means the plan for services required by the ECI program and developed by an interdisciplinary team.

**Individual Service Plan (ISP) or Healthcare Service Plan** means an individualized and Person-Centered plan, developed with and for Members with Special Healthcare Needs, with assistance from the Medical Consenter, DFPS caseworker, and Providers as needed.

The ISP identifies and documents the following:

1. The Member's history;
2. The Member's preferences, strengths, and a summary of current medical and social needs;
3. Short- and long-term goals and action steps that ensure personal outcomes are achieved within a least restrictive setting by using identified supports and services; and
4. A treatment plan to address the Member's physical, psychosocial, and emotional healthcare needs, including a description of the services that will benefit the Member, the frequency with which each service will be provided, and a description of who will provide each service.

**Inpatient Stay** means at least a 24-hour stay in a facility licensed to provide Hospital care.

**Inquiry** means a request by a Member, Medical Consenter, or Provider for information about HHS programs or services.

**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)** means an intermediate care facility that provides residential care and services for individuals with intellectual disabilities or related conditions based on their functional needs.

**Joint Interface Plan (JIP)** means a document used to communicate basic system interface information. This information includes: file structure, data elements, frequency, media, type of file, receiver and sender of the file, and file identification. The JIP must include each of the MCO's interfaces required to conduct business under this Contract. The JIP must address the coordination with each of the MCO's interface partners to ensure the development and maintenance of the interface and the timely transfer of required data elements between contractors and partners.

**Legally Authorized Representative (LAR)** means the Member's representative defined by State or federal law, including Tex. Health & Safety Code § 166.164 and Tex. Occ. Code § 151.002(6). See generally, Tex. Est. Code ch. 752 (durable power of attorney for financial decisions).

**Licensed Medical Personnel** means, in the context of Mental Health Rehabilitative Services day programs, the following provider types: physician; Advanced Practice Registered Nurse (APRN); physician assistant; Registered Nurse (RN); Licensed Vocational Nurse (LVN); or pharmacist.

**Licensed Practitioner of the Healing Arts (LPHA)** means a person who is:

1. A physician;
2. A licensed professional counselor;
3. A licensed clinical social worker;
4. A licensed psychologist;
5. An advanced practice nurse (Texas Board of Nursing rules, 22 Tex. Admin. Code pt. 11, ch. 221); or
6. A licensed marriage and family therapist.

**Limited English Proficient (LEP)** has the meaning assigned to it in 42 C.F.R. § 438.10. Accordingly, the phrase means potential Members and Members who do not speak English

as their primary language and who have a limited ability to read, write, speak, or understand English.

**Linguistic Access** means translation and interpreter services, for written and spoken language to ensure effective communication. Linguistic access includes sign language interpretation, and the provision of other Auxiliary Aids and Services to persons with Disabilities.

**Local Behavioral Health Authority (LBHA)** has the meaning assigned in Tex. Health & Safety Code § 533.0356.

**Local Health Department** means a local health department established under Tex. Health & Safety Code § 121.031, Local Public Health Reorganization Act.

**Local Mental Health Authority (LMHA)** has the meaning assigned in Tex. Health & Safety Code § 531.002(13).

**Long-Term Services and Supports (LTSS)** means assistance with daily healthcare and living needs for individuals with a long-lasting illness or Disability.

**Main Dental Home Provider, Main Dentist** or **Dental Home** means a Provider who provides dental services to Members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to Members; maintaining the Continuity of Care; and initiating referrals for care. Provider types that can serve as Main Dental Home Providers are FQHCs, Rural Health Clinics, and individuals who are general dentists or pediatric dentists.

**Major Systems Change** means a new version of an existing Software platform often identified by a new Software version number or conversion to an entirely new Software platform.

**Major Population Group** means any population that represents at least 10% of the Medicaid population in the SA served by the MCO.

**Mandated Services** or **Required Services** means services that a state is required to offer to categorically needy clients under a state Medicaid plan.

**Marketing** means any communication from the MCO to a Medicaid client who is not enrolled with the MCO that can reasonably be interpreted as intended to influence the client to:

1. Enroll with the MCO; or
2. Not enroll in, or to disenroll from, another MCO.

**Marketing Materials** means materials that are produced in any medium by or on behalf of the MCO and can reasonably be interpreted as intending to market to potential Members. Health-related Materials are not Marketing Materials.

**MCO Internal Appeal** means the formal process by which a Member, or his or her representative, requests a review of an Adverse Benefit Determination by the MCO.

**MCO Internal Appeal and Complaint System** means the process the MCO implements to handle MCO Internal Appeal of a Complaint or Adverse Benefit Determination, as well

as the process to collect and track information about the MCO internal appeals of a Complaint or Adverse Benefit Determination.

**Medicaid for Transitioning Foster Care Youth (MTFCY) Program** means the Medicaid program, administered in accordance with 1 Tex. Admin. Code pt. 15, ch. 366, subch. F.

**Medical Consenter** means the person who may consent to medical care for the Member under Tex. Fam. Code ch. 266.

**Medical Home** has the meaning assigned to a patient-centered Medical Home in Tex. Gov't Code § 533.0029(a).

**Medical Home Services Model** means an enhanced approach to the Medical Home through which primary care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

**Medically Dependent Children Program (MDCP)** means a program that provides home and community-based LTSS for individuals under the age of 21 with complex medical needs as a cost-effective alternative to living in a nursing facility.

**Medically Necessary** has the meaning defined in 1 Tex. Admin. Code pt.15, ch. 353, subch. A, § 353.2(69).

**Medicare** means the federal health insurance program for people age 65 or older, under 65 with certain disabilities, or any age with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

**Medication Assisted Treatment (MAT)** means the use of U.S. Food and Drug Administration (FDA) approved medications in combination with psychosocial treatment to treat SUDs, primarily alcohol and opioid use disorders.

**Member** means a person who:

1. Is entitled to benefits under Title XIX of the Social Security Act (42 U.S.C. §1396-1) and Medicaid, is in a Medicaid eligibility category included in the Program, and is enrolled in the Program and MCO; or
2. Is entitled to benefits under Title XIX of the Social Security Act (42 U.S.C. §1396-1) and Medicaid, is in a Medicaid eligibility category included as a voluntary participant in the Program and is enrolled in the Program and the MCO.

**Member Advocate(s)** means the individual who assists Members in writing Complaints and MCO Internal Appeals and monitoring the Complaint or MCO Internal Appeal through the MCO's internal Complaint and MCO Internal Appeals process. Member Advocates also help or refer Members to Covered Services or community resources available to meet Member needs that are not available from the MCO as Covered Services.

**Member Hotline** means the toll-free telephone line operated by the MCO that responds to inquiries from Members, DFPS Staff, SSCC staff, Caregivers, and Medical Consenters.

**Member Materials** means all written materials produced or authorized by the MCO and distributed to Members or potential Members containing information concerning the

Program. Member Materials include Member identification (ID) cards and Member handbooks and Provider directories.

**Member Month** means one capitated paid enrollment month per Member. The total Member Months for each month of a year comprise the annual Member Months.

**Member Services** means the administrative functions performed by the MCO for the purpose of informing Members about Covered Services.

**Member(s) with Complex Care Needs and High Costs (MCN)** means a Member who, because of their health or social condition, experiences high levels of costly but preventable service utilization. Also known as "super-utilizers."

**Member(s) with Special Healthcare Needs (MSHCN)** means a Member, including a child enrolled in the HHSC Child Health and Children with Special Health Care Needs (CSHCN) Program as further defined in Tex. Health & Safety Code § 35.0022, who:

1. Has a serious ongoing illness, a Chronic or Complex Condition, or a Disability that has lasted or is anticipated to last for a significant period of time; and
2. Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained healthcare personnel.

All STAR Health Members are considered MSHCN.

**Mental Health Rehabilitative Services** means age-appropriate services determined by HHSC and federally-approved protocol as Medically Necessary to reduce a Member's Disability resulting from severe mental illness for adults or serious emotional, behavioral, or mental disorders for children, and to restore the Member to his or her best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a Member achieve a rehabilitation goal as defined in the Member's rehabilitation plan.

**Mental Health Targeted Case Management (Mental Health TCM)** means services designed to assist Members with gaining access to needed medical, social, educational, and other services and supports. Members are eligible to receive these services based on standardized assessment using either the Child and Adolescent Needs and Strengths (CANS) or the Adult Needs and Strengths Assessment (ANSA) and other diagnostic criteria used to establish medical necessity.

**Minor Home Modifications** means necessary physical modifications of a person's home to prevent institutionalization or support de-institutionalization. The modifications must be necessary to ensure health, welfare, and safety or to support the most integrated setting for an MDCP-enrolled Member to remain in the community.

**National Committee for Quality Assurance (NCQA)** means the independent organization that accredits MCOs and managed BH organizations and accredits and certifies DM programs. HEDIS and the Quality Compass are registered trademarks of NCQA.

**Net Income Before Taxes** or **Pre-tax Income** means an aggregate excess of Revenues over Allowable Expenses.

**Non-capitated Services** means the Texas Medicaid programs and services that are excluded from MCO Covered Services but Members may be eligible to receive from Texas Medicaid providers on a FFS basis. Non-capitated services are identified in **Section 2.6.60.7 of this Exhibit H, SOW.**

**Non-provider Subcontracts** means contracts between the MCO and a third party that performs a function, excluding delivery of Healthcare Services that the MCO is required to perform under its Contract with HHSC.

**Nurse Hotline** means the toll-free telephone line operated by the MCO that Members, DFPS Staff, SSCC staff, Caregivers, and Medical Consenters can call for clinical information, guidance on specialty referrals or requests for specialty Provider consultations.

**OB/GYN** means obstetrician-gynecologist.

**Operational Start Date** means the first day on which an MCO is responsible for providing Covered Services to Members under the Contract.

**Operations Phase** means the period of time when an MCO is responsible for providing the Covered Services and all related Contract functions. The Operations Phase begins on the Operational Start Date.

**Out-of-Network (OON)** means an appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the MCO for the delivery of Covered Services to the MCO's Members.

**Overpayment** means any payment made to a Provider by an MCO, Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) to which the Network Provider is not entitled to under Title XIX or Title XXI of the Social Security Act or any payment to an MCO, a PIHP, or a PAHP by HHSC to which the MCO, PIHP, or PAHP is not entitled to under Title XIX or Title XXI of the Social Security Act. 42 U.S.C. §§1396-1396w-5 (Title XIX); 42 U.S.C. §§ 1397aa-1397mm (Title XXI).

**PCP Team** means an interdisciplinary team that agrees to function as a Medical Home, of which the Member, Medical Consenter, Caregiver, DFPS caseworker, Member's PCP, other Providers, SSCC staff, and Service Coordinator may be a part.

**Peer Provider** means a Mental Health Rehabilitative Services provider who meets the following minimum requirements: (1) high school diploma or high school equivalency; and (2) one cumulative year of receiving mental health services.

**Performance Indicator Dashboard** means a contract monitoring tool used by HHSC and updated annually by HHSC to measure the MCO's performance on a number of quality measures.

**Permanency Care Assistance (PCA)** means the Medicaid eligibility group enrolled in the PCA Program.

**Permanency Care Assistance Program (PCA Program)** is the program administered by DFPS under 40 Tex. Admin. Code pt.19, ch. 700, subch. J, Div. 2 (Permanency Care Assistance Program). The PCA Program provides Medicaid coverage for the adopted Member.

**Person-Centered** means the opportunity to achieve greater independence and community integration, through exercising self-direction, incorporation of individual perceptions and experiences, personal preferences and choices, and control with respect to services and Providers, while ensuring medical and non-medical needs are met via means that are exclusively for the benefit of the individual in reaching their personal outcomes and allowing them to have the quality of life and level of independence they desire.

**Person with Disability,** see Disabled Person.

**Personal Care Services (PCS)** means support services furnished to a Member who has physical, cognitive, or behavioral limitations related to the Member's Disability or chronic health condition that limit the Member's ability to accomplish ADLs, IADLs, or health-maintenance activities.

**Pharmacy Benefit Manager (PBM)** is a third-party administrator of prescription drug programs.

**Post-stabilization Care Services** has the meaning assigned to it in 42 C.F.R. § 438.114(a). Accordingly, the phrase means Covered Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.113(c)(2) to improve or resolve the Member's condition.

**Pre-tax Income,** see Net Income Before Taxes.

**Prescribed Pediatric Extended Care Center (PPECC)** means a facility under Tex. Health & Safety Code § 248A.001(10) that provides nonresidential basic services, including medical, nursing, psychosocial, therapeutic, and developmental services, to medically dependent or technologically dependent individuals under the age of 21.

**Prevalent Language** has the meaning assigned to "prevalent" in 42 C.F.R. § 438.10(a) or means a non-English language determined to be spoken by a significant number or percentage of potential Members and Members that are Limited English Proficient. For the purposes of the Contract, the terms "significant number or percentage" will mean ten percent (10%) of the population in the SA speaks the non-English language.

**Primary Care Provider (PCP)** means a physician or provider who has agreed with the MCO to provide a Medical Home to Members and who is responsible for providing initial and primary care to Members, maintaining Continuity of Care for the Member, and initiating referral for care.

**Prior Authorization (PA)** means a form of prospective Utilization Review by the MCO of Healthcare Services proposed to be provided to a Member.

**Private Duty Nursing (PDN)** has the meaning assigned in 42 C.F.R. § 440.80.

**Provider** means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors that has a Provider Contract with the MCO for the delivery of Covered Services to the MCO's Members.

**Provider Contract** means a contract entered into by a direct Provider of Healthcare Services and the MCO or an intermediary entity.

**Provider Hotline** means the toll-free telephone line for Provider inquiries.

**Provider Materials** means all written materials produced or authorized by the MCO or its Administrative Services Subcontractors concerning the Program that are distributed to Providers.

**Psychiatric Hospital** means a Hospital that provides inpatient mental health services to individuals with mental illness or with a SUD except that, at all times, a majority of the individuals admitted are individuals with a mental illness. Such services include psychiatric assessment and diagnostic services, physician services, professional nursing services, and monitoring for patient safety provided in a restricted environment. See 26 Tex. Admin. Code, pt. 1, ch. 510.

**Public Health Entity** means a Department of State Health Services (DSHS) health service regional office in a public health region administered by a regional director under Tex. Health & Safety Code § 121.007 and acting in the capacity of a local public health entity; a local health department established under Tex. Health & Safety Code ch. 121, subch. D; a public health district established under Tex. Health & Safety Code ch. 121, subch. E; a local health unit described by Tex. Health & Safety Code § 121.004; or a hospital district providing covered services to Medicaid Members.

**Quality Improvement** or **Quality Assurance** means a system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

**Rate Period** means the period in which Capitation Payments are made until the next Capitation Rate adjustment.

**Rate Period 1** means the 12-month period beginning on TBD, and ending on TBD.

**Rate Period 2** means the 12-month period beginning on TBD, and ending on TBD.

**Readily Accessible** has the meaning assigned to it in 42 C.F.R. § 438.10(a) and "means electronic information and services which comply with modern [A]ccessibility [S]tandards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions."

**Readiness Review** means HHSC or its agent's process of review, assessment, and determination of the MCO's ability, preparedness, and availability to fulfill its obligations under the Contract.

**Real-Time Captioning** (also known as Communication Access Real-Time Translation or CART) means a process by which a trained individual uses a shorthand machine, a computer, and real-time translation Software to type and simultaneously translate spoken language into text on a computer screen. Real-Time Captioning is provided for individuals who are deaf, have hearing impairments, or have unintelligible speech. It is usually used to interpret spoken English into text English but may be used to translate other spoken languages into text.

**Respite** means direct care services that relieve a primary Caregiver temporarily from caregiving activities for an MDCP-enrolled Member.

**Retaliation** means action, including refusal to renew or termination of a contract, against a Provider because the Provider filed a complaint against the MCO or appealed an Adverse Benefit Determination of the MCO on behalf of a Member.

**Revenue** means income, excluding non-risk payments, received under the Contract. Under the accrual basis of accounting, revenues are recorded at the time of delivering the service or the item, even if cash is not received at the time of delivery. Revenue received by the MCO pursuant to this Contract includes retroactive adjustments made by HHSC and any funds earned on Medicaid or CHIP managed care funds such as investment income and interest. Revenue excludes reinsurance recoveries, which will be reported as a contra-cost, an offset to reinsurance expense.

**Risk Management Plan** means the written plan developed by the MCO, and approved by HHSC, that describes the MCO's methods for managing risks that emanate from the Program and any corresponding processes, resources, and constraints.

**Routine Care** means healthcare for covered preventive and Medically Necessary Healthcare Services that are non-emergent or non-urgent.

**Rural County** means any county with fewer than 50,000 residents as reported by the Texas Association of Counties on the Texas Association of Counties website.

**Rural Health Clinic (RHC)** means an entity that meets all of the requirements for designation as a Rural Health Clinic under 42 U.S.C. § 1395x(aa)(1) and (2) and approved for participation in the Texas Medicaid program.

**Scope of Work** means the description of Services and Deliverables specified in the Contract, including without limitation the RFP and the MCO's Proposal, and any agreed modifications to these documents.

**Screening and Assessment Instrument (SAI)** means the electronic assessment and screening tool that the MCO must administer, using only the designated mandatory fields as specified in the SAI document map, to help determine a Member's eligibility for MDCP and CFC enrollment. This assessment must also be administered to determine PCS eligibility.

**Security Management Plan** means a document that contains detailed management, operational, and technical information about a system, its security requirements, and the controls implemented to provide protection against risks and vulnerabilities. The plan should include methods to prevent vulnerabilities, procedures for addressing incidents, methods for recovering from incidents, and training. The plan should address the process to comply with HHSC security policies including the development of system security plans, risk assessments and security assessments.

**Service Area (SA)** means all counties in the State of Texas.

**Service Coordination** means the service performed or arranged by the MCO to facilitate development of a Service Plan, or Individualized Service Plan as appropriate, and coordination of services among a Member's PCP, specialty providers and non-medical providers to ensure appropriate access to Covered Services, Non-capitated Services, and Community-Based services.

**Service Coordinator(s)** means the person with primary responsibility for providing Service Coordination to Members.

**Service Plan (SP)** means an individualized and Person-Centered plan in which an individual, with assistance as needed, identifies and documents his or her preferences, strengths, and needs in order to develop short-term objectives and action steps to ensure personal outcomes are achieved within the most integrated setting by using identified supports and services.

**Severe and Persistent Mental Illness (SPMI)** means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another BH disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by:

1. Impaired functioning or limitations of daily living, including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment, due to this disorder, or
2. Impaired emotional or behavioral functioning that interferes substantially with the Member's capacity to remain in the community without supportive treatment or services.

**Severe Emotional Disturbance (SED)** means psychiatric disorders in children and adolescents that cause severe disturbances in behavior, thinking, and feeling.

**Significant Traditional Provider (STP)** means PCPs, long-term care providers, DSHs, BH Providers, including LBHAs and LMHAs, and pharmacy providers identified by HHSC as having provided a significant level of care to children and young adults in DFPS conservatorship.

**Single Source Continuum Contractor (SSCC)** means an entity with whom DFPS contracts to provide the full continuum of community-based care, Substitute Care, case management, and reunification services to children and youth in DFPS legal conservatorship in designated catchment areas.

**Special Hospital** means any inpatient Hospital that is not a general or Psychiatric Hospital. It is an establishment that:

1. Offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals who are regularly admitted, treated, and discharged and who require services more intensive than room, board, personal services, and general nursing care;
2. Has clinical laboratory facilities, diagnostic X-ray facilities, treatment facilities, or other definitive medical treatment;
3. Has a medical staff in regular attendance; and
4. Maintains records of the clinical work performed for each patient.

See 25 Tex. Admin. Code pt.1, ch. 133, subch. A, § 133.2(55).

**Specialty Therapy** means physical therapy, speech therapy, or occupational therapy.

**Stabilize** means to provide such medical care as to assure within reasonable medical probability that no deterioration of the condition is likely to result from, or occur from, or occur during Discharge, Transfer, or admission of the Member.

**STAR Health Liaison** means the designated MCO staff person who will serve as the point-of-contact to answer questions and resolve issues with DFPS Staff regarding the STAR Health Program. Their job duties include coordinating with the MCO and DFPS to ensure effective and efficient responses by the MCO to operational issues, training needs, and other concerns of DFPS.

**STAR Health Program, STAR Health,** or **Program,** means the managed care program administered by HHSC for the Target Population, and the subject matter of this Contract.

**STAR Health Representatives** means dedicated MCO staff located in each regional office, who are responsible for Service Coordination functions that include:

1. Assisting Members, Caregivers, and Medical Consenters with coordination of care needs to include the scheduling of appointments and transportation;
2. Conducting outreach efforts; and
3. Educating Members, Caregivers, Medical Consenters regarding Service Coordination services.

**State Fair Hearing** means the process adopted and implemented by HHSC in 1 Tex. Admin. Code pt.15, ch. 357, in compliance with federal regulations and State rules relating to Medicaid State Fair Hearings.

**Substance Use Disorder (SUD)** means the recurrent use of alcohol and/or drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home..

**Substitute Care** means the placement of a child or young adult who is in the conservatorship of DFPS in care outside the child's or young adult's home. The term includes foster care, institutional care, adoptive placement, or placement with a relative of the child or young adult.

**Substitute Care Services** means services provided to or for children or young adults in Substitute Care and their families, including the recruitment, training, and management of foster parents, the recruitment of adoptive families, and the facilitation of the adoption process, family reunification, independent living, emergency shelter, residential group care, foster care, therapeutic foster care, and post-placement supervision, including relative placement.

**Supplemental Security Income (SSI)** means the federal cash assistance program of direct financial payments to the aged, blind, and disabled administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act, 42 U.S.C. §§1381-1385.

**Supplemental Security Income (SSI) Beneficiary** means a person that receives SSI cash assistance as cited in 42 U.S.C. § 1320a-6 and as described in the definition of SSI.

**Supported Employment** means assistance provided, in order to sustain competitive employment, to an MDCP enrolled Member who, because of a Disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work

setting at which individuals without Disabilities are employed. Supported Employment includes employment adaptations, supervision, and training related to a Member's assessed needs. Individuals receiving Supported Employment earn at least minimum wage, if not self-employed. Supported Employment is not available to Members receiving services through a program funded by the Rehabilitation Act of 1973 (29 U.S.C. §§ 701-797) or the Individuals with Disabilities Education Act (20 U.S.C. § 1400).

**Systems Quality Assurance Plan** means the written plan developed by the MCO, and approved by HHSC, that describes the processes, techniques, and tools that the MCO will use for assuring that the MIS systems meet the Contract requirements.

**Target Population** has the meaning as defined in **Section 1.3 of this Exhibit H, SOW.**

**Telecommunication Device for the Deaf (TDD)** is a machine that employs graphic communication in the transmission of coded signals through a wire or radio communication system as cited in 47 U.S.C. § 225(a)(2).

**Telehealth** has the meaning assigned to the definition of "Telehealth service" in Tex. Gov't Code § 531.001(7).

**Telemedicine** has the meaning assigned to the definition of "Telemedicine medical service" in Tex. Gov't Code § 531.001(8).

**Telemonitoring** has the meaning assigned to the definition of "Home telemonitoring service" in Tex. Gov't Code § 531.001(4-a).

**Texas Comprehensive Child and Adolescent Needs and Strengths 2.0 (Texas CANS 2.0)** means the comprehensive and developmentally appropriate child welfare assessment administered to Members age 3-17 in the manner required by Tex. Fam. Code § 266.012.

**Texas Health Steps (THSteps)** is the name adopted by the State of Texas for the federally mandated EPSDT program. It includes the State's CCP extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 U.S.C. § 1396d(r), and defined and codified at 42 C.F.R. §§ 440.40 and 441.56–.62. Rules relating to EPSDT are contained in 25 Tex. Admin. Code pt.1, ch. 33.

**Texas Health Steps Outreach and Informing Unit (THSteps Outreach and Informing Unit)** means the HHSC Texas Health Steps vendor contracted to provide outreach and education to parents, caretakers, and older children about Texas Health Steps benefits and services.

**Texas Medicaid Provider Procedures Manual (TMPPM), Exhibit E,** means the manual published by or on behalf of HHSC that contains policies and procedures required of all healthcare providers who participate in the Texas Medicaid program

**The Joint Commission** means the nonprofit organization that accredits certain types of medical services, which is comprised of a 21-member board of commissioners that include health care providers, educators, and advocates.

**Third Party Liability (TPL)** means the legal responsibility of another individual or entity to pay for all or part of the Services provided to Members under the Contract.

**Third Party Recovery (TPR)** means the recovery of payments on behalf of a Member by HHSC or the MCO from an individual or entity with the legal responsibility to pay for the Covered Services.

**Transfer** means the movement of the Member from one Acute Care Hospital or long-term care Hospital/facility and readmission to another Acute Care Hospital or long-term care Hospital or facility within 24 hours for continued treatment.

**Transition Phase** includes all activities the MCO is required to perform between the Effective Date and the Operational Start Date for each SA of a Contract resulting from an award through procurement or an assignment and assumption due to termination, merger, expiration, or acquisition.

**Transition Plan** means the written proposal for readiness developed by the MCO, approved by HHSC, to be employed during the Transition Phase.

**Transition Planning** means the process of anticipating and preparing for changes in life circumstances and Healthcare Services to ease an adolescent's shift to adulthood and independent living.

**Transition Specialist** means an MCO employee or Subcontractor who works with adolescent and young adult Members and their support network to prepare such Members for successful transitions out of the STAR Health Program and into adulthood and independent living.

**Turnover Phase** includes all activities the MCO is required to perform prior to, upon, and following the termination of the Contract or the Expiration Date in order to close out the Contract and transition Contract activities and operations to HHSC or a subsequent contractor.

**Turnover Plan** means the written proposal developed by the MCO, and approved by HHSC, to be employed during the Turnover Phase.

**Unexplained Death** means a death with unknown causes including a death not caused by a previously identified diagnosis or a death that occurred during or after an unusual incident.

**Urgent Behavioral Health (BH) Situation** means a BH condition that requires attention and assessment within 24 hours, but that does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.

**Urgent Condition** means a health condition, including an urgent BH situation, that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the Member’s PCP or PCP designee to prevent serious deterioration of the Member’s condition or health.

**Utilization Review (UR)** means the system for retrospective, concurrent, or prospective review of the medical necessity and appropriateness of Healthcare Services provided, being provided, or proposed to be provided to a Member. The term does not include elective requests for clarification of coverage.

**Utilization Review Accreditation Commission dba American Accreditation HealthCare Commission, Inc. (URAC)** means an independent, nonprofit accreditation entity that accredits health plans, case management and DM programs, pharmacy quality management programs as well as provider integration and coordination programs to increase healthcare quality.

**Value-added Services (VAS)** means additional services for coverage beyond those specified in **Section 2.6.32 of this Exhibit H, SOW**. VAS may be actual Healthcare Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve health outcomes among Members. VAS that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be VAS, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered VAS.

**Wrap-Around Services** means services for Dual Eligible Members that are covered by Medicaid:

1. When such Members have exceeded their Medicare coverage limits; or
2. That are not covered by Medicare.

## 1.5 MISSION STATEMENT

HHSC's mission in this Scope of Work (SOW) is to:

1. Ensure continuous and uninterrupted delivery of integrated Covered Services, centralized Service Coordination, and the effective management of healthcare data and information;
2. Ensure the Target Population is provided with a consistent source of healthcare through a Medical Home; and
3. Continue to improve healthcare outcomes for the Target Population through enhanced quality of services.

## 1.6 MISSION OBJECTIVES

The mission objectives of this SOW are as follows.

### 1.6.1 NETWORK ADEQUACY AND ACCESS TO CARE

The MCO must provide timely access to quality care through a Network designed to meet the needs of the Members. The MCO must create and maintain a Network capable of delivering all Covered Services to Members throughout the SA and accessible to all Members for prompt delivery of Covered Services. The MCO must provide Members with access to qualified Providers within the distance, travel time, and waiting time for appointment standards identified in this SOW. Refer to the **Procurement Library** for current and projected Member enrollment.

### 1.6.2 Quality

The MCO must ensure that all Members receive efficient and effective quality services that positively impact desired health outcomes. The MCO must provide high quality services delivered in a professional and ethical manner and must take actions to improve its performance on measures related to healthcare quality while utilizing evidence-based and trauma-informed practices. The MCO must ensure it and its Providers implement innovative approaches that ensure quality Covered Services, cost-effective service delivery, and careful stewardship of public resources.

### 1.6.3 Timeliness and Accuracy of Claims Payment

The MCO must ensure Providers receive timely and accurate payment for services rendered. The MCO must strictly comply with HHSC's claims adjudication requirements as set forth in **Exhibit B, UMCM**.

### 1.6.4 Service Coordination

The MCO must ensure coordinated and integrated healthcare for Members through a Medical Home. Service Coordinators will assist PCPs and specialists providing primary care in managing Covered Services for Members with needs that require specialty care. The MCO will be responsive to inquiries and requests from HHSC, DFPS Staff, Members, and Caregivers.

Through screening and assessment and other strategies designed by the MCO to identify Member needs and preferences, Service Coordinators must design an ISP that is thoughtfully crafted, regularly monitored, and altered appropriately over time to suit the needs of the Members. Service Coordinators are responsible for ensuring that each Member has access to a coordinated and integrated package of services that best meets the Member's needs, and for assisting and educating Members, Medical Consenters, Caregivers, and DFPS Staff in how to access healthcare information and services.

### 1.6.5 Medical Home

The MCO must develop and maintain the Medical Home Services Model through the management and coordination of Covered Services.

### 1.6.6 Timeliness of Initial Texas Health Steps Checkups

The MCO must ensure all Members birth through age 20 receive a THSteps medical checkup as soon as practicable, but no later than 30 Days of enrollment. The MCO must ensure all Members 6 months through age 20 receive a THSteps dental checkup as soon as practicable, but no later than 60 Days of enrollment. The MCO must ensure all Members less than 6 months old at the time of enrollment receive a THSteps dental checkup within 30 Days of turning six months old.

### 1.6.7 HEALTH PASSPORT

The MCO must maintain an electronic Health Passport for Members to ensure that health information provided to DFPS Staff, DFPS residential contractors, SSCC staff, the court system, Court Appointed Special Advocate (CASA) staff, Providers, Members, and Medical Consenters is timely, accurate, portable, and Readily Accessible as set forth in **Section 2.6.24**.

### 1.6.8 TIMELINESS AND ACCURACY OF ENCOUNTERS SUBMISSION

The MCO must ensure timely submission of Encounter Data to HHSC or through its designee. The MCO must submit complete and accurate Encounter Data of the Covered Services provided to Members by Providers. The integrity and quality of the Encounter Data must facilitate data analytics to support research, monitor quality performance, verify costs, set rates, efficiently administer the STAR Health Program, and ultimately ensure Members are served accordingly.

### 1.6.9 BEHAVIORAL HEALTH SERVICES

The MCO must ensure Members have timely access to Medically Necessary BH Services, which may include mental health and SUD treatment, and crisis hotlines, as well as timely and appropriate follow-up care. Non-crisis BH Services must include Member choice options, which means the MCO cannot require Members to receive all such services through a single Provider.

The MCO must emphasize the importance of integration of care and formal, regular communication between Providers for Members who need assessment and evaluation for BH concerns, or who are receiving primary physical health and BH Services.

The Network must include Providers experienced in treating victims of child abuse, and Providers who specialize in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and other Evidence-Based Practices (EBPs).

The MCO must ensure that health information is shared securely, efficiently, and effectively between Members' PCPs and BH Providers. If the MCO uses a Material Subcontractor to deliver BH Services, the MCO must ensure that the MCO and Material Subcontractor have shared, integrated data systems to facilitate care coordination.

### 1.6.10 OUTPATIENT PHARMACY SERVICES

The MCO must provide access to covered outpatient drugs, biological products, certain Limited Home Health Supplies (LHHS), and vitamins and minerals through formularies and a Medicaid Preferred Drug List (PDL) developed by the Vendor Drug Program (VDP). The VDP will negotiate rebate agreements used to develop and maintain formularies and the Medicaid PDL. The MCO must administer the PDL in a way that allows timely access to all non-preferred drugs that are on the Medicaid formulary through a structured PA process. The MCO must use a PBM to process prescription claims.

### 1.6.11 DELIVERY OF HEALTHCARE TO DIVERSE POPULATIONS

The MCO must deliver Covered Services without discrimination. The MCO must implement a Cultural Competency plan to avoid disparities in the delivery of Medically Necessary Covered Services to diverse populations and provide services with Cultural Competency.

### 1.6.12 CONTINUITY OF CARE

The MCO must ensure the care of Members is not interrupted or disrupted during the term of the Contract. Established Member and Provider relationships, existing treatment protocols, and ongoing care plans are not to be negatively affected by the procurement and the resulting Contract.

### 1.6.13 DISEASE MANAGEMENT REQUIREMENTS

The MCO must provide comprehensive DM programs or coverage for DM services for asthma, diabetes, and other Chronic or Complex Conditions, including BH conditions or diseases, identified by the MCO, based upon an evaluation of the prevalence of the diseases within the MCO's Member population.

### 1.6.14 FRAUD, WASTE, AND ABUSE (FWA) REQUIREMENTS

The MCO must actively participate in safeguarding Program integrity against fraudulent claims and other types of Program FWA by Members and service providers. The MCO and its Special Investigative Unit (SIU) must have effective processes to identify, report, and recover from service providers, Subcontractors, and Members related to FWA.

### 1.6.15 COST-EFFECTIVE PROVISION OF SERVICES

A primary objective in having a managed care model is to provide more cost-effective services. This includes both medical and administrative costs. In conjunction with this objective, the MCO must be transparent in its reporting of cost and other data to HHSC, and must provide truthful, accurate, reliable, and non-misleading information in its reports to HHSC.

## 1.7 SERVICE AREA

All the counties in the State of Texas comprise a single statewide SA.

## 1.8 AUTHORITY

The Texas Legislature has designated HHSC as the single state agency to administer Medicaid through managed care models in the State of Texas. Tex. Fam. Code ch. 266, Tex. Gov't Code chs. 531 and 533, and Tex. Hum. Res. Code ch. 32 provide that HHSC

has authority to contract with MCOs to carry out the duties and functions of the Medicaid managed care program as described by Title XIX of the Social Security Act. HHSC remains the only entity authorized to contract with an MCO and to modify any resulting Contract or otherwise further bind the State of Texas. The MCO must be authorized to enter into the Contract and the individuals signing the contract must have authorization to bind the MCO.

# ARTICLE 2 SCOPE OF WORK

The specifics of the SOW for the STAR Health Program are set forth below in **Sections 2.1 through 2.8 of this Exhibit H, SOW,** and, as appropriately referenced, in applicable exhibits.

## 2.1 REQUIRED FEDERAL AND STATE APPROVAL AND FUNDING

The SOW is contingent upon federal and state approvals and funding, including the CMS' approval and funding. Should any part of the SOW under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must do no work on that part after the effective date of the loss of program authority. The State must adjust Capitation Payments to remove costs that are specific to any program or activity that is no longer authorized by law. If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work. If the State paid the MCO in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work must be returned to the State. However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

## 2.2 REMEDIES AND LIQUIDATED DAMAGES

All responsibilities and all requirements of the MCO in the Contract will be subject to performance evaluation, review, and audit by HHSC. All responsibilities or requirements not fulfilled by the MCO may have remedies, and HHSC may assess damages, including liquidated damages. Refer to **Exhibit A, STAR Health Uniform Terms and Conditions,** and **Exhibit C, <u>Deliverables Liquidated Damages Matrix</u>,** for particular performance standards that carry liquidated damage values.

## 2.3 ANTITRUST

MCO will assign to HHSC all of the MCO's State and federal antitrust claims and causes of action that relate to all goods, Services, or Deliverables provided for or related to the Contract.

## 2.4 MEMBER ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

HHSC makes no guarantees or representations to the MCO regarding the number of eligible Members who will ultimately be enrolled into the MCO or the length of time any enrolling Members will remain enrolled with the MCO. The MCO has no ownership interest in the Member base, and cannot sell or transfer this base to another entity.

### 2.4.1 ELIGIBILITY DETERMINATION AND DISENROLLMENT

HHSC or its designee will make eligibility determinations for each potential enrollee for the Program. Should a Member become ineligible for Medicaid, HHSC will disenroll the Member from the managed care plan.

MCO must notify HHSC within 10 Business Days of becoming aware that a Member is no longer Medicaid-eligible, for example the Member has moved outside of the State or is deceased.

### 2.4.2 MEMBER ENROLLMENT AND DISENROLLMENT

The MCO must not induce or accept disenrollment from Members in Target Population categories 1 and 2, as defined in **Section 1.3 of this Exhibit H, SOW,** but must refer Members or potential Members to DFPS. DFPS is responsible for enrollment and disenrollment of eligible individuals in the Program. A Member's disenrollment from the MCO will be effective on the Date of Disenrollment.

For Members in categories 1 and 2, DFPS will electronically transmit new Member information and change information applicable to active Members to the MCO on a daily basis via the DNF. The DNF will be uploaded to the MCO seven Days a week, inclusive of holidays. The DNF contains each Member's name, social security number if known, and name and address of the Member's Caregiver or Medical Consenter. HHSC or its designee will subsequently electronically transmit the official Medicaid Member identification numbers on the Enrollment Files.

For Members in categories 3, 4, and 5 of the Target Population, as defined in **Section 1.3 of this Exhibit H, SOW,** HHSC or its designee will electronically transmit new Member information and change information applicable to active Members in Enrollment Files or capitation adjustment files. These files are generated on daily or monthly intervals. The Medicaid Enrollment Files will contain the Member's official Medicaid identification number.

Members will be enrolled in the MCO on the Effective Date of Coverage. Individuals already enrolled for Texas' Medicaid managed care, FFS, or CHIP on the Effective Date of Coverage with the MCO will be disenrolled from the applicable Texas Medicaid program or CHIP, effective the Day prior to the Effective Date of Coverage with the MCO.

HHSC or its designee will notify Members in the Target Population categories 2 and 3, as defined in **Section 1.3 of this Exhibit H, SOW,** of their right to disenroll from the MCO and receive services through the STAR program.

The MCO must assign each Member a PCP within one Day of receiving notification of the Member's enrollment via the DNF or Enrollment Files. DFPS, the Member's Medical Consenter, or the Member can change the PCP designation at any time.

The MCO will begin providing Covered Services to all Members across the State of Texas on the Operational Start Date. HHSC will not phase in enrollment.

#### 2.4.2.1 ENROLLMENT AND DISENROLLMENT FOR INFANTS BORN TO PREGNANT WOMEN IN STAR HEALTH

If a newborn is born to a Medicaid-eligible mother enrolled with the STAR Health MCO, HHSC or its designee will enroll the newborn into the MCO's STAR Health product. All requirements related to STAR Health newborn enrollment will apply to the newborn. See Medicaid Managed Care Handbook § 2.3.2.2 Newborn Enrollment, Vol. 2 of the TMPPM, **Exhibit E**.

#### 2.4.2.2 ENROLLMENT AND DISENROLLMENT FOR CHILDREN TRANSITIONING TO ADOPTION ASSISTANCE OR PERMANENCY CARE ASSISTANCE

Members in AA Program or PCA Program who are receiving SSI, who were receiving SSI before becoming eligible for AA or PCA, and those who are enrolled in a 1915(c) Medicaid waiver may choose to continue enrollment under STAR Health or enroll into STAR Kids with the option of choice to enroll back into STAR Health if requested. A Member choosing enrollment in STAR Kids will remain enrolled in STAR Health until the transition to STAR Kids occurs.

### 2.4.3 SPAN OF COVERAGE

The MCO must accept all persons who choose to enroll as Members in the MCO or who are assigned as Members in the MCO by HHSC, without regard to the Member's previous coverage, health status confinement in a healthcare facility, or any other factor.

#### 2.4.3.1 INPATIENT HOSPITAL

The following table describes the MCO's payment responsibility for Medicaid enrollment changes that occur during an Inpatient Stay, as of the Member's Effective Date of Coverage with the receiving MCO (new MCO):

| | Scenario | Hospital Facility Charge | All Other Covered Services |
|---|---|---|---|
| 1. | Member moves from FFS to STAR Health | FFS | STAR Health MCO |
| 2. | Member moves from STAR, STAR Kids, or STAR+PLUS to STAR Health | STAR, STAR Kids, or STAR+PLUS MCO | New STAR Health MCO |
| 3. | Member moves from STAR Health to FFS | STAR Health MCO | FFS |
| 4. | Member moves from STAR Health to STAR, STAR Kids, or STAR+PLUS | STAR Health MCO | New STAR, STAR Kids, or STAR+PLUS MCO |

The responsible party will pay the Hospital facility charge until the earlier of:

1. Date of Discharge from the Hospital;
2. Date of Transfer, or
3. Loss of Medicaid eligibility.

For Members who move into STAR Health, the date of Discharge from the Hospital for mental health stays includes Medically Necessaryextended stay Days (also known as "placement days"), as described in **Exhibit E**, Inpatient and Outpatient Hospital Services Handbook, Vol. 2 of the **TMPPM**. HHSC has determined that extended stay Days are Medically Necessary for Members without placement. The MCO is bound by that determination and may not deny payment.

The following table describes the MCO's payment responsibility for Medicaid enrollment changes that occur during a stay in a residential SUD treatment facility or residential detoxification for SUD treatment facility (collectively, CDTF), beginning on the Member's Effective Date of Coverage with the receiving MCO (new MCO):

| | Scenario | CDTF Charge | All Other Covered Services |
|---|---|---|---|
| 1. | Member moves from FFS to STAR Health | FFS | STAR Health MCO |

| 2. | Member moves from STAR, STAR Kids, or STAR+PLUS to STAR Health | STAR, STAR Kids, or STAR+PLUS MCO | New STAR Health MCO |
|---|---|---|---|
| 3. | Member moves from STAR Health to FFS | STAR Health MCO | FFS |
| 4. | Member moves from STAR Health to STAR, STAR Kids, or STAR+PLUS | STAR Health MCO | New STAR, STAR Kids, or STAR+PLUS MCO |

If the Member is receiving services through a commercial insurer or CHIP prior to the Effective Date of Coverage, then the STAR Health MCO will be responsible for all facility charges and all other Covered Services on the Effective Date of Coverage with the STAR Health MCO.

#### 2.4.3.2 NURSING FACILITIES

Medicaid recipients in a nursing facility are not included. A Member who enters a nursing facility will be disenrolled on the date of entry into the nursing facility.

#### 2.4.3.3 CUSTOM DURABLE MEDICAL EQUIPMENT AND AUGMENTATIVE DEVICES

If the Member has an existing PA in place for custom Durable Medical Equipment (DME) from Texas Medicaid FFS, CHIP MCO, or commercial insurer at the time of the Effective Date of Coverage with the STAR Health MCO, but prior to the delivery of the product, the STAR Health MCO is responsible for paying for the custom DME.

If the Member has an existing PA in place for custom DME from another Medicaid managed care program at the time of the Effective Date of Coverage with the STAR Health MCO, but prior to the delivery of the product, the STAR Health MCO is not responsible for paying for the custom DME.

If the Member has an existing PA in place for custom DME from the STAR Health MCO, but prior to the delivery of the DME the Member is disenrolled from the STAR Health MCO and enrolled in FFS or in another Medicaid managed care program, the STAR Health MCO is responsible for paying for the custom DME.

#### 2.4.3.4 VERIFICATION OF MEMBER ELIGIBILITY

The MCO is prohibited from entering into an agreement to share information regarding their Members with an external vendor that provides verification of Medicaid recipients' eligibility to Medicaid or other providers.

#### 2.4.3.5 EFFECTIVE DATE OF SSI STATUS

When a Member in Target Population categories 1 or 2 becomes qualified for SSI, they will remain enrolled in STAR Health.

When a Member in Target Population Category 3 becomes qualified for SSI, they have a choice between STAR Health and STAR Kids.

When a Member in Target Population Category 4 becomes qualified for SSI, HHSC will open the SSI Medicaid prospectively making the individual mandatory for STAR Kids.

When a Member in Target Population Category 5 becomes qualified for SSI, the Member will continue to have the choice between STAR Health and STAR Kids.

A Member's SSI eligibility is determined by the Social Security Administration (SSA) and is effective on the date the HHSC's eligibility system identifies the Member as Type Program 13 (TP13). HHSC is responsible for updating the HHSC's eligibility system based on official notice of the Member's federal SSI eligibility by SSA.

## 2.5 TRANSITION PHASE SCOPE

This section includes the requirements for the Transition Phase, which begins on the Effective Date and includes those activities that must take place between the Effective Date and the Operational Start Date.

### 2.5.1 INTRODUCTION

HHSC, DFPS, and the MCO will work together during the initial Transition Phase to:

1. Define project management and reporting standards;
2. Establish communication protocols between HHSC and the MCO;
3. Establish contacts with other HHSC contractors;
4. Establish a schedule for key activities and milestones; and
5. Clarify expectations for the content and format of Deliverables.

The MCO must timely and successfully complete each of the Transition Phase tasks per the approved Transition Plan, including, but not limited to:

1. Providing all materials requested by HHSC, or its designee.
2. Providing access to all facilities, systems, staff, etc.
3. Clearly specifying and requesting information needed from HHSC, or other contractors, in a manner that does not delay the schedule or work to be performed.

The Transition Phase includes Readiness Reviews, which must be completed to HHSC's satisfaction no later than 30 Days prior to the Operational Start Date, unless otherwise indicated in **Section 2.5 of this Exhibit H, SOW,** or agreed upon by HHSC.

No later than 30 Days after the Effective Date the MCO must submit an initial Transition Plan, and thereafter on a monthly basis throughout the Transition Phase, the MCO must update the Transition Plan and submit these updated plans to HHSC on a monthly basis for review. HHSC may require more frequent reporting as it determines necessary.

If there are changes that occur to the information after the deadlines listed above, the MCO must notify HHSC within five Business Days. HHSC will have the sole discretion to accept or reject updates to information.

The MCO must successfully complete each of the Transition Phase tasks per the approved Transition Plan.

During the Transition Phase, the MCO must remedy any identified Transition Phase deficiencies within 10 Days of HHSC's request. The MCO must notify HHSC of any deficiencies upon discovery. If any errors or deficiencies are evident during the Transition Phase, the MCO must implement an HHSC-approved resolution procedure to address and resolve the errors or deficiencies prior to the Operations Phase.

The MCO must secure advanced written approval from HHSC for a delay in the Operational Start Date or a delay in the MCO's compliance with the applicable Readiness Review requirements.

The MCO is required to mitigate risk associated with not being prepared for the Operations Phase in coordination with HHSC with consideration of the following high-level processes:

1. HHSC will identify key events based on a Deliverable timeline that the MCO must achieve by a specified time;
2. To ensure the MCO is on track to meet Readiness Review milestones, HHSC may conduct Readiness Review webinars on a weekly basis;
3. If the MCO consistently fails to meet the established Readiness Review milestones, it will be identified as high-risk and targeted for increased technical assistance;
4. Upon MCO remediation of the issues identified by HHSC to HHSC's satisfaction, the MCO status will change to "Go"; and
5. Readiness Review will occur prior to the Operational Start Date, and if at this point the MCO is identified as a "No-Go" then the Operational Start Date may be delayed in HHSC's sole discretion.

### 2.5.2 Administration and Key Personnel

The MCO must comply, to the satisfaction of HHSC, with all provisions set forth in this Contract, including all applicable provisions of State and federal laws, rules, regulations, and waiver agreements with CMS.

No later than 10 Days after the Effective Date, the MCO must:

1. Designate and identify Key Personnel that meet the requirements in **Section 4.02 of Exhibit A, STAR Health Uniform Terms and Conditions**;
2. Provide résumés of each Key Personnel and the percent of allocated time Key Personnel are dedicated to the Contract;
3. Report on any organizational information that has changed since submission of the MCO's Proposal, such as updated job descriptions and updated organizational charts, if applicable;
4. The MCO must also provide information on the anticipated maximum caseload per Service Coordinator (i.e., number of Members per Service Coordinator) and the anticipated number of STAR Health Liaisons needed to fulfill contractual requirements;
5. Provide the organizational chart for Material Subcontractors; and
6. Provide necessary information for HHSC to confirm the identity and determine the exclusion status of the MCO and their Material Subcontractors as well as any owner or person with a controlling interest or who is an agent or managing employee of the MCO through routine checks of federal databases as required in 42 C.F.R. § 438.608(c).

The MCO must notify HHSC no later than 10 Days following a change in the Key Personnel.

#### 2.5.2.1 MATERIAL SUBCONTRACTORS

The MCO or its designee must conduct, at a minimum, one annual site visit to each Material Subcontractor per Contract Year to ensure compliance with the performance of all delegated functions. The MCO must develop and use a standard site visit tool. During the site visit, the MCO must review the policies, procedures, and applicable files and interview Material Subcontractor staff. The MCO must maintain a monitoring plan for each Material Subcontractor, which includes the following:

1. The requirements for performance of all delegated functions with which the entity must comply;
2. The MCO's responsibilities for the financial oversight of a Material Subcontractor who has an at-risk contract with the MCO for the provision of Covered Services;
3. Required and periodic reporting and interfaces with Material Subcontractors required to perform an administrative function on behalf of the MCO;
4. A review of the entity's solvency status, financial operation, and amounts paid for Covered Services (if applicable); and
5. A review of the entity's contract compliance, logged complaints, and functional performance measurements.
6. Provide necessary information for the State to confirm the identity and determine the exclusion status of the MCO's Material Subcontractors as well as any owner or person with a controlling interest or who is an agent or managing employee of the MCO through routine checks of federal databases as required in §438.608(c).

The MCO must maintain documentation as to the compliance of the Material Subcontractor with all requirements defined in **Chapter 5.21 of Exhibit B, UMCM**. This documentation

must contain evidence that all appropriate and necessary actions were taken to correct any noncompliance.

The MCO must contractually require periodic reporting from each Material Subcontractor. The MCO must monitor each reporting entity to ensure accurate and timely Deliverables. The MCO must meet with each Material Subcontractor on a regular basis to discuss any issues that may exist. These meetings will include Key Personnel and designated staff by functional area and their Material Subcontractor counterparts. All meetings will have agendas and documented minutes. The MCO must allow HHSC to attend meetings between the MCO and its Material Subcontractors and to receive the minutes from these meetings.

The MCO or its agent must demonstrate, upon HHSC's request, oversight of each Material Subcontractor based on MCO's assessed risk of Material Subcontractor's performance. During the Transition Phase, the MCO must notify HHSC no later than 10 Days following a change in Material Subcontractors.

### 2.5.3 Readiness Review

During the Readiness Review, the MCO must satisfy the requirements identified in the subsections below. HHSC reserves the right to update the Readiness Review requirements and related reporting at any time prior to and during the Contract Term.

#### 2.5.3.1 Statement Regarding any Material Change in Financial Condition

No later than 60 Days prior to the Operational Start Date, the MCO must submit a statement identifying any material changes in its financial condition. The MCO and its ultimate parent must definitively state whether either entity has, or has not, experienced any material financial deterioration subsequent to submission of its Proposal or not disclosed in its Proposal. This statement must also state if there are, or are not, any known or potential issues with respect to changes in ownership or control. The MCO must not submit "not applicable," "N/A," or a similar response, or leave this section of the statement blank.

If either the MCO or its ultimate parent has experienced any such material financial deterioration, then the statement must also identify and briefly describe any changes to the financial statements, including changes to net worth; cash flow; loss of contracts; credit, audit, regulatory, and/or legal issues; major contingencies; and any known potential material issues.

#### 2.5.3.2 Documentation Demonstrating the Securing of all Required Bonds

No later than 60 Days before the Operational Start Date, the MCO must submit documentation demonstrating it secured all required bonds in accordance with TDI rules, Tex. Ins. Code ch. 843, and **Article 15 of Exhibit A, STAR Health Uniform Terms and Conditions**.

#### 2.5.3.3 EMPLOYEE INCENTIVE PAYMENT PLAN

No later than 60 Days before the Operational Start Date, the MCO must furnish a written employee incentive payment plan to HHSC, if the MCO intends to claim employee incentive payment as Allowable Expenses in its FSRs. The written employee incentive payment plan must include a description of the MCO's criteria for establishing incentive payment, the methodology to calculate incentive payment, and the timing of incentive payment. If the MCO revises the employee incentive payment plan during the Operations Phase, the MCO must submit the revised employee incentive payment plan to HHSC at least 30 Days in advance of its effective date.

HHSC reserves the right to disallow all or part of a plan that it deems not to be Allowable Expenses in the MCO's FSRs. Employee incentive payments are subject to audit and must conform to **Chapter 6 of Exhibit B, UMCM**.

#### 2.5.3.4 UPDATED INFORMATION ON MATERIAL SUBCONTRACTORS

No later than 60 Days prior to the Operational Start Date, the MCO must submit an updated listing of Material Subcontractors. Material Subcontractors include Affiliates and non-Affiliates. Additional documentation may be required at HHSC's discretion. This updated list must, at a minimum, include the following:

1. The Material Subcontractor's legal name, trade name, acronym, dba, and any other name under which the Material Subcontractor does business, or has done business, in the past five years;
2. The full and exact legal name of the Material Subcontractor's ultimate parent;
3. All of the MCO's estimated annual payments to each Material Subcontractor that may be included, directly or indirectly, in any FSR submitted by the MCO under the Contract or any other HHSC contract, including separate amounts for each Material Subcontractor;
4. The physical address, mailing address, and telephone number of the Material Subcontractor's headquarters and the name of its chief executive officer;
5. A definitive statement regarding whether the Material Subcontractor is an Affiliate of the MCO or an unrelated third party;
6. If the Material Subcontractor is an Affiliate:
    a. The name of the Material Subcontractor's parent organization, and the Material Subcontractor's relationship to the MCO;
    b. The proportion, if any, of the Material Subcontractor's total revenues that are received from non-Affiliates. If the Material Subcontractor has significant revenues from non-Affiliates, then also indicate the portion, if any, of those external, non-Affiliate revenues that are for services similar to those that the MCO would procure under the proposed Subcontract;
    c. A description of the proposed method of pricing under the Subcontract;
    d. A statement as to whether there is, or is not, any anticipated mark-up, margin, profit, or amount in excess of actual costs incurred by the Material Subcontractor that is anticipated to be included in the pricing;

   e. The number of employees, both staff and management, who are dedicated full-time to the Affiliate's business. Do not include any staff or management that have other duties in addition to working on this specific Affiliate's business;
   f. Whether the Affiliate's office facilities are completely separate from the MCO and the MCO's ultimate parent. If Affiliate's office facilities are not completely separate from the MCO and MCO's owner, identify the approximate number of square feet of office space that are dedicated solely to the Affiliate's business;
   g. An organization chart for the Affiliate, showing head count, Key Personnel names, titles, and locations; and
   h. Indicate if the staff and management of the Affiliate are directly employed by the Affiliate itself or legally employed by a different legal entity such as an ultimate parent corporation. The employee's Form W-2 identifies the name of the corporation and is indicative of the actual employer.
7. Whether the Material Subcontractor or any of its Affiliates had a managed care contract with a state, federal, or governmental agency terminated or not renewed for any reason within the past five years. In such instance, the MCO must describe the issues, the parties involved, and provide the name, title, email address and telephone number of the principal contact for the party with whom the contract was held. The MCO must also describe any corrective action taken by the Material Subcontractor to prevent any future occurrence of the problem that may have led to the termination or non-renewal; and
8. Necessary information for the State to confirm the identity and determine the exclusion status of the MCO's Material Subcontractors as well as any owner or person with a controlling interest or who is an agent or managing employee of the MCO through routine checks of federal databases as required in 42 C.F.R. § 438.608(c).

The MCO must list the Material Subcontractors in descending order of estimated MCO annual payments to the Material Subcontractor across all HHSC contracts, wherein such payments may be included, directly or indirectly, in a FSR.

#### 2.5.3.5 CARVE-IN READINESS

The MCO must participate in Readiness Review as dictated by HHSC for the expansion of Medicaid managed care to populations currently served by FFS.

#### 2.5.3.6 SYSTEMS READINESS AND TRANSFER OF DATA

HHSC will provide a test plan to the MCO outlining the activities the MCO needs to perform prior to the Operational Start Date. The MCO must be prepared to assure and demonstrate system readiness.

During systems readiness, the MCO must:

1. Submit a systems readiness plan for HHSC approval 30 Days after the Contract Effective Date to test and validate the interfaces among trading partners for the operational and administrative areas listed in **Section 2.6.28**;
2. Plan and execute system readiness test cycles with all trading partners, to include all interfaces based on the activities provided in systems readiness plan, nine months prior to the Operational Start Date;
3. Accept secure transmission of data files and information among trading partners per the file structure, with data elements, and on a frequency specified in HHSC's JIPs located in a centralized secure file transfer site designated by HHSC;
4. Demonstrate to HHSC that systems services will not be disrupted or interrupted during the Operations Phase by successfully completing all tasks in the systems readiness plan;
5. Coordinate with HHSC, other trading partners, and contractors to ensure the business and systems continuity for the processing of all healthcare claims and data;
6. Satisfy internet website and portal requirements described in **Section 2.6.18 of this Exhibit H, SOW**;
7. Submit to HHSC descriptions of data flow, process flow, and interfaces for each key business process described in **Section 2.6.28 of this Exhibit H, SOW;**
8. Submit documentation on systems and facility security as defined in the Security Management Plan;
9. Provide a summary of external audit reports, including findings and corrective actions, relating to the MCO's MIS and subsystems. The summary must include any Service Organization Controls (SOC) 1 examinations, formerly called Statement on Standards for Attestation Engagements (SSAE) 16 audits, that have been conducted in the 3 years prior to the Effective Date;
10. Provide additional documentation to support the readiness of systems as requested by HHSC and DFPS;
11. Install and test all hardware, Software, and telecommunications infrastructure required to support the Contract;
12. Define and test modifications to the MCO's system(s) required to support the business functions of the Contract;
13. Produce data extracts and receive all electronic data transfers and transmissions; and
14. Demonstrate the ability to produce the 837 encounter file 90 Days prior to the Operational Start Date.

The MCO must clearly define and document the policies, processes, and procedures required to support day-to-day systems operations. The MCO must develop, and submit for HHSC review and approval, the following information no later than 120 Days prior to the Operational Start Date:

1. Disaster Recovery Plan;
2. Business Continuity Plan;
3. Security Management Plan;
4. Joint Interface Plan;
5. Risk Management Plan;
6. Systems Quality Assurance Plan; and

7. Change Management Plan.

The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document. At any time during the Contract Period, the MCO must provide updated plans within 15 Business Days of HHSC's request.

HHSC will assess the MCO's understanding of its responsibilities, the MCO's capability to assume the MIS functions required under the Contract, and whether the MCO can commence operations under the Contract.

#### 2.5.3.7 Operations Readiness

The MCO must clearly define and document the policies and procedures to support day-to-day business activities related to the provision of Covered Services, including coordination with Subcontractors. The MCO must clearly document all policies and procedures to produce contract Deliverables. The MCO must develop, document, and maintain its approach to Quality Assurance.

During Readiness Review, the MCO must perform the following activities or develop and submit to HHSC the following Deliverables as well as, any additional items HHSC deems necessary to ensure readiness, in accordance with the HHSC operations readiness Deliverables timeline:

1. Operations procedures and associated documentation to support the MCO's proposed approach to conducting operations activities in compliance with the Contract;
2. A comprehensive plan for Network adequacy that includes a list of all contracted and credentialed Providers, in a format approved by HHSC. At a minimum, the list must include the Provider types identified in Tex. Gov't Code § 533.005(a)(21)(B). The plan must include a description of additional contracting and Credentialing activities scheduled to be completed before the Operational Start Date;
3. A comprehensive plan to recruit and retain Providers statewide to meet the minimum requirements for psychiatrists (to include child and adolescent psychiatrists), psychologists, and BH therapy providers.
4. A plan documenting how the MCO will track Provider certifications and trainings such as TF-CBT, Trauma Informed Care (TIC), Parent Child Interaction Therapy (PCIT), Trust-Based Relational Intervention (TBRI), and Child Parent Psychotherapy (CPP); how the MCO will indicate these designations in the Provider directory; and what system is in place to encourage additional Providers to receive these trainings and certifications from the MCO;
5. A Member Services staff training curriculum and related materials and a Provider training curriculum and related materials, and provide documentation demonstrating compliance with training requirements (e.g., attendance rosters dated and signed by each attendee or other written evidence of training).
6. A coordination plan documenting how the MCO will coordinate its business activities with those activities performed by HHSC or its contractors, the MCO's PBM and other Material Subcontractors, if any. The coordination plan must include identification of coordinated activities and protocols for the Transition Phase;

7. A plan for providing BH Services, including oversight and management of any Subcontracted BH Services. The plan must also address strategies, structures, and incentives for coordinating behavioral and physical Covered Services at the organizational and practitioner level;
8. A plan for conducting ongoing retrospective reviews of any psychotropic medication regimen that is not compliant with HHSC's *Psychotropic Medication Utilization Parameters for Children and Youth in Texas Public Behavioral Health* (Parameters) or standards of care. The plan must address strategies for correcting any non-compliant regimen. The plan must also address strategies and incentives that encourage Providers to comply with the Parameters and standards of care;
9. A Service Coordination plan that addresses requirements provided in **Section 2.6.47 of this Exhibit H, SOW.** The plan must include detailed processes for engaging PCPs, specialty providers, and non-capitated community service providers in the development and implementation of a Member's ISP. The plan must also include scenarios featuring a variety of Target Population categories, Member needs, and service delivery types.
10. A coordination plan for ongoing coordination with HHSC, DFPS, or their contractors, including strategies for sharing information and resolving issues;
11. Drafts of the Member handbook, Provider directory, and Member identification (ID) card for HHSC's review and approval. The materials must meet the requirements specified in **Section 2.6.15 of this Exhibit H, SOW, and** include the critical elements defined in the **Chapter 3 of Exhibit B, UMCM**. The MCO must submit a final Member handbook, Provider directory, and Member ID card incorporating all changes required by **HHSC**;
12. The required number of the final Provider directories to the HHSC Enrollment Broker (EB) by the due date specified by HHSC to meet the enrollment schedule.
13. Drafts of the Provider manual and Provider Contract templates to HHSC for review and approval. The materials must meet the requirements specified in **Section 2.6.7 of this Exhibit H, SOW,** and include the critical elements defined in **Chapters 3** and **8 of Exhibit B, UMCM.** The MCO must submit a final Provider manual and final Provider Contract templates incorporating all changes required by HHSC;
14. The MCO's proposed Member MCO Internal Appeal and Complaint System to HHSC provided in **Section 2.6.31 of this Exhibit H, SOW;**
15. The MCO's proposed provider appeals and Complaints system provided in **Section 2.6.30 of this Exhibit H, SOW;**
16. The MCO's proposed Utilization Management (UM) processes provided in **Chapter 15 of Exhibit B, UMCM**;
17. The MCO's proposed Encounters processes provided in **Section 2.6.28.2 of this Exhibit H, SOW;**
18. The MCO's proposed processes affecting claims provided in **Section 2.6.28.3 of this Exhibit H, SOW;**
19. Demonstrate toll-free telephone systems, including inter-connectedness, and reporting capabilities for all call centers required by the Contract no less than 60 Days prior to the Operational Start Date;
20. A written FWA compliance plan for approval in accordance with **Chapter 5.5.1** of **Exhibit B, UMCM**, unless otherwise approved by HHSC. In addition, **Section**

**2.6.29 of this Exhibit H, SOW,** provides the requirements of the FWA compliance plan, including the requirements for SIUs;

21. Complete hiring and training of STAR Health Service Coordination staff provided in **Section 2.6.47 of this Exhibit H, SOW** no later than 45 Days prior to the Operational Start Date**;**
22. Submit a written plan for providing pharmacy services identified in **Section 2.6.53 of this Exhibit H, SOW**, including proposed policies and procedures for:
    a. Routinely updating formulary data within two Business Days following receipt of HHSC's daily files and off-cycle upon HHSC's request;
    b. PA of drugs, including how HHSC's PDLs will be incorporated into PA systems and processes. The MCO must adopt HHSC's PA processes, criteria, and edits unless HHSC grants a written exception. HHSC's approval is required for all clinical edit policies;
    c. Implementing drug Utilization Review;
    d. Monitoring the use of psychotropic medications;
    e. Overriding standard drug Utilization Review criteria and clinical edits when Medically Necessary based on the Member's circumstances (e.g., overriding quantity limitations, drug-drug interactions, refill too soon);
    f. Call center operations, including how the MCO will ensure that staff for all appropriate hotlines are trained to respond to PA inquiries and other inquiries regarding pharmacy services; and
    g. Monitoring the MCO's PBM Subcontractor, including:
        i. A written description of the assurances and procedures that must be put in place under the proposed PBM Subcontract, such as an independent audit, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information.
        ii. A written attestation by the PBM Subcontractor in the plan stating, in the three years preceding the Effective Date, the PBM Subcontractor has not been: (1) convicted of an offense involving a material misrepresentation or any act of Fraud or of another violation of state or federal criminal law; (2) adjudicated to have committed a breach of contract; or (3) assessed a penalty or fine of $500,000 or more in a state or federal administrative proceeding. If the PBM Subcontractor cannot affirmatively attest to any of these items, then it must provide a comprehensive description of the matter and all related corrective actions.
23. A privacy notice, commonly referred to as Notice of Privacy Practice (NPP), as required by Health Insurance Portability and Accountability Act (HIPAA), including 45 C.F.R. § 164.520;
24. A Cultural Competency plan for approval. The plan must align with the federal and State standards as described in **Section 2.6.17.1 of this Exhibit H, SOW;**
25. A Trauma-Informed Care implementation plan to HHSC no later than 90 Days prior to the Operational Start Date that fully describes all programs and incentives the MCO will develop to increase the Network's expertise in child welfare, TIC, and TF-CBT. The implementation plan must include ways in which Providers will be

required to utilize their special skills in these areas to improve the well-being of Members; and

26. A plan documenting the process it will use to ensure continuation of Covered Services and access to OON providers.

At HHSC's request, the MCO must provide HHSC with certain operating procedures and updates to documentation to support the provision of Medically Necessary Covered Services and provide assurance of the MCO's understanding of its responsibilities and the MCO's capability to assume the functions required under the Contract, based in part on the MCO's assurances of operational readiness, information contained in its Proposal, and in its Transition Phase documentation.

#### 2.5.3.8 Member Enrollment During Transition

Beginning three months prior to the Operational Start Date, HHSC will provide the MCO a monthly Member Prospective Enrollment File (PME).

The MCO must:

1. Coordinate and comply with the appropriate file layouts and timelines for transfers between the MCO, DFPS, and HHSC; and
2. Load the monthly PME and process changes as needed for Member enrollment.

#### 2.5.3.9 Other Reports For Organizational and Financial Readiness

During Readiness Review, the MCO must update the organizational and financial information previously submitted to HHSC.

### 2.5.4 Health Passport Readiness

The MCO must demonstrate that the MCO's developed web-based Health Passport application and system has the capability and capacity to meet all requirements set forth in **Exhibit F, Health Passport Overview and Requirements**.

### 2.5.5 Texas Department of Insurance Licensure, Certification or Approval

The MCO must be licensed by TDI in accordance with the Texas Insurance Code or certified as an ANHC formed in compliance with Tex. Ins. Code ch. 844. The MCO must receive TDI licensure, certification, or approval, as applicable, for all zip codes in the State no later than 60 Days after the Effective Date. If the MCO fails to provide proof of the required licensure, certification, or approval from TDI by this deadline, HHSC may terminate the Contract at no additional cost to HHSC and with no penalty to HHSC.

### 2.5.6 MCO Accreditation

The MCO must achieve accreditation with either NCQA or URAC by September 1, 2022. The MCO may choose an accreditation option most appropriate to its organization and the populations it serves.

## 2.6 Operations Phase Scope

This section describes SOW requirements for the Operations Phase of the Contract, which begins on the Operational Start Date. HHSC will notify the MCO of the Operational Start Date after the completion of Readiness Review.

HHSC may require the MCO to perform activities and submit Deliverables for Readiness Review during the Operations Phase, for example if the MCO begins providing a new service or benefit, expands into a new managed care program, or implements a Major Systems Change after the Effective Date. See **Section 2.6.3 of this Exhibit H, SOW**, for examples of activities and Deliverables.

At HHSC's request, the MCO must provide operating procedures and updates to documentation to support the provision of Covered Services through the Contract Term.

The MCO must provide Covered Services to Members enrolled with the MCO on and after the Operational Start Date.

### 2.6.1 Administrative Services

The MCO must perform the Administrative Services outlined in **Sections 2.6.2 through 2.6.31 of this Exhibit H, SOW.**

### 2.6.2 Administration and Contract Management

The MCO must comply, to the satisfaction of HHSC, with all provisions set forth in the Contract, and all applicable provisions of State and federal laws, rules, regulations, and waivers at all times during the Contract Term. Within 10 Business Days of HHSC's written request, the MCO must provide written updates to any information contained in its Proposal, or any information provided by MCO that is determined by either Party to be incomplete, inadequate, erroneous, or missing. HHSC will have the sole discretion to accept any such updates to any information in the Proposal.

### 2.6.3 Operations Phase Readiness Review and Targeted Operational Reviews

HHSC may conduct desk or onsite reviews related to Contract performance. HHSC may also require MCOs to submit detailed policies and procedures that document day-to-day business activities related to Contract requirements for HHSC's review and approval.

The MCO may be subject to additional Readiness Reviews if it makes changes deemed by HHSC to require such Readiness Reviews. Changes made during the Operational Phase that may lead to additional Readiness Reviews include, but are not limited to:

1. Location change;
2. Major Systems Change;
3. Processing system changes, including changes in Material Subcontractors performing MIS, UM, Service Coordination, or claims processing functions;
4. Carve-ins of new membership; and
5. Carve-ins of new Services.

HHSC will determine, in its sole discretion, whether the proposed changes will require a desk and/or onsite review.

If the MCO makes a change to any other operational systems, or undergoes any major transition, it may be subject to additional Readiness Review(s). HHSC will determine, in its sole discretion, whether the proposed changes will require a desk or onsite review and are subject to HHSC desk review and onsite review of the MCO's facilities, as necessary, to test readiness and functionality prior to implementation. The MCO must not implement any changes to its MIS or supporting systems without prior HHSC approval of the Major Systems Change.

Unless the MCO receives HHSC approval for an exception in writing, the MCO must provide HHSC secure access rights as an authorized or guest user to all Member and Provider access points, including but not limited to Health Passport, its Member and Provider portals and call center services, for remote monitoring capability. To qualify for an exception to this requirement, the MCO must demonstrate to HHSC the required functionality for Member and Provider portals via WebEx or onsite reviews. Portal demonstrations must be conducted in the MCO or Subcontractor production environment or an environment that mirrors the production environment functionality

The MCO must develop and submit a Risk Management Plan and contingency plan to ensure risks and issues are effectively monitored and managed as to limit impact business operations.

The MCO must document and report resolution of system or service related issues to HHSC, including the length of time from discovery to resolution, severity level, and provide corrective measures, and a root cause analysis (RCA) to prevent future problems from occurring.

For MIS Changes Only, the MCO must provide HHSC updates to the MCO's organizational charts and descriptions of MIS responsibilities at least 30 Days prior to the effective date of an MIS change. The MCO must provide up-to-date official points of contact to HHSC for MIS issues on an ongoing basis.

The MCO or its designee must be able to demonstrate, upon HHSC's request, oversight of each Material Subcontractor based on MCO's assessed risk of Material Subcontractor's performance. Refer to **Section 2.5** for additional information regarding Readiness Reviews and **Section 4.08(3) of Exhibit A** for information regarding Readiness Reviews of the MCO's Material Subcontractors.

### 2.6.4 FUTURE INITIATIVES

HHSC may, at its discretion, add new services or populations to STAR Health at any time. The federal government or Texas Legislature may also direct new populations or services to be added to STAR Health. HHSC may designate providers of services as STPs for purposes of providing services to Members in accordance with **Section 2.6.35.4 of this Exhibit H, SOW.** If any new services or populations are added to the STAR Health Program and Contract, then the MCO must participate in Readiness Reviews as required by HHSC.

Recently, HHSC developed a 10-year system-wide plan outlining HHSC's approach to transition its information technology and data-related services and capabilities into a more modern, integrated, secure, and effective environment. The MCO may be required to interface with multiple systems during the modernization effort.

#### 2.6.4.1 NONEMERGENCY MEDICAL TRANSPORTATION

Acts 2019, H.B. 1576, 86th Leg., R.S., ch. 1235 (codified in Tex. Gov't Code chs. 531 and 533) requires the MCO to deliver Nonemergency Medical Transportation (NEMT) Services commencing June 1, 2021. NEMT means non-emergency transportation-related services available under the Medicaid State plan, including Nonmedical Transportation (NMT) Services, which has the meaning assigned by Tex. Gov't Code § 533.00258(a)(1). NEMT Services will include:

1. Demand response transportation services, including NMT Services, and public transportation services;
2. Mass transit;
3. Individual Transportation Participant (ITP) mileage reimbursement;
4. Meals;
5. Lodging;
6. Advanced funds; and
7. Commercial airline transportation services.

NEMT Services will be added as a Covered Service prior to the Operational Start Date and the MCO will be required to use the most cost-effective and cost-efficient method of delivery that allows the Member to meet his or her health care needs, including delivering NMT Services through a Transportation Network Company (TNC) or other transportation vendor if available and medically appropriate. The provisioning of NEMT services will be included in the Capitation Rates developed for the Contract. The resulting Contract, through the amendment process, will be updated to include NEMT services. These requirements can be found in the existing STAR Health contract at https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/star-health-contract.pdf and in **Exhibit B, UMCM**. HHSC reserves the right to amend these requirements at any time.

### 2.6.5 HHSC Performance Review and Evaluation

In accordance with **Section 10.01 of Exhibit A, STAR Health Uniform Terms and Conditions,** HHSC, at its discretion, will review, evaluate, and assess the development and implementation of the MCO's policies and procedures related to the timely and appropriate delivery of Services and Deliverables as required under the Contract. For example, HHSC may review, evaluate, and assess:

1. The MCO's reviews of its own policies and procedures and the corrective actions taken by the MCO;
2. The MCO's workflows;
3. The MCO's use of PAs, including adherence to timeliness requirements and appropriateness of medical necessity determinations;
4. The UM program, including MCO internal Utilization Review policies and processes;
5. The potential for overutilization or underutilization of services;
6. Assessments and Service Plans;
7. Service Coordination and delivery of Services; and
8. Case notes.

Upon notice, and at no charge to HHSC, the MCO and its Subcontractors must cooperate with HHSC and provide any assistance required to complete the review, evaluation, or assessment, including providing prompt and adequate access to related documents, internal systems containing Member information and records, appropriate staff, case notes, and service locations or facilities related to Services and Deliverables provided under the Contract.

HHSC will monitor the MCO to ensure UM is appropriately used by the MCO to prevent overutilization or underutilization of services.

### 2.6.6 PROVIDER CREDENTIALING AND RE-CREDENTIALING

The MCO must use the Texas Association of Health Plans' (TAHP's) contracted Credentialing Verification Organization (CVO) as part of its Credentialing and re-credentialing process regardless of membership in the TAHP. The CVO is responsible for receiving completed applications, attestations, and primary source verification documents. The MCO retains the sole responsibility for Credentialing the Provider. Credentialing documentation must be submitted to HHSC upon request.

At least once every three years, the MCO must review and approve the credentials of all licensed and unlicensed Providers participating in the MCO's Provider Network. The MCO may enter into a Subcontract with another entity to which it delegates Credentialing activities if the delegated Credentialing is maintained in accordance with the NCQA delegated Credentialing requirements and requirements defined by HHSC.

At a minimum, the scope and structure of the MCO's Credentialing and re-credentialing processes must be consistent with recognized MCO industry standards and relevant State and federal regulations including 42 C.F.R. §§ 438.12 and 438.214, and 28 Tex. Admin.

Code pt.1, ch. 11, subch. O § 11.1402(c) and pt. 1 ch. 11, subch. T, § 11.1902(4), relating to provider notice and Credentialing. The re-credentialing process must take into consideration Provider performance data including Member Complaints and appeals, quality of care, and UM.

The MCO must complete the Credentialing process for a new provider, and its claim systems must be able to recognize the provider as a Provider, no later than 30 Days after receiving a complete application requiring expedited Credentialing, and no later than 90 Days after receiving all other complete applications. If an application does not include required information, the MCO must provide the provider written notice of all missing information no later than five Business Days after receipt. For new providers, the MCO must complete the Credentialing process prior to the effective date of the Provider Contract.

#### 2.6.6.1 DFPS Background Check

The MCO must require outpatient BH therapy providers completing the Credentialing or re-credentialing process to submit to a DFPS background history check. A finding of physical or sexual abuse of a child or adult will result in an automatic bar from participation as a Provider. For all other finding types, the MCO must collaborate with DFPS to review the findings and decide whether participation in the Network will be allowed. The MCO must consider the following information prior to issuing a decision to include or bar a Provider from the Network or from terminating a Provider:

1. The severity of the finding;
2. The length of time that has passed since the finding occurred;
3. Any pattern of abuse or neglect;
4. The age of the victim(s); and
5. Any other relevant risk factors.

#### 2.6.6.2 Provider Profiling

The Credentialing profile sheet completed by a PCP, specialty care, BH care, or dental provider during the Credentialing process, and by such Providers during re-credentialing, must include foster care specific questions that address the provider's experience with conditions that are prevalent in the foster care population. Foster care specific questions must address the provider's experience with:

1. The treatment of physical or sexual abuse;
2. Developmental Disability;
3. Post-Traumatic Stress Disorder (PTSD);
4. EBPs or promising practices; and
5. Treatments that utilize a trauma informed approach.

The Credentialing and re-credentialing profile sheets completed by a BH provider or other provider must also track training and certifications in EBPs and promising practices such as:

1. TF-CBT;
2. TIC;
3. PCIT;
4. TBRI; and
5. CPP.

The MCO must also identify a process to track BH Providers becoming certified to administer the Texas CANS 2.0. BH Providers must recertify annually to continue administering this assessment. The MCO must ensure that Providers performing this assessment have not allowed their certification to expire and must ensure that those Providers with expired certifications or nonexistent certifications are not allowed to participate in the assessment.

The MCO may not discriminate against any Provider with regard to Network participation, reimbursement, or indemnification, who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. If the MCO declines to include individual or groups of providers in its Network, it must give the affected provider(s) written notice of the reasons for its decision.

#### 2.6.6.3 EXPEDITED CREDENTIALING PROCESS

The MCO must comply with the requirements of Tex. Ins. Code ch. 1452, subchs. C, D, and E, regarding expedited Credentialing and payment of physicians, podiatrists, and therapeutic optometrists who have joined established medical groups or professional practices that are already contracted with the MCO.

The MCO must also establish and implement an expedited Credentialing process, as required by Tex. Gov't Code § 533.0064, that allows applicant providers to provide Covered Services to Members on a provisional basis for the following provider types:

1. Dentists;
2. Dental specialists, including dentists and physicians providing dental specialty care;
3. Licensed Clinical Social Workers (LCSWs);
4. Licensed Professional Counselors (LPCs);
5. Licensed Marriage and Family Therapists (LMFTs); and
6. Psychologists.

The MCO must allow providers to qualify for expedited Credentialing, if the provider:

1. Is a member of an established healthcare Provider group that has a current contract in place with an MCO;
2. Is a Medicaid-enrolled provider;
3. Agrees to comply with the terms of the contract between the MCO and the healthcare provider group; and
4. Submits all documentation and information required by the MCO in a timely manner as necessary for the MCO to begin the Credentialing process.

Additionally, if a provider qualifies for expedited Credentialing, the MCO must treat the provider as a Network Provider upon submission of a complete application. This includes

paying the in-network rate for claims with a date of service on or after the submission date of a complete application, even if the MCO has not yet completed the Credentialing process. The MCO's claims system must be able to process claims from the provider no later than 30 Days after receipt of a complete application.

#### 2.6.6.4 Minimum Credentialing Requirements for Unlicensed or Uncertified LTSS Providers

Before contracting with unlicensed LTSS providers or LTSS providers not certified by HHSC or another required HHS Agency, the MCO must ensure that the provider:

1. Has not been convicted of a crime listed in Tex. Health & Safety Code § 250.006;
2. Is not listed as "unemployable" in the employee misconduct registry or the nurse aide registry maintained by HHSC by searching or ensuring a search of such registries is conducted, before hire and annually thereafter;
3. Is not listed on the following websites as excluded from participation in any federal or state healthcare program by searching or ensuring a search of such registries is conducted:
    a. U.S. Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE); and
    b. HHSC Office of the Inspector General (HHSC OIG) Texas Exclusions Database;
4. Is knowledgeable of acts that constitute ANE of a Member;
5. Is instructed on and understands how to report suspected ANE;
6. Adheres to applicable State laws if providing transportation; and
7. Is not a spouse of, Caregiver, Medical Consenter for, or employment supervisor of, the Member who receives the services.

#### 2.6.6.5 Board Certification Status

The MCO must maintain a policy that encourages participation of board-certified PCPs and specialty physicians in its Network. The MCO must make information on the percentage of board-certified PCPs and specialty physicians, by specialty, in its Network available to HHSC upon request.

### 2.6.7 Provider Relations Including Manual, Materials, and Training

The MCO must maintain provider relations staff within the SA to provide timely technical assistance to providers having issues with claims denials or rejections, and to facilitate the exchange of information between providers and the Complainants, claims processing, and provider relations systems. The MCO must ensure its provider relations staff are proficient regarding appropriate claims submission requirements, coding updates, electronic claims transactions, and electronic funds transfer to resolve provider issues promptly.

The MCO must designate a dedicated provider relations email address and telephone number for provider relations issues requiring additional follow up or escalation and

include this information in the Provider manual. The MCO must provide an email response or a return phone call to providers within three Business Days of receipt of the Inquiry; an auto-generated or pre-recorded response acknowledging the Inquiry does not qualify as meeting this requirement.

The MCO must provide a named provider relations specialist to Providers, upon request. If the named provider relations specialist changes, the MCO must notify impacted Providers within five Days of the change. Notification must be in writing, by email, or through the Provider portal. The notification must include the new provider relations specialist's name, phone number, and email address.

#### 2.6.7.1 PROVIDER MANUAL

The MCO must prepare and issue a Provider manual, including any specialty manuals, e.g. BH, to all Providers. The MCO must issue copies of the Provider manual to Providers within five Business Days from inclusion of the Provider into the Network. The Provider manual must contain the critical elements defined in **Chapter 3 of Exhibit B, UMCM**, including the special requirements of the STAR Health Program.

The MCO must provide information and education in its Provider manual explaining how Members, Caregivers, and Medical Consenters may access Service Coordination and the role Providers should take in a Member's Service Coordination services.

The MCO must secure HHSC approval for any substantive revisions to the Provider manual before the MCO publishes or distributes the manual to Providers.

#### 2.6.7.2 PROVIDER MATERIALS

The MCO must ensure its Provider Materials comply with State and federal laws governing Medicaid materials. **Chapters 3 and 4 of Exhibit B, UMCM,** set forth material and submission requirements. HHSC may require discontinuation or correction of any Provider Materials, including those previously approved by HHSC. Provider Materials include the MCO’s Provider manual, training materials regarding Program requirements, and mass communications directed to all or a large group of Providers (e-mail or fax “blasts”). Provider Materials do not include written correspondence between the MCO and a Provider regarding individual business matters.

#### 2.6.7.3 PROVIDER TRAINING

The MCO must provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members, including the sensitivities associated with foster care and expectations surrounding care coordination.

The MCO must ensure Providers complete such training within 30 Days of placing a newly contracted Provider on active status. The MCO must provide ongoing training through web-based sessions and regional outreach to new and existing Providers, upon request, and as required by the MCO or HHSC to comply with the Contract. The MCO must make available to Providers a variety of web-based training modules. The MCO must maintain

and make available upon request the enrollment or attendance rosters dated and signed by each attendee or other written evidence of training of each Provider and their staff.

The MCO must hire a team of internal trainers who have experience in Covered Services, Non-capitated Services, and have an understanding of child welfare, TIC, and special requirements of the Contract. The MCO must seek to partner with groups that provide direct services to the foster care population or represent foster care service providers, in order to deliver effective training programs to Providers. The MCO will collaborate with DFPS, SSCCs, the courts, and other child welfare stakeholders to provide Providers with additional insight into the STAR Health Program.

The MCO must establish ongoing Provider training that includes the following topics:

1. Covered Services, including any limitations, and the Provider's responsibilities for providing or coordinating those services:
    a. Special emphasis must be placed on areas that vary from commercial coverage rules, e.g., ECI, EPSDT, therapies, and DME or medical supplies;
    b. Special emphasis must be placed on the availability of mental health and SUD treatment, including Mental Health Rehabilitative Services and Mental Health TCM for qualified Members; treatment for opioid use disorder; screening, brief intervention, and referral to treatment;
    c. Special emphasis on the availability of PDN, PCS and CFC services for qualified Members;
    d. Special emphasis on pharmacy services and processes, including information regarding outpatient drug benefits, HHSC's drug formulary, preferred drugs, PA processes, 72-hour emergency supplies of prescription drugs, using HHSC's free subscription service for accessing the Medicaid formulary and PDL through the Internet or hand-held devices, and scope of DME and other items commonly found in a pharmacy that are available for Members through age 20; and
    e. How a provider should notify the MCO about court-ordered psychiatric services or SUD treatment.
2. THSteps Provider training topics listed in **Section 2.6.58.6 of this Exhibit H, SOW;**
3. Requirements for screenings, exams, and assessments listed in **Section 2.6.46 of this Exhibit H, SOW**, and the provision of or referral for all physical health services and BH Services indicated by the results of such screenings, exams, and assessments.
4. Coordination with Non-capitated Services, such as NEMT services, and Case Management for Children and Pregnant Women services;
5. The processes for making referrals, including required referrals for SED, mental illness, SUD, and ECI;
6. Availability of Service Coordination, including how and when to contact a Member's Service Coordinator;
7. Availability of DM, VAS, and Case-by-case Services;
8. Billing for services for hospice recipients and Dual Eligible Members;
9. Claims processing and policies specific to the MCO, including:

a. Claims data element requirements;
b. Recoupments;
c. Disposition codes for Hospitals;
d. Continuity of Care requirements;
e. Network and OON referrals and PAs;
f. Span of coverage requirements, including for extended stays; and
g. EVV.

10. Medical Home Services Model;
11. Relevant requirements of the Contract, including:
    a. Policies related to MCO Retaliation against Providers;
    b. Prohibitions on balance-billing Members for Covered Services;
    c. UM reviews;
    d. FWA, including oversight activities such as pre-payment reviews, audits, and monitoring;
    e. Providers' obligations to identify and report to the State Critical Events or Incidents, such as ANE, related to LTSS delivered in the Program;
    f. The MCO's Quality Assessment and Performance Improvement (QAPI) program and the Provider's role;
    g. EVV expectations;
    h. The importance of updating contact information to ensure accurate Provider directories and the Medicaid online Provider lookup;
    i. The importance of advance directives and how the MCO can facilitate;
    j. Member rights and responsibilities; and
    k. The MCO Internal Appeal and Complaint System.
12. Cultural Competency training based on federal and state requirements, including the need for Providers and their staff to address Members, Medical Consenters, Caregivers, and DFPS Staff with dignity, sensitivity, and respect;
13. Population-specific issues, including:
    a. Health Passport, as explained in **Section 2.6.24 of this Exhibit H, SOW**;
    b. Coordinating care with Medical Consenters, DFPS caseworkers, guardians ad litem, attorneys ad litem, DFPS Staff, SSCC staff, and involved parties from other state agencies;
    c. Requirements for providing Covered Services to the Members in accordance with the STAR Health Contract, and as defined in Tex. Fam. Code § 266.003 and DFPS policies (see DFPS website) including:
        i. Medical consent and informed consent requirements;
        ii. Required timelines for scheduling physical health services and BH Services appointments;
        iii. Specific medical information required for judicial review of medical care under Tex. Fam. Code § 266.007;
        iv. Provision of medical records to DFPS Staff; and
        v. Compliance with the *Psychotropic Medication Utilization Parameters for Children and Youth in Texas Public Behavioral Health*;
    d. EBPs and promising practices, including:
        i. For BH Providers, TF-CBT, PCIT, TBRI and CPP;

ii. For all other Providers, TIC, PTSD and Attention-Deficit/Hyperactivity Disorder (ADHD); and

14. Specific behavioral and physical health needs of the population, such as ADHD Covered Services for Members including reimbursement for ADHD and availability of follow-up care for Members who have been prescribed ADHD medications.

Training in all the topics above must be offered and made available within a reasonable time after the date the Provider begins providing services and in accordance with **Section 2.5.3.7 of this Exhibit H, SOW.**

The MCO must consult with experts in the healthcare field, including its medical advisory committee, to determine which additional topics may be relevant to Providers in providing services to the Members.

As directed by HHSC, the MCO must also develop a training plan for BH Providers that will ensure successful implementation of the comprehensive assessment process required by Tex. Fam. Code § 266.012.

All Provider training and education materials and associated presentations specific to Medicaid benefits, services and programs must be submitted to HHSC for approval prior to use.

### 2.6.8 CONTINUING EDUCATION CREDITS

The MCO is encouraged to inform Providers of the availability of and arrange for access to training programs that provide continuing education credits to Providers. The MCO may coordinate with national and local provider associations to deliver continuing education training. Continuing education training must at least focus on enhancing Provider understanding of the complex and special physical and BH needs of Members. To improve Provider access to these continuing education training programs, the MCO must make every effort to allow Providers to complete training programs through the internet.

### 2.6.9 PROVIDER HOTLINE

The MCO must operate a toll-free telephone line for Providers during normal business hours, which are, for the purposes of this section, Business Days from 8:00 a.m. to 5:00 p.m. local time for all areas of the State. This Provider Hotline must be staffed with personnel who are knowledgeable about Program-specific requirements, Covered Services, Non-capitated Services, Case-by-case Services, and VAS. The Provider Hotline may serve other Medicaid programs administered by the MCO, if the Provider Hotline staff is knowledgeable about all the managed care programs.

The MCO must ensure that during non-business hours the Provider Hotline is answered by an automated system with the capability to provide callers with operating-hours information and instructions on how to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition. The MCO must have a process in place to

address non-business hour inquiries from Providers seeking to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition.

The MCO must ensure that the Provider Hotline meets the following minimum performance requirements for the MCO Program:

1. Average hold time: no more than two minutes; and
2. Call abandonment rate: no more than seven percent (7%) of the calls are abandoned.

The MCO must conduct ongoing call Quality Assurance to ensure these standards are met. The MCO must submit performance reports summarizing call center performance for the Provider Hotline as indicated in **Chapter 5.24 of Exhibit B, UMCM.** If the MCO's Provider Hotline serves more than one Medicaid program administered by the MCO, the MCO must have the capability to report hotline performance by program and SA. If the MCO subcontracts with a Behavioral Health Organization (BHO) that is responsible for Provider Hotline functions related to BH Services, the BHO's Provider Hotline must also meet the requirements in **Section 2.6.50.3 of this Exhibit H, SOW**, and the MCO must provide the Deliverables regarding the BHO's performance.

### 2.6.10 PROVIDER REIMBURSEMENT

The MCO must pay for all Medically Necessary and functionally necessary Covered Services provided to Members. The MCO must ensure its Provider Contracts include a complete description of the payment methodology or amount, as described in **Chapter 8 of Exhibit B, UMCM**. The MCO must identify in its Provider Contract if it is using the Texas Medicaid fee schedule or another source.

The MCO must ensure its Provider Contracts require Providers to comply with the requirements of Tex. Gov't Code § 531.024161 regarding reimbursement of claims based on orders or referrals by supervising Providers.

The MCO must pay OON providers using the Medicaid methodology as defined by HHSC in 1 Tex. Admin. Code pt 15, ch. 353, subch. A, § 353.4 and ensure claims payments are timely and accurate as described in **Section 2.6.28.3 of this Exhibit H, SOW,** and **Chapter 2 of Exhibit B, UMCM.**

The MCO must require tax identification numbers (TINs) from all Providers. The Provider may use the federal TIN of the residential treatment center where he or she is an employee and provides services. The MCO is required to do back-up withholding from all payments to Providers who fail to give TINs or who give incorrect numbers.

MCO must ensure payments to all Providers comply with all applicable State and federal laws, rules, and regulations, including 42 U.S.C. § 1396a(a)(80) related to the prohibition on payments to institutions or entities located outside of the United States.

The MCO must comply with registration requirements in Tex. Ins. Code § 1458.051 and with reimbursement and fee schedule requirements in Tex. Ins. Code §§ 1451.451 and 1458.101–102.

As required by Tex. Gov't Code § 533.005(a)(25), the MCO must not implement significant, non-negotiated, across-the-board Provider reimbursement rate reductions unless:

1. The MCO requests and receives HHSC's prior approval; or
2. The reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by HHSC.

For purposes of this requirement, an across-the-board rate reduction is a reduction made by an MCO or MCO Subcontractor that applies to all similarly situated Providers or types of Providers.

The MCO must submit a written request for an across-the-board rate reduction to HHSC's Director of Managed Care Compliance and Operations (MCCO) and provide a copy to HHSC's health plan manager, if the reduction is not based on a change in the Medicaid fee schedule or a cost containment initiative implemented by HHSC.

The MCO must submit the request no later than 90 Days prior to the planned effective date of the reduction. If HHSC does not issue a written statement of disapproval within 45 Days of receipt, then the MCO may move forward with the rate reduction on the planned effective date.

The MCO must give Providers at least 30 Days' written notice of changes to the MCO's fee schedule, excluding changes derived from changes to the Medicaid fee schedule, before implementing the change. If the MCO fee schedule is derived from the Medicaid fee schedule, the MCO must implement fee schedule changes after the Medicaid fee schedule change, and any retroactive claim adjustments must be completed within 60 Business Days after HHSC retroactively adjusts the Medicaid fee schedule.

The MCO may deny a claim submitted by a Provider for failure to file in a timely manner as provided for in **Chapter 2 of Exhibit B, UMCM**.

The MCO must not pay any claim submitted by a Provider excluded or suspended from the Medicare, Medicaid, or CHIP programs, or with debts, settlements, or pending payments due to HHSC, or the State or federal government. Furthermore, the MCO must not pay any claim submitted by a Provider after HHSC OIG determines there is a credible allegation of Fraud for which an investigation is pending unless HHSC OIG has good cause not to suspend payments or to suspend payment only in part.

The MCO must complete all audits of a provider claim no later than two years after receipt of a Clean Claim, regardless of whether the provider participates in the MCO's Network, with the following exceptions:

1. This limitation does not apply in cases of provider FWA that the MCO did not discover within the two-year period following receipt of a claim.
2. This limitation does not apply when the officials or entities identified in **Section 8.02(3) of Exhibit A, STAR Health Uniform Terms and Conditions**, conclude an examination, audit, investigation review, or inspection of a provider more than two years after the MCO received the claim.

If an exception to the two-year limitation applies, the MCO may recoup related payments from providers only if approved by HHSC.

If payment is due to a provider as a result of an audit, the MCO must make the payment no later than 30 Days after it completes the audit. If the audit indicates the MCO is due a refund from the Provider, the MCO must send the Provider written notice of the basis and specific reasons for the recovery no later than 30 Days after it completes the audit. If the Provider disagrees with the MCO's request, the MCO must give the Provider an opportunity to appeal and may not attempt to recover the payment until the Provider has exhausted all appeal rights. If the MCO recouped the payment and did not allow the Provider time to appeal, the MCO must repay the Provider for funds recouped.

The MCO must inform all Providers about the information required to submit a claim at least 30 Days prior to the Operational Start Date and as a provision within the Provider Contract.

The MCO must not require a Provider to submit documentation that conflicts with the requirements of 28 Tex. Admin. Code pt. 1, ch. 21, subchs. C and T.

The MCO must ensure the Provider Contract specifies that Program violations arising out of performance under the agreement are subject to administrative enforcement by the HHSC OIG as specified in 1 Tex. Admin. Code pt.15, ch. 371, subch. G.

#### 2.6.10.1 CLAIMS PROJECT

For purposes of this section, Claims Project ("Project") means a project initiated by an MCO outside of the Provider appeal process after payment or denial of claims for the purpose of conducting any necessary research on the claims or to adjust the claims, if appropriate. The MCO must not include nursing facility daily/unit rate claims as part of a Project.

The MCO may initiate a Project at its own initiative. All claims included in a particular Project must be finalized within 60 Days of the initiation date of the Project or within the timeframe agreed upon between the Provider and the MCO. If the MCO is unable to complete the Project within 60 Days, the MCO must enter a written agreement with the Provider before the expiration of the initial 60 Day period to establish the Project's agreed upon timeframe. Any Project that exceeds 60 Days must receive prior approval for an extension from MCCO. The MCO must maintain the agreement for 18 months from the conclusion of the Project and make the agreement available to HHSC upon request. The MCO must report monthly to HHSC MCCO the start and end date for all Projects using HHSC's report template.

Projects must be included in the quarterly claims reports including interest paid. Projects exceeding 60 Days, without prior approval, are subject to any remedies under the Contract.

#### 2.6.10.2 NATIONAL CORRECT CODING INITIATIVE

Effective for all claims filed, the MCO must comply with the requirements of 42 U.S.C. § 1396b(r), regarding mandatory State use of the National Correct Coding Initiative,

including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

### 2.6.10.3 Electronic Funds Transfer

The MCO must offer Providers Electronic Funds Transfer (EFT) for claims payment or other direct deposit operations, such as paycheck deposits, as a safe alternative to paper checks. The MCO must make EFT available to Providers whether claims are filed electronically or in hard copy. The MCO must utilize a financial subsystem that provides the technological capability to process EFT using HIPAA national standards for electronic payment and remittance advice. The MCO must process and issue no less than 85% of claims payment dollars via EFT.

An MCO not meeting the stated EFT processing standard must submit a plan and corresponding timeline for HHSC approval that moves the MCO toward achieving the stated performance standard. The MCO must report on progress and status of implementation of the HHSC-approved plan upon HHSC request.

### 2.6.10.4 Provider Overpayments

In accordance with 42 C.F.R. § 438.608(d)(2), the MCO must require, through Provider Contracts, Providers to report to the MCO in writing any Overpayments received and the reason for the Overpayment, and when applicable, to return the Overpayment to the MCO no later than 60 Days after the date on which the Overpayment was identified. For purposes of this section, "identified" refers to the date upon which the Provider has or should have, through the exercise of reasonable diligence, determined an Overpayment was received and has quantified the amount of the Overpayment.

### 2.6.10.5 Provider Preventable Conditions

The MCO must identify Present on Admission (POA) indicators as required in **Chapter 2 of Exhibit B, UMCM**, and must reduce, deny, or recoup payments for provider preventable conditions that were not POA as set forth in 42 C.F.R. §§ 434.6(a)(12) and 447.26. This includes any Hospital-acquired conditions or healthcare-acquired conditions identified in **Exhibit E, TMPPM**.

As a condition of payment to Hospital providers, the MCO must require providers to report provider preventable conditions on institutional claims using appropriate POA indicators. The MCO must include all POA indicators on Encounter Data submitted to HHSC. Upon request by HHSC, the MCO must report the amount of provider payments reduced, denied, or recouped from an individual provider for the requested service dates for provider preventable conditions that were not POA.

### 2.6.10.6 SUPPLEMENTAL PAYMENTS FOR QUALIFIED PROVIDERS

HHSC or its designee will conduct the provider self-attestation process and determine which providers and services are eligible for supplemental payments. HHSC will use Encounter Data and other data provided by the MCO to calculate supplemental payments and will provide the MCO with detailed reports identifying qualified providers, claims, and supplemental payment amounts. The MCO will use this information to respond to Provider inquiries and Complaints regarding supplemental payments and will refer all cases for resolution, as directed by HHSC.

The MCO must pay claims from qualified Providers at the MCO's contracted rates and OON providers in accordance with 1 Tex. Admin. Code pt.15, ch.353, subch. A, § 353.4. The MCO's Encounter Data must reflect the actual amount paid to providers and should not be adjusted to include supplemental payment amounts.

As described in **Section 2.8.15 of this Exhibit H, SOW,** the MCO must pay the full amount of supplemental payments to qualified providers no later than 30 Days after receipt of HHSC's supplemental payment report, contingent upon MCO's receipt of payment of the allocation. The MCO must submit a report and certification, in the form and manner identified in **Chapter 13 of Exhibit B, UMCM**, to validate that payments have been made to qualified providers in accordance with HHSC's calculations. In addition, the MCO must provide reports, in the manner and frequency prescribed in **Exhibit B, UMCM**, documenting all claims adjustments that alter the supplemental payment amounts, including documentation of recoupments of overpaid amounts. The MCO must collect and refund all overpayments of supplemental payments to HHSC in the format and manner prescribed in **Exhibit B, UMCM**. In cases where a third party is responsible for all or part of a Covered Service and the MCO recovers only part of the amount paid by the MCO, then the amount recovered must be applied first to the supplemental payment and returned to HHSC. If the amount recovered is less than the supplemental payment, then the MCO must return the full amount of the recovery to HHSC.

### 2.6.10.7 FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

The MCO must make reasonable efforts to include FQHCs and RHCs (freestanding and Hospital-based) in its Provider Network. The MCO must pay full Encounter rates to RHCs for Covered Services using the prospective payment methodology described in in Sections 1902(bb) and 2107(e)(1) of the Social Security Act, 42 U.S.C. 1396a (Section 1902), 1397gg (Section 2107). Because the MCO is responsible for the full payment amount in effect on the date of service for RHCs, cost settlements or wrap payments do not apply.

When the MCO negotiates payment amounts with FQHCs for Covered Services provided to its Members, the amounts must be greater than or equal to the average of the MCO's payment terms for other Providers providing the same or similar services. Because the MCO may negotiate payment amounts with FQHCs, wrap payments apply. The MCO may elect to pay the FQHC wrap payment at the time of claim adjudication but must make the wrap payment no later than the 15th Day of the following month for claims paid in the prior month. After the MCO pays a wrap payment, HHSC will make a supplemental

payment to the MCO in the amount of the wrap payment by the last Day of the following month.

If a Member visits an FQHC, RHC or a municipal health department's public clinic (public clinic) for Covered Services, at a time that is outside of regular business hours, the MCO must reimburse the FQHC, RHC, or public clinic for Covered Services. The MCO must do so at a rate that is equal to the allowable rate for those services as determined under Tex. Hum. Res. Code § 32.028. The MCO must not require a referral from the Member's PCP. In this context, outside regular business hours has the meaning given in 1 Tex. Admin. Code pt.15, ch. 353, subch. A, § 353.2, as required by 1 Tex. Admin. Code pt.15, ch.353, subch. E, § 353.407.

If a Member visits an OON IHCP enrolled as an FQHC for Covered Services, the MCO must reimburse the OON IHCP a full Encounter rate as if the provider were a Network Provider. The MCO must pay this Encounter rate entirely as a wrap payment no later than the 15th Day of the following month for services provided in the prior month. After the MCO pays a wrap payment, HHSC will make a supplemental payment to the MCO in the amount of the wrap payment by the last Day of the following month. An OON FQHC's claim is subject to the same claim standards requirements as the MCO's Providers.

### 2.6.11 MINIMUM WAGE REQUIREMENTS FOR ATTENDANTS

The MCO must comply with 1 Tex. Admin. Code, pt. 15, ch. 355, subch. H, § 355.7051.

### 2.6.12 ELECTRONIC VISIT VERIFICATION

The MCO must use an EVV system(s) approved by HHSC, or its designee, in a manner consistent with terms and conditions of the Contract, including **Chapter 8 of Exhibit B, UMCM**.

The MCO must follow any applicable requirements to exchange EVV data. The MCO may not pass any EVV-related costs to Providers or Members.

### 2.6.13 MANAGED CARE ORGANIZATION TERMINATION OF PROVIDER CONTRACTS

The MCO must notify HHSC in writing within five Days prior to MCO termination of the following Provider Contracts:

1. A PCP contract that impacts more than 10% of Members; or
2. Any Provider Contract that impacts more than 10% of its Network for the SA.

The MCO must also notify HHSC of all Provider terminations in accordance with **Chapter 5.24 of Exhibit B, UMCM**.

Additionally, the MCO must give written notice of Provider termination or disenrollment to each Member who receives his or her primary care, or who is seen on a regular basis, i.e., two or more visits, by the Provider as follows:

1. For a Provider disenrolled by HHSC, the MCO must provide written notice to affected Members no later than five Days after disenrollment.
2. For involuntary terminations of a Provider, i.e., terminations initiated by the MCO, the MCO must provide notice to HHSC and the Member within 15 Days after issuance of the termination notice unless State or federal law, including Tex. Ins. Code § 843.308, permits or requires notice to be provided under a different timeframe. In cases of imminent harm to Member health, the MCO must immediately give HHSC and the Member notice that the Provider will be terminated even if a final termination notice to the Provider has not been issued.
3. For voluntary terminations by a Provider, i.e. terminations initiated by the Provider, the MCO must provide notice to the Member 30 Days prior to the termination effective date. In the event that the Provider sends untimely notice of termination to the MCO making it impossible for the MCO to send Member notice within the required timeframe, the MCO must provide notice as soon as practical, but no later than 15 Days after the MCO receives notification to terminate from the Provider.

The MCO must send notice of termination of a Provider to:

1. All Members in a PCP's panel; and
2. All Members who have had two or more visits with the Provider for home-based or office-based care in the past 12 months prior to termination.

### 2.6.14 PROVIDER PROTECTION PLAN

The MCO must comply, as required by Tex. Gov't Code § 533.0055, with the requirements of HHSC's Provider protection plan for reducing the administrative burdens placed on Providers and ensuring efficacy in Network enrollment and reimbursement. The MCO must have a Provider protection plan that complies with the following standards:

1. Responds to authorization requests within three Days of routine requests and in compliance with **Section 2.6.22 of this Exhibit H, SOW**.
2. Provides for timely and accurate claims adjudication and claims payment in accordance with **Chapter 2 of Exhibit B, UMCM.**
3. Educates and trains Providers on the requirements for claims submission and appeals, including the corresponding MCO's policies and procedures. See also **Section 2.6.7 of this Exhibit H, SOW.**
4. Ensures Member access to care, in accordance with **Section 2.6.33 of this Exhibit H, SOW.**
5. Ensures prompt Credentialing, as required by **Section 2.6.6 of this Exhibit H, SOW.**
6. Ensures compliance with State and federal standards regarding PAs, as described in **Sections 2.6.22 and 2.6.53.2 of this Exhibit H, SOW.**
7. Ensures no Retaliation by the MCO staff against a Provider for filing appeals, grievances, or Complaints against the MCO on the Provider's or Member's behalf.
8. Provides 30 Days' notice to Providers before implementing changes to policies and procedures affecting the PA process. In the case of suspected FWA by a single

Provider, the MCO may implement changes to policies and procedures affecting the PA process for that single provider without the required notice period.

9. Includes other measures developed by HHSC or measures developed by the MCO and approved by HHSC.

### 2.6.15 MEMBER SERVICES

The MCO must maintain a Member Services department to assist Members and Medical Consenters in obtaining Covered Services for Members. The MCO must maintain employment standards and requirements (e.g., education, training, and experience) for Member Services department staff and provide a sufficient number of staff for the Member Services department to meet the requirements of **Sections 2.6.15 and 2.6.16 of this Exhibit H, SOW**, including Member Hotline response times and Linguistic Access capabilities.

#### 2.6.15.1 MEMBER MATERIALS

The MCO must design, print, and distribute Member ID cards and a Member handbook to Members. The MCO must only accept a PCP assignment request or change request from the Member's Medical Consenter. In the absence of an initial PCP assignment request from the Medical Consenter, the MCO must auto-assign a PCP to the Member and include the name of the PCP on the Member's ID card.

For Members in DFPS conservatorship and Members with voluntary agreements (i.e., Target Population categories 1 and 2) no later than the fifth Business Day following the MCO's receipt of the DNF or Enrollment Files, the MCO must mail a Member ID card and enrollment packet to the Caregiver of each new Member. For purposes of this section enrollment packet includes: a welcome letter, Provider directory, Member handbook, and informational and training materials on how to access the Health Passport, and how to schedule the THSteps exam within the required timeframe. The five Business Day timeline begins on the date the MCO first receives the Member on either the DNF or the Enrollment File. When a Caregiver represents two or more new Members, the MCO is required to send only one enrollment packet to the Caregiver. Thereafter, a new enrollment packet should not be mailed to the Caregiver's address for a new Member more frequently than every six months. Each time a Member moves to a new placement, the MCO must send a new Member ID card and welcome letter to the new Caregiver's address.

For all Members in categories 3 through 5 of the Target Population, no later than the fifth Business Day following receipt of the Enrollment Files, the MCO must mail a Member ID card and enrollment packet to the new Member, as appropriate.

In cases in which the Caregiver of the Member is not designated as the Medical Consenter, the MCO is responsible for mailing the designated primary Medical Consenter a welcome letter and PCP change form for each Member. This mailing should occur no later than the fifth Business Day following receipt of the DNF or Enrollment File.

The MCO is responsible for mailing materials only to those Members or Caregivers for whom valid address data are contained in the Enrollment Files and Medical Consenters for whom valid address data are contained in the DNF.

The MCO welcome letter must provide Members with information regarding the Program and how to locate more detailed information in their Member handbooks. The welcome letter must provide the name of the PCP the MCO has assigned to the Member and provide information regarding how Members, Caregivers, or Medical Consenters may:

1. Access their PCP;
2. Change their PCP;
3. Seek help scheduling THSteps appointments including the required timeframe;
4. Access the Member and Nurse Hotlines, including hotline numbers;
5. Provide information to the MCO regarding the Member's special healthcare needs and specific services the MCO may need to coordinate; and
6. Access the appropriate level of Service Coordination.

The MCO must ensure all information provided by the MCO to Members complies with the information requirements in 42 C.F.R. § 438.10, as applicable.

All Member Materials must be at or below a sixth-grade reading level, as measured by the appropriate score on the Flesch reading ease test. Member Materials must be written and distributed in English, Spanish, and any Prevalent Languages in the State of Texas. All Member Materials must be available in a format accessible to the visually impaired, which may include large print (font size no smaller than 18 point), braille, and compact disc (CD) or other electronic format. Member Materials must comply with the requirements set forth in **Chapters 1, 3**, and **4 of Exhibit B, UMCM**, including required critical elements and any applicable Marketing policies and procedures.

The MCO must ensure Member Materials critical to obtaining Covered Services, including Provider directories, Member handbooks, appeal and grievance notices, and denial and termination notices, are created using a font size no smaller than 12 point. The MCO must ensure these Member Materials include large print (conspicuously visible) taglines in the Prevalent Languages of the State explaining the availability of written translation or oral interpretation to understand the information provided; the toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) telephone number of the MCO's Member Hotline; and information on how to request Auxiliary Aids and Services, including the provision of materials in alternative formats. Auxiliary aids and Services and materials in alternative formats must be made available upon request of the Member, Medical Consenter, or Caregiver at no cost.

The MCO must submit Member Materials to HHSC for approval prior to publication or distribution, including revisions to previously approved Member Materials. See **Chapters 3** and **4 of Exhibit B, UMCM,** for material and submission requirements. HHSC reserves the right to require discontinuation, revision, or correction of any Member Materials, including those previously approved by HHSC. The MCO must adhere to other requirements specified in 42 C.F.R. § 438.10 associated with Member Material management.

The MCO's Member Materials and other communications cannot contain discretionary clauses, as described in Tex. Ins. Code § 1271.057(b).

#### 2.6.15.1.1 MEMBER IDENTIFICATION CARDS

All Member ID cards must include all the critical elements identified in **Chapter 3 of Exhibit B, UMCM**.

The MCO must reissue the Member ID card within seven Days at no charge in the following circumstances:

1. If a Member, DFPS Staff, Caregiver, or Medical Consenter reports a lost card;
2. There is a Member name change;
3. If the Member, Medical Consenter, or DFPS Staff requests a new PCP;
4. The Member moves to a new placement;
5. Or for any other reason that results in a change to the information disclosed on the Member ID card.

#### 2.6.15.1.2 MEMBER HANDBOOK

The MCO must ensure the Member handbook satisfies the Member Materials requirements specified by **Section 2.6.15.1 of this Exhibit H, SOW,** and must include critical elements in **Chapter 3 of Exhibit B, UMCM**.

The MCO must produce and distribute a revised Member handbook, or an insert, informing Members, Medical Consenters, and their Caregivers of changes to Covered Services, upon HHSC notification and at least 30 Days prior to the effective date of such changes to Covered Services.

The MCO must ensure the Member handbook is written to provide Members and Caregivers with information regarding the medical consent and informed consent process. The Member handbook should also provide the information necessary for Medical Consenters to understand their roles in the Member's treatment planning and care decisions and providing consent to the provision of services.

The MCO must provide information in its Member handbook explaining how Members, Caregivers, and Medical Consenters may access Service Coordination.

### 2.6.15.2 PROVIDER DIRECTORY

The MCO must have a quality plan and have a process in place to compare the information in the master Provider file provided by HHSC or its designee with the MCO's Provider directory. On an annual basis, the MCO must verify the accuracy of Provider directory information for a statistically valid random sample of its Network PCPs and specialists. When the MCO identifies a discrepancy, the MCO must assist the Provider through the process of updating inaccurate information with HHSC or its designee. The MCO must contact Providers monthly until the information on the master Provider file reflects the information attested to by the Provider. This includes, but is not limited to, information identified through the MCO Provider verification report in **Section 2.6.33.4 of this Exhibit H, SOW,** or other data sources provided to the MCO by HHSC or identified by the MCO. The MCO must include in its Provider Contract that the Provider will update its

information with HHSC or its designee in a timely fashion or immediately upon request by the MCO. The MCO must use United States Postal Service (USPS) address standards when entering Provider information into the Provider directory.

The Provider directory, including substantive revisions, must be approved by HHSC before publication and distribution. Substantive revisions are revisions to the information required by **Chapter 3 of Exhibit B, UMCM**, except for information contained in the Provider listings and indices and any additional information that the MCO adds to the directory at its discretion.

The Provider directory must comply with HHSC's Marketing policies and procedures, as set forth in the **Chapter 4 of Exhibit B, UMCM**.

The Provider directory must be consistent with, particularly as to specialty providers, **Chapter 3 of Exhibit B** and include critical elements in **Chapter 3 of Exhibit B, UMCM**. The Provider directory must indicate which providers have certifications or training in:

1. TIC;
2. TF-CBT;
3. PCIT;
4. TBRI; and
5. CPP.

The Provider directory must include only Providers credentialed by the MCO in accordance with **Section 2.6.6 of this Exhibit H, SOW**. If the MCO contracts with limited Provider Networks, the Provider directory must comply with the requirements of 28 Tex. Admin. Code pt. 1, ch. 11, subch. Q, § 11.1600(b)(12), relating to the disclosure and notice of limited Provider Networks.

#### 2.6.15.2.1 HARD COPY PROVIDER DIRECTORY

The hard copy Provider directory must contain the required critical elements of **Chapter 3 of Exhibit B, UMCM**.

The MCO must update the Provider directory in accordance with 42 C.F.R. § 438.10 or as directed by HHSC. The MCO must make the updates available to existing Members, Caregivers, DFPS Staff, and Medical Consenters upon request. The MCO must inform Members that the Provider directory is available in paper form without charge upon request of the Member, Medical Consenter, Caregiver, or DFPS Staff.

The MCO must send the most recent Provider directory, including any updates, to Members upon request and provide it within five Business Days of the request. The MCO must, at least annually, provide written communication to its Members to inform of and offer the most recent Provider directory. The MCO is responsible for all Provider directory mailings.

#### 2.6.15.2.2 ONLINE PROVIDER DIRECTORY

The MCO must have an online Provider directory to provide an electronic Provider look-up search of its Provider Network. The MCO must have policies and procedures with respect to its Provider Network database, which must include predictable scheduled algorithms for systematically updating the database. The online Provider directory must be updated on a weekly basis to reflect the most current Network.

The online Provider directory must include the required critical elements of **Chapter 3 of Exhibit B, UMCM**, including any specialist designations and credentials or certifications, such as for CANS, TIC, TF-CBT, PCIT, TBRI, or CPP.

Upon Member, Medical Consenter, Caregiver, or DFPS Staff request, the MCO must send an electronic version of the Provider directory to the Member via email within five Business Days of the request.

### 2.6.16 REQUIREMENTS COMMON TO ALL MEMBER-FACING CALL CENTERS

All Member-facing call centers, including the Member Hotline, Nurse Hotline, and the BH Crisis Services Hotline, are subject to the requirements of this section. All Member-facing call centers must be staffed with personnel designated solely to the Program. Staff trained to manage general calls may provide back-up to dedicated hotline staff during peak periods or in cases of emergency, in order to maintain hotline performance standards and respond to urgent Member calls, but at least 95% of calls must be answered by dedicated hotline staff.

All Member-facing call center staff must be properly trained, competent, and knowledgeable about the Program and population, the child welfare system, TIC, and Medical Consenter requirements.

The MCO must ensure that Member-facing call centers meet Cultural Competency requirements and that Member-facing call center staff appropriately handle calls from callers who speak Prevalent Languages, including Spanish, as well as calls from individuals who are deaf or hard-of-hearing. To meet the Cultural Competency requirements, the MCO must employ Member Services and BH crisis services staff who are bilingual in English and Spanish, must provide oral interpretation services to all Member-facing call center callers free of charge, and must secure the services of other contractors as necessary to meet these requirements.

The MCO must provide personal health information through Member-facing call centers to only those persons who can identify themselves through the caller verification process approved by HHSC. The MCO must ensure all Member-facing call center staff treat callers with dignity and respect the callers' needs for privacy. Member-facing call center staff must be trained to assist callers in scheduling an appointment with a Provider during the Provider's hours of operation and within the Member's availability, in accordance with **Section 2.6.33.2 of this Exhibit H, SOW**. Member-facing call center staff must always offer the Member, Medical Consenter, Caregiver, or DFPS Staff the opportunity to participate in a facilitated three-way call with a Provider's office to schedule an

appointment. The MCO may have dedicated staff for this purpose. If the caller does not want this type of assistance with scheduling non-emergency appointments, the MCO must document refusal and offer a list of Providers.

The MCO must process all incoming Member calls in a timely and responsive manner. The MCO must not impose call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Member. The MCO must ensure all Member-facing call centers, and transfers within and among its Member-facing call centers, meet the following minimum performance standards for the MCO Program:

1. Queue Hold Rate: at least 80% of calls must be answered by call center staff within 30 seconds measured from the time the call is placed in queue after the caller's last automated menu selection;
2. Call abandonment rate: no more than seven percent (7%) of the calls are abandoned; and
3. Average hold time: no more than two minutes.

The MCO must conduct ongoing call Quality Assurance monitoring to ensure these standards are met. The MCO must submit performance reports summarizing call center performance for its Member-facing call centers as indicated in **Chapter 5.24 of Exhibit B, UMCM**.

### 2.6.16.1 MEMBER HOTLINE

The MCO must operate a toll-free Member Hotline that Members, Medical Consenters, Caregivers, and DFPS Staff can call 24 hours a Day, 7 Days a week. The Member Hotline must be staffed between the hours of 8:00 a.m. to 5:00 p.m. local time for all areas of the State, Monday through Friday, excluding State-approved holidays. The State-approved holiday schedule is updated annually and can be found at www.hr.sao.texas.gov/Holidays/.

The MCO must ensure that, during non-business hours, the Member Hotline is answered by an automated system that provides callers with operating hours, instructions regarding how to access the Nurse Hotline, and instructions on what to do in cases of emergency. The MCO must ensure that all Member Hotline recordings are available to callers in English, Spanish, and any Prevalent Languages. A voice mailbox must be available during non-business hours for callers to leave messages. The MCO's Member Hotline staff must return calls received by the automated system on the next Business Day.

If the Member Hotline does not have a voice-activated menu system, the MCO must have a menu system that will accommodate Members who cannot access the system through other physical means, such as pushing a button. The menu system must direct callers to the most appropriate team to resolve the Member's call.

In addition to the requirements identified in **Section 2.6.16 of this Exhibit H, SOW**, the MCO's Member-facing hotline staff must also have training in and knowledge about:

1. Covered Services and limitations, VAS, Case-by-case Services, health education initiatives, and medical necessity as described in **Sections 2.6.17, 2.6.32, 2.6.37, and 2.6.38 of this Exhibit H, SOW**, and offered by the MCO;

2. Answering non-clinical questions pertaining to accessing Non-capitated Services, community and social service resources, and Community-Based Services for which the population may be eligible;
3. Service Coordination and Service Plans offered by the MCO, Member advocacy, and how to transfer Members to Service Coordinators;
4. Referring callers to information regarding Covered Services and Non-capitated Services, as appropriate;
5. Answering non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services;
6. The emergency prescription process and how to immediately address problems when pharmacies do not provide a 72-hour supply of emergency medicines;
7. How Members in the HHSC OIG Lock-In Program can fill prescriptions at a non-designated pharmacy in an emergency situation;
8. Processes for obtaining DME services and how to address common problems;
9. Answering non-technical questions pertaining to the role of the PCP and the Medical Home Services Model;
10. Issues related to child abuse and how to assist Members and Medical Consenters seeking care and services;
11. Providers in a particular geographical area;
12. FWA including the HHSC OIG Lock-In Program and the requirements to report any conduct that, if substantiated, may constitute FWA in the Program;
13. Triaging calls to the appropriate MCO staff person, warm transferring calls, and issue escalation;
14. Providing information on Member Complaints and appeals, and the State Fair Hearing process;
15. Responding to questions regarding the availability of and access to SUD treatment services, including information on self-referral;
16. How to identify and report a Critical Event or Incident such as ANE to the State; and
17. Responding to questions regarding the availability and access to BH Services, and prohibitions related to restraint and seclusion.

#### 2.6.16.2 NURSE HOTLINE

The MCO must operate a toll-free Nurse Hotline that Providers, Members, DFPS Staff, Caregivers, and Medical Consenters can call 24 hours a Day, 7 Days a week, including State approved holidays. The Nurse Hotline must be staffed with RNs who are knowledgeable about the Program and population, Covered Services, Non-capitated Services, the child welfare system, TIC, Medical Consenter requirements, and Provider resources. Nurses must be available to answer calls 24 hours per Day and able to respond to callers seeking clinical information, guidance on specialty referrals, and requests for specialty Provider consultations.

Members, DFPS Staff, Caregivers, and Medical Consenters may access the Nurse Hotline and Member Hotline through the same toll-free number; but must be given the option to have their call directed based on whether the call relates to a clinical or non-clinical issue,

or emergent or Routine Care. However, the MCO must report hotline call statistics separately for the Member Hotline and the Nurse Hotline. The MCO must ensure Members can reach a nurse either by a warm transfer from another Member Hotline staff or by selecting a menu option.

Nurses must have access to an on-call licensed BH clinician 24 hours per Day, 7 Days a week, to assist with crisis calls. The Nurse Hotline team must have the capability to notify the MCO of a Member's admission to a facility, pending or post-discharge from a facility, Change in Condition, or request for Covered Services.

In addition to the requirements identified in **Section 2.6.16 of this Exhibit H, SOW**, the Nurse Hotline team must also meet the training requirements listed in **Section 2.6.7.3 of this Exhibit H, SOW,** and have training in and knowledge about:

1. Answering clinical questions related to the role of the PCP, the Medical Home Services Model, and identifying PCPs who Members may access that practice according to the models;
2. Answering clinical questions related to referrals or the process for receiving authorization for procedures or services;
3. Triaging and assisting Members and Medical Consenters with clinical concerns;
4. Responding to Provider questions regarding specialty referrals and to arrange for consultations with MCO clinical staff, Service Coordinators, or other Providers;
5. The DM programs included in the STAR Health Program;
6. Offering to contact a pharmacy that is refusing to fill a 72-hour supply of emergency medicines and explain the 72-hour supply policy and DME processes;
7. The HHSC OIG Lock-In Program pharmacy override process, which ensures Member access to Medically Necessary outpatient drugs;
8. Responding to questions regarding the availability of and access to SUD treatment, including information on self-referral; and
9. Responding to questions regarding the availability and access to BH Services.

### 2.6.17 MEMBER EDUCATION

The MCO must develop educational materials and implement health education initiatives that educate Medical Consenters, Caregivers, Members, DFPS Staff, SSCC staff, guardians ad litem, judges, and attorneys ad litem about:

1. How the MCO system operates, including the role of the PCP, how to obtain referrals for services, and access to OON providers;
2. Covered Services and limitations described in **Section 2.6.32 of this Exhibit H, SOW**;
3. Any VAS and Case-by-case Services offered by the MCO, as described in **Sections 2.6.37 and 2.6.38 of this Exhibit H, SOW**;
4. The value of screening, preventive care, and other Medical Home services;
5. How to obtain Covered Services, including:
    a. Contacting the MCO's Member-facing hotlines;
    b. The MCO's Complaint, appeals, and State Fair Hearing process described in **Section 2.6.31 of this Exhibit H, SOW**;

c. Requesting a State Fair Hearing;
d. Emergency Services described in **Section 2.6.33.2.1 of this Exhibit H, SOW**;
e. Obstetrics-Gynecology (OB/GYN) services and specialty care including oncology described in **2.6.33.2.4 of this Exhibit H, SOW**;
f. The availability of and access to SUD treatment services described in **Section 2.6.50.9 of this Exhibit H, SOW**;
**g.** Mental Health Rehabilitative and Mental Health TCM Services, and information on self-referral described in **Section 2.6.50.7 of this Exhibit H, SOW**;
h. State requirements in Tex. Fam. Code § 266.012 for a Texas CANS 2.0 assessment within 30 Days of enrollment;
i. State requirements in Tex. Fam. Code § 264.1076 for an initial medical exam within three Business Days of entering DFPS conservatorship;
j. Non-capitated Services, including the HHSC NEMT, described in **Section 2.6.60.7 of this Exhibit H, SOW**;
k. Service Coordination as described in **Section 2.6.47 of this Exhibit H, SOW**;
l. ECI Services described in **Section 2.6.44 of this Exhibit H, SOW**;
m. THSteps medical and dental checkups described in **Section 2.6.58 of this Exhibit H, SOW**, and **Exhibit E, TMPPM**;
n. How to obtain 72-hour supplies of emergency prescriptions from Network pharmacies as described in **Section 2.6.53.2 of this Exhibit H, SOW**;
o. Information maintained in the Health Passport;
p. How Members in the HHSC OIG Lock-In Program can receive outpatient drugs in an emergency situation; and
q. Community-Based Services and LTSS such as PCS, CFC, and MDCP, and the availability of different service delivery options.

6. Availability of Program and population specific health initiatives, including:
   a. Suicide prevention;
   b. Identification and health education related to obesity; and
   c. The availability of Transitioning Youth Program (TYP) services and supports.

The MCO must provide a range of health promotion and wellness information and activities for Medical Consenters, Members, DFPS Staff, SSCC Staff, Caregivers, guardians ad litem, judges, and attorneys ad litem in formats that meet their needs. The MCO must propose, implement, and assess innovative Member education strategies for wellness care and immunization, as well as general health promotion and prevention, and for addressing risk factors and stressors that may give rise to future abuse and neglect of a child. The MCO must conduct wellness promotion programs to improve the health status of its Members. The MCO must work with its Providers to integrate health education, and wellness and prevention training into the care of each Member.

The MCO also must provide condition and disease-specific information and educational materials to Members, Medical Consenters, DFPS Staff or Caregivers, including information on its Service Coordination and DM programs described in **Sections 2.6.47**

**and 2.6.49 of this Exhibit H, SOW**. Condition and disease specific information must be oriented to various groups within the STAR Health Program, such as persons with Disabilities and non-English speaking Members.

The MCO also must offer TIC training, guidance, and related educational materials to Medical Consenters, Caregivers, and DFPS Staff upon request.

Per Tex. Health & Safety Code § 48.052(c), the MCO may employ or contract with certified Community Health Workers or Promotoras, as described in Tex. Health & Safety Code § 48.052, to conduct outreach and Member education activities.

### 2.6.17.1 Cultural Competency Plan

The MCO must have a comprehensive written Cultural Competency plan describing how the MCO will ensure culturally competent Services and provide Linguistic Access and Disability-related Access. The plan must be developed in adherence to the federal and State Cultural Competency standards in the format as required by HHSC as described in **Chapter 16 of Exhibit B, UMCM**. The Cultural Competency plan must adhere to the following:

1. Title VI of the Civil Rights Act guidelines and the Americans with Disabilities Act (ADA);
2. 28 C.F.R. § 36.303 and 42 C.F.R. § 438.206(c)(2); and
3. 1 Tex. Admin. Code pt.15, ch.353, subch. E, § 353.411.

Additionally, the Cultural Competency plan must detail how the MCO will implement each component of the federal and State standards and how its implementation of these standards impact implementation of the principal standard from the U.S. Department of Health & Human Services' National Culturally and Linguistically Appropriate Services (CLAS) Standards: "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."

The Cultural Competency plan must describe how the individuals and systems within the MCO organization will effectively provide Services to people of all cultures, races, ethnic backgrounds, languages, communications needs, Disabilities, and religions, in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

The plan must be made available to the MCO's Providers.

At HHSC's request, the MCO must update the plan to incorporate new or amended requirements based on HHSC guidance. In that event, the MCO has 60 Days to submit the updated plan to HHSC for approval.

#### 2.6.17.1.1 Competent Interpreter Services

The MCO must arrange and pay for Competent Interpreter services, including written, spoken, and sign language interpretation, for Members and Medical Consenters to ensure effective communication regarding treatment, medical history, and health conditions. The

MCO must maintain policies and procedures describing the process by which Members, Medical Consenters, and the Members' Providers can access Competent Interpreter Services, including written, spoken, and sign language interpretation when the Member or Medical Consenter is receiving services from a Provider in an office or other location, or accessing Emergency Services.

Over-the-Phone Interpretation (OPI), including three-way calls facilitated between the MCO, Provider and telephone interpreter, must not require advance notification by the Member, Medical Consenter, or Provider.

Upon a Provider, Member, or Medical Consenter request, in-person interpreters for scheduled appointments must be arranged as quickly as possible, with "rush" appointments available for Urgent Conditions. For Routine Care, in-person requests must be scheduled according to the requested date and time, or upon the next availability of the interpreter for the requested language, including American Sign Language (ASL). If an in-person interpreter is not available for the requested date and time, the MCO must notify and coordinate with the Provider and Member, or Medical Consenter, as applicable, and offer alternative interpretation options, such as OPI, video remote interpretation, or the earliest availability of an in-person interpreter. Members may select an in-person interpreter whether they require ASL or another language. The MCO may recommend, but must not require, an advance notice timeframe for arranging an in-person interpreter. MCO must make a good faith effort to arrange an in-person interpreter when one is requested, regardless of the advance notice.

### 2.6.17.2 ADVISORY GROUPS

The MCO must partner with existing community groups, councils, or collaborations to establish a process by which the MCO receives feedback on behalf of Members. Existing statewide groups that are appropriate for this role include:

1. The Parent Collaboration Group, which is a partnership between CPS and parents who have been recipients of CPS services.
2. The Statewide Youth Leadership Council, which includes elected youth currently residing in foster care settings. This council is charged with identifying issues and recommending improvements to DFPS program initiatives.
3. The Statewide Kinship Collaboration Group, which includes kinship Caregivers receiving services from DFPS and provides feedback to DFPS on improving service delivery to kinship families and children in their care.
4. The Texas Foster Families Association, which is made up of foster parents and agency staff and provides recommendations to improve service delivery to children in their care.

### 2.6.17.3 MEMBER SERVICE EMAIL ADDRESS

The MCO must have a secure email address through which a Member, Medical Consenter, DFPS Staff, or Provider may contact the MCO to receive assistance with identifying Providers, scheduling an appointment for the Member, or accessing services. The MCO

must, within one Business Day, acknowledge a request for assistance with an email response informing the Member, Medical Consenter, DFPS Staff, or Provider that by communicating via email the Member, Medical Consenter, DFPS Staff, or Provider consents to receive information through the same means. Member Services staff must provide the Member, Medical Consenter, DFPS Staff, or Provider with the requested assistance within three Business Days following the receipt of the email.

#### 2.6.17.4 Member Advocates

The MCO must provide Member Advocates to assist Members, DFPS Staff, and Medical Consenters. Member Advocates may be Service Coordinators (or other MCO staff) as long as they also meet the Contract requirements for serving as Service Coordinators. Member Advocates must be physically located within the State of Texas. The MCO must ensure Member Advocates receive training in TIC prior to assisting Members. Member Advocates must inform Members, DFPS Staff, and Medical Consenters of the following:

1. Their rights and responsibilities;
2. The Complaint process;
3. The appeal process;
4. Available Covered Services, including preventive services; and
5. The availability of and access to Non-capitated, non-covered, and community services.

Member Advocates must assist Members and Medical Consenters in writing Complaints and are responsible for monitoring the Complaint through the MCO's Complaint process. Requirements for assisting DFPS Staff with Complaints and appeals are found in **Section 2.6.25.3 of this Exhibit H, SOW**.

The MCO must ensure that Member Advocates make recommendations to MCO's management regarding any changes needed to improve either the care provided or the way care is delivered. In addition, the MCO must ensure Member Advocates are able to help or refer Members and Medical Consenters to community resources available to meet Member needs that are not available from the MCO as Covered Services.

### 2.6.18 Managed Care Organization Website

The MCO must develop and maintain a website consistent with HHSC standards, Tex. Ins. Code § 843.2015, and all other applicable State and federal laws and regulations, Accessibility Standards, guidelines, policies, and procedures, to provide the following minimal general information about:

1. The MCO and its Network, including an online Provider directory as outlined in **Chapter 3 of Exhibit B, UMCM**;
2. The STAR Health Program;
3. The MCO's Member Services and its Complaints and appeals process;
4. An updated Member handbook; and
5. A link to the STAR Health Contract.

The MCO must comply with the Texas Department of Information Resources (DIR) guidance for all web development and publications, which include bilingual and accessibility requirements, in compliance with 1 Tex. Admin. Code pt.10, chs. 206 and 213.

The MCO's website must also meet the required critical elements of **Chapter 3 of Exhibit B, UMCM** and comply with State and federal Accessibility Standards, guidelines, policies, and procedures for all work products, including Section 508 compliance in accordance with Accessibility Standards; and 29 U.S.C. § 794.

The website must contain a link to financial literacy information on the Texas Office of Consumer Credit Commissioner webpage. The MCO must also maintain a mobile optimized site for mobile device use. The MCO may develop a page within its existing website to meet the requirements of this section.

The MCO must minimize download and wait time and not use tools or techniques that require significant memory, disk resources, or special user interventions. The MCO must develop mobile device applications in addition to tools that take advantage of efficient data access methods, reduce server load, and consume less bandwidth.

The MCO must provide a publicly-accessible, region specific, searchable copy of its Provider directory on the website.

The MCO's website must comply with HHSC's Marketing policies and procedures, as set forth in the **Chapter 4 of Exhibit B, UMCM**.

The website's content must include for providers:

1. Training program schedules and topics, and directions for Provider enrollment in training, including continuing education credits for training on issues related to the Members;
2. Information on how to apply to become a Provider;
3. Information on Cultural Competency and how to provide culturally sensitive care;
4. Information on the 24-hour Nurse Hotline and how to seek specialty consultations and referrals; and
5. Links to DFPS policies and information required of Providers to meet the needs of the Members.

HHSC may require discontinuation, revision, or correction of any Member Materials posted on the MCO's website, including those previously approved by HHSC.

The MCO must provide clear and obvious information on their Member-facing website regarding the availability of the 24/7 BH crisis services support through its hotline. The information should specify that a licensed mental health professional is available to support a Member and their Caregiver during a BH crisis.

### 2.6.18.1 ELECTRONIC INFORMATION RESOURCES (EIR)

All EIR that is provided by the MCO in the delivery of the information and services requested in this SOW must provide equivalent access to HHSC staff and the public as required under Title I and Title II of the ADA, 42 U.S.C. § 12101 et seq., through

compliance with the revised standards in 36 C.F.R. pt. 1194 (March 23, 2018) for Section 508 of the Rehabilitation Act of 1973, 29 U.S.C. § 798. This includes conformance with the WCAG Version 2.0 at levels A and AA.

The MCO must provide a completed Voluntary Product Accessibility Template (VPAT) indicating evidence of conformance for each Information and Communications Technology (ICT)/EIR product developed or indicating compliance with technical and functional standards. The VPAT can be found in the **Procurement Library**.

All electronic email, documents, or reports provided to fulfill any part of this SOW must also meet the standards in these requirements.

To assure adherence to all standards and guidelines in accordance with Section 508 of the Rehabilitation Act, 29 U.S.C. § 798, and compliance with the ADA 42 U.S.C. § 12101 et seq., contractor accessibility testing must be validated through either testing by HHSC accessibility staff or testing by an independent third party.

### 2.6.18.2 PROVIDER PORTAL AND TOLL-FREE FAX LINE

The MCO must provide a Provider portal with the objective of reducing the administrative burden on Providers at no cost to the Providers as described in **Chapter 3 of Exhibit B, UMCM**.

The Provider portal must support online claims processing, both single claims and batch processing.

To facilitate the exchange of clinical data and other relevant documentation, the Provider portal must provide a secure exchange of information between the Provider, MCO, and Subcontractor of the MCO, if applicable.

The MCO must provide access to a toll-free fax line where Providers may send requests for PAs and any supplemental information related to a PA. The fax line and Provider portal must be available 24 hours per Day, 7 Days per week.

If the MCO and its BHO maintain separate Provider portals for physical health and BH Providers, the MCO must comply with the requirements in **Chapter 16 of Exhibit B, UMCM.** The Provider portal functionality must include at least the following:

1. Member eligibility verification;
2. Submission of electronic claims;
3. PA requests;
4. Updates to Provider profiles;
5. Password reset functionality;
6. Claims appeals and reconsiderations;
7. Exchange of clinical data and other documentation necessary for PA and claim processing; and
8. An online process through the provider portal or Health Passport, for Providers to access the following information related to a Member with the Member's consent:
    a. SAI;

b. Member SAI MDCP Review signature page (Form 2605), as applicable; and
c. ISP, as applicable.

### 2.6.19 Smart Phone Application

The MCO must agree to facilitate access to selected data in the MIS through secure communications between a Smart Phone Application (App) and the MIS. All functionality in the App must be HIPAA compliant, including offline storage of Member data on the Member's device. Offline storage is not required by HHSC.

The MCO must ensure Members are required to authenticate themselves to the MIS using multi-factor authentication such as providing their Primary Account Numbers (PAN) or usernames and Personal Identification Numbers (PIN) or passwords through secure connection between the Members' smart phones and the MIS. The MCO must ensure the App meets industry standards for secure data transmission and must be approved by HHSC.

The MCO must provide the App for web services and platforms (iOS, Android, and web) as directed by HHSC. The MCO must ensure that, upon successful verification of the PAN (or username) and PIN (or password), the App securely provides users the following features that allow users the ability to:

1. View current case and personal information, including:
    a. Provider visits;
    b. Vaccinations;
    c. Prescription drugs;
    d. Lab results; and
    e. ISPs, if applicable;
2. Search for Providers;
3. Request a PCP; and
4. Update their security profile, including modification to demographics and reset of application password.

### 2.6.20 Marketing and Prohibited Practices

The MCO must comply with all applicable federal and state laws, rules, regulations, policies, and guidance regarding Marketing, gifts, and other inducements, including:

1. 15 U.S.C §§ 6101-6108;
2. 15 U.S.C §§ 7701-7713;
3. 42 U.S.C. § 1396u-2;
4. 16 C.F.R. Part 310;
5. 16 C.F.R. Part 316;
6. 42 C.F.R. § 422.2264;
7. 42 C.F.R. § 423.2264;
8. 42 C.F.R. § 438.104;
9. 42 C.F.R. § 457.1224;
10. Tex. Gov't Code §§ 531.02115 and 533.008;

11. 1 Tex. Admin. Code pt. 15, ch. 353, subch. E, § 353.405;
12. 1 Tex. Admin. Code pt. 15, ch. 354, subch B, § 354.1452;
13. 1 Tex. Admin. Code pt.15, ch.354, subch F, div. 4, § 354.1871;
14. 1 Tex. Admin. Code pt. 15, ch. 370, subch. G, § 370.601;
15. 1 Tex. Admin. Code pt. 15, ch. 371, subch G, div. 2, § 371.1669; and
16. U.S. Department of Health and Human Services Office of the Inspector General Special Advisory Bulletin: Offering Gifts and Other Inducements to Beneficiaries, August 2002.

Marketing Policies and Procedures as set forth by HHSC in **Chapter 4 of Exhibit B,UMCM**.

## 2.6.21 QUALITY IMPROVEMENT AND PERFORMANCE EVALUATION

The MCO must provide for the delivery of quality care with the primary goal of improving the health status of Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO must work in collaboration with Providers to actively implement the Medical Home Services Model for physical and BH needs, and the main Dental Home model for dental needs. The MCO must work in collaboration with Providers to actively improve the quality of care provided to Members, consistent with the MCO's Quality Improvement goals and all other requirements of the Contract. The MCO must provide mechanisms for Members, Caregivers, Medical Consenters, DFPS and HHSC staff, and Providers to offer input into the MCO's Quality Improvement activities.

### 2.6.21.1 PERFORMANCE MEASURES

The MCO must provide all Services and Deliverables under the Contract at an acceptable quality level and in a manner consistent with acceptable industry standards, customs, and practices. The MCO must provide to HHSC all information necessary to analyze the MCO's provision of quality care to Members using measures to be determined by HHSC.

### 2.6.21.2 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)

The MCO must develop, maintain, and implement a QAPI program consistent with the Contract, 42 C.F.R. § 438.330, and TDI requirements, including 28 Tex. Admin. Code, pt. 1, ch. 11, subch. T.

The MCO must submit a QAPI program annual summary using the QAPI template found in **Chapter 5.7.1 of Exhibit B, UMCM**.

The MCO must inform participating physicians and other Providers about the QAPI program and related activities on a consistent basis. The MCO must include a requirement in its Provider Contracts that ensures Provider cooperation and participation with the MCO's QAPI program.

As part of the QAPI program, the MCO must notify HHSC whether it has been accredited by a private independent accrediting entity and must authorize the private independent

accrediting entity to provide HHSC or its EQRO a copy of its most recent accreditation review in accordance with 42 C.F.R. § 438.332.

The MCO must approach all clinical and non-clinical aspects of QAPI based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and must:

1. Evaluate performance using objective quality indicators;
2. Foster data-driven decision-making;
3. Recognize that opportunities for improvement are unlimited;
4. Solicit Member, Medical Consenter, Caregiver, DFPS Staff, Provider, and other stakeholder input on performance and QAPI activities;
5. Support continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;
6. Support programmatic improvements of clinical and non-clinical processes and Member satisfaction based on findings from ongoing measurements; and
7. Support re-measurement of effectiveness and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

#### 2.6.21.2.1 Quality Assessment and Performance Improvement Program Structure

The MCO must maintain a well-defined QAPI program structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The MCO must designate a senior executive responsible for the QAPI program, and the Medical Director must have substantial involvement in QAPI program activities. The MCO must ensure that the QAPI program structure:

1. Is organization-wide, with clear lines of accountability within the organization;
2. Includes a set of essential functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;
3. Includes annual objectives or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and
4. Evaluates the effectiveness of clinical and non-clinical initiatives.

#### 2.6.21.2.2 Clinical Indicators

The MCO must collect clinical indicator data. The MCO must use such clinical indicator data in the development, assessment, and modification of its QAPI program.

#### 2.6.21.2.3 Quality Assessment and Performance Improvement Program Subcontracting

If the MCO Subcontracts any of the essential functions or reporting requirements contained within the QAPI program to another entity, the MCO must maintain detailed files documenting the work of the Subcontractors. The files must be available for review by HHSC and the EQRO upon request.

#### 2.6.21.2.4 Behavioral Health Integration into Quality Assessment and Performance Improvement Program

The MCO must integrate BH into its QAPI program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of BH Services provided to Members. The MCO must collect data and monitor and evaluate improvements to physical and BH outcomes resulting from the integration of BH and physical health to improve the Member's overall care and health outcomes.

#### 2.6.21.2.5 Clinical Practice Guidelines

The MCO must adopt and maintain four or more evidence-based clinical practice guidelines that apply to the STAR Health Program, two for physical health and two for BH. These practice guidelines must be:

1. Based on valid and reliable clinical evidence;
2. Considerate of the needs of Members;
3. Adopted in consultation with Providers, and
4. Reviewed and updated, as appropriate.

The MCO must maintain practice guidelines based on the Members' health needs and opportunities for improvement identified as part of the QAPI program. The MCO must disseminate the practice guidelines to all affected Providers and, upon request, to Medical Consenters, DFPS Staff, Caregivers, and Members.

The MCO must take steps to encourage the adoption of the guidelines and to measure compliance with the guidelines, until such point that 90% or more of the Providers are consistently in compliance based on MCO measurement findings. The MCO must employ substantive Provider incentive strategies to improve Provider compliance with clinical practice guidelines. The MCO's decisions regarding UM, Member education, coverage of services, and other areas included in the practice guidelines must be consistent with the MCO's clinical practice guidelines.

#### 2.6.21.2.6 Medical Advisory Committee

The MCO must establish a medical advisory committee comprised of community providers and other physical health and BH experts that is chaired by the MCO's STAR Health Medical director or a provider member of the medical advisory committee. The medical advisory committee must conduct quarterly meetings. The MCO must maintain a record of the medical advisory committee meetings, including agendas and minutes, for the time period established in **Section 8.01 of Exhibit A, STAR Health Uniform Terms and Conditions**.

The MCO may either establish separate and multiple medical advisory committees, which must be composed of members with specific expertise in major areas, such as dental or BH Services, or one medical advisory committee that is composed of various provider types to enable it to provide specialized review, expertise, and consultation on a variety of health issues. Membership in the medical advisory committees must include the CPS medical

director or designee, Acute Care, BH, LTSS, dental, and pharmacy providers, as well as a specialist or pediatrician experienced in the needs of medically fragile children. The MCO must require that all Provider members of the medical advisory committee have experience working with the Target Population.

The medical advisory committee must assist the MCO in:

1. Developing, reviewing, and revising clinical practice guidelines, based on clinical best practices and community standards;
2. Reviewing general clinical practice patterns and assessing Provider compliance with clinical guidelines; and
3. Working with HHSC and the EQRO to develop Quality Improvement strategies and studies.

#### 2.6.21.2.7 PROVIDER CREDENTIALING AND PROFILING

In accordance with **Section 2.6.6 of this Exhibit H, SOW**, the MCO must review and approve the credentials of all licensed and unlicensed Providers participating in the MCO's Network. As part of the QAPI program, the MCO must report annually to HHSC the results of any Credentialing activities conducted during the previous reporting year. The MCO must use the QAPI form in **Chapter 5.7.1 of Exhibit B**, **UMCM,** or other method specified by HHSC upon request for this report.

If the MCO wishes to move to a preferred Provider arrangement, the MCO must profile all Providers of the service or supply for a period of no less than 12 months. The results of the Provider profiles must be used to determine the Provider or Providers selected for a preferred Provider arrangement. If an MCO enters into a preferred Provider arrangement, the MCO must notify Members of the arrangement in writing at least 30 Days in advance of execution of the arrangement, consistent with **Chapter 4 of Exhibit B, UMCM**. The MCO must also develop and implement a process whereby Members have the opportunity to opt out of the preferred Provider arrangement and use another Provider. The MCO must provide clear written instructions on how a Member may opt out of using the preferred Provider. The MCO must manage the opt out process, including the receipt and review of all Member requests, and may not delegate any process steps to its Providers.

For preferred Provider arrangements already in effect prior to the issuance of HHSC guidance, the MCO must provide notification to impacted Members and provide clear written instructions on how the Member may opt out of using the preferred Provider. Furthermore, the MCO may not change a Member's Provider without notifying the Member of the change and providing clear written instructions on how the Member may opt out of using the Provider.

The MCO must conduct PCP and other Provider profiling activities at least annually. As part of its QAPI program, the MCO must describe the methodology it uses to identify which and how many Providers to profile and to identify measures for profiling such Providers. Provider profiling activities must include:

1. Developing PCP and Provider-specific reports that include a multi-dimensional assessment of a PCP or Provider's performance using clinical, administrative, and

Member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;
2. Involving the medical advisory committees in reviewing general Provider practice patterns and preparing recommendations for categories of Providers who are not in compliance with clinical practice guidelines;
3. Establishing PCP, Provider, or group Benchmarks for areas profiled, where applicable; the MCO can compare the performance of its Providers to providers delivering similar types of services in other states; and
4. Providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Network.

### 2.6.21.3 NETWORK MANAGEMENT

The MCO must:

1. Use the results of its Provider review activities to identify areas of improvement for individual PCPs and Providers, and groups of Providers;
2. Establish Provider-specific Quality Improvement goals for priority areas in which a Provider or Providers do not meet established MCO standards or improvement goals;
3. Develop and implement incentives to motivate Providers to improve performance on profiled measures, which may include financial incentives and non-financial incentives; and
4. Implement action plans and modify incentives for Providers who are not meeting improvement goals and conduct quarterly evaluations of the Provider's progress until the Provider has met improvement goals or the MCO determines the Provider Contract should be terminated.

### 2.6.21.4 PHYSICIAN INCENTIVE PLANS

The MCO must not make payments under a physician incentive plan if the payments are designed to induce Providers to reduce or limit Covered Services to Members. If the MCO implements a physician incentive plan under 42 C.F.R. § 438.3(i), the plan must comply with all applicable requirements, including 42 C.F.R. §§ 422.208 and 422.210.

If the physician incentive plan places a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, the MCO must ensure adequate stop-loss protection and conduct and submit annual Member surveys no later than five Business Days after the MCO finalizes the survey results. Refer to 42 C.F.R. § 422.208(d) for information concerning "substantial financial risk" and 42 C.F.R. § 422.208(f) for information concerning "stop-loss protection."

The MCO must make information regarding physician incentive plans available to Members upon request, in accordance with **Chapter 3 of Exhibit B, UMCM**. In responding to a request, the MCO must provide the following information to the Member:

1. Whether the Member's PCP or other Providers are participating in the MCO's physician incentive plan;

2. Whether the MCO uses a physician incentive plan that affects the use of referral services;
3. The type of incentive arrangement; and
4. Whether stop-loss protection is provided.

No later than five Business Days prior to implementing or modifying a physician incentive plan, the MCO must provide the following information to HHSC:

1. Whether the physician incentive plan covers services that are not furnished by a physician or physician group.
2. If the physician or physician group is at substantial financial risk, proof that the physician or group has adequate stop-loss coverage, including the amount and type of stop-loss coverage.
3. If the physician incentive plan covers services that are not furnished by a physician or physician group:
    a. The type of incentive arrangement, e.g., withhold, bonus, capitation;
    b. The percent of the withhold or bonus, if applicable; and
    c. The panel size and the method used if patients are pooled; the MCO must secure HHSC approval for the method used if patients are pooled.

### 2.6.21.5 Alternative Payment Models and Value Based Payments with Providers

The MCO must implement Alternative Payment Models (APMs) that link provider payments to measures of quality and efficiency. The purpose is to move away from a FFS reimbursement system that rewards volume, to a system that incentivizes the highest value care. APM requirements are in place both for overall and risk-based models. The MCO will be required to maintain or increase the percentage of APM-based payments to providers relative to total payments to providers each calendar year under the Contract calculated from the Operational Start Date.

The MCO must design APMs to improve health outcomes for Members, empower Members, encourage innovation and Provider coordination/collaboration, improve experience of care, lower healthcare cost trends, increase quality and efficiency and incentivize Providers. Examples of APMs are programs to improve access to primary care, support care coordination or integration, reduce inappropriate utilization of services, and improve medication adherence. Currently, MCOs are required to :

1. Achieve a minimum overall APM ratio and a risk-based APM ratio within the first full calendar year from the Operational Start Date and reach target ratios identified in the Methodology worksheet in **Chapter 8 of Exhibit B, UMCM,** as calculated from the Operational Start Date. If a Contract begins towards the end of a calendar year (i.e. the beginning of an SFY, it is the next full calendar year when the target requirements start). If the Operational Start Date coincides with the first working date of a new calendar year, then that calendar year will be considered the first year that an annual target must be achieved. The target ratios are expressions of APM-based Provider payments relative to total Provider payments. The calculations and

minimum yearly values for the APM ratios, as well as exceptions to the APM ratios, are delineated under the methodology tab of **Chapter 8 of Exhibit B, UMCM.**

2. Submit to HHSC its inventories of APMs with Providers by July 1 of each year, using the data collection tool in **Chapter 8 of Exhibit B, UMCM**. The data collection tool must be used to capture APM activity for the previous calendar year and must be used to calculate the APM ratios. Provider types include, but are not limited to: PCPs, specialists, Hospitals, LTSS Providers, BH Service Providers, pharmacies and pharmacists, at either individual or group level. Upon request by HHSC, the MCO must submit to HHSC underlying data for the information reported on the data collection tool, e.g., names of Providers, National Provider Identifier (NPI) numbers, and/or Texas Provider Identification (TPI) numbers.
3. Implement processes to share data and performance reports with Providers on a regular basis, via the MCO's Provider portal or other electronic repositories. The MCO must dedicate sufficient resources for Provider outreach and negotiation, assistance with data or report interpretation, and other activities to support Provider's improvement. HHSC may request evidence of these reports and processes from the MCO.
4. Dedicate resources to evaluate the impact of APMs on utilization, quality, and cost, as well as, return on investment.
5. Obtain HHSC approval of all APMs altering the outpatient drug benefit (pharmacy and clinician-administered) in advance of implementation. In its request for HHSC approval, the MCO must provide a brief description of each APM including: overall goal, a description of how the APM will operate, information on how providers are impacted, information on how Members are impacted, and the target implementation date. Request must be submitted to HHSC Pharmacy Operations inbox at vdp-operations@hhs.texas.gov. approvals and denials will be issued within 30 Days of the proposal submission.

HHSC reserves the right to change the current minimum overall APM ratios or structure, contained in **Chapter 8 of Exhibit B, UMCM**, prior to the Operational Start Date.

### 2.6.21.6 PERFORMANCE INCENTIVES AND DISINCENTIVES

Performance incentives and disincentives are subject to change by HHSC over the course of the Contract. The methodologies required to implement these incentives and disincentives will be refined by HHSC after collaboration with the MCO. The MCO must not pass along to providers financial disincentives or sanctions imposed on the MCO, except on an individual Provider basis and related to the individual Provider's inadequate performance. For further information, refer to **Section 2.8.8 of this Exhibit H, SOW**.

#### 2.6.21.6.1 PERFORMANCE PROFILING

HHSC will distribute information on key performance indicators to the MCO on a regular basis, identifying the MCO's performance, and comparing that performance with HHSC's standards or external Benchmarks. For example, HHSC will post performance results on its website, where they will be available to both stakeholders and members of the public.

#### 2.6.21.6.2 ADDITIONAL INCENTIVES AND DISINCENTIVES

HHSC will evaluate all performance-based incentive and disincentive methodologies annually and in consultation with the MCO. HHSC may modify the methodologies as needed, or develop additional methodologies as funds become available, or as mandated by court decree, statute, or rule to promote and recognize MCO performance under the Contract. The MCO must participate in any incentive or disincentive programs or methodologies as determined by HHSC.

### 2.6.21.7 FREW INCENTIVES AND DISINCENTIVES

As required by the *Frew v. Young Corrective Action Order: Managed Care*, the MCO will be subject to incentives and disincentives in the Contract. The incentives and disincentives and corresponding methodology are set forth in **Chapter 12 of Exhibit B, UMCM**.

### 2.6.21.8 COLLABORATION WITH THE EQRO

The MCO must collaborate with the EQRO to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to Members and to identify opportunities for MCO improvement.

The MCO must supply claims data to the EQRO, or another vendor identified by HHSC, in a format identified by HHSC in consultation with the MCO. The MCO must supply the EQRO, or another vendor identified by HHSC, medical records for focused clinical reviews conducted by the EQRO, or another vendor identified by HHSC.

The MCO must work collaboratively with HHSC and the EQRO to annually measure HHSC-selected HEDIS measures that require chart reviews. The MCO must conduct chart reviews for HEDIS hybrid measures and submit results to the EQRO in a format and timeline specified by HHSC. The MCO is responsible for all costs associated with these reviews.

The MCO must comply with any data requests from the EQRO, including data required for these activities:

1. Performing medical record review;
2. Performing Encounter Data validation for data certification purposes; and
3. Calculating measure results using Encounter and enrollment data.

### 2.6.21.9 PERFORMANCE IMPROVEMENT PROJECTS (PIPS)

HHSC seeks to accelerate the MCO's improvement efforts in areas of high priority. One of HHSC's methods for accelerating improvement is to annually establish with the MCO a series of PIPs. The MCO must be committed to making its best efforts to achieve the goals of the established projects. These projects must be specified and measurable. The projects must reflect areas that present significant opportunities for performance improvement.

PIPs must be designed, conducted, and reported in a methodologically sound manner in accordance with **Chapter 10 of Exhibit B, UMCM**. HHSC will determine the PIP topics, and the MCO must complete the PIP templates in accordance with **Chapter 10 of Exhibit B, UMCM**. The MCO must also complete progress reports as outlined in the **Chapter 10 of Exhibit B, UMCM**.

Once finalized and approved by HHSC, the PIPs will become part of the MCO's annual plan for its QAPI program and will be incorporated by reference into the Contract. HHSC anticipates that incentives and disincentives will be linked to some of the measures in the Performance Indicator Dashboards, as found in **Chapter 10 of Exhibit B, UMCM**.

The MCO must conduct one PIP in collaboration with other MCOs, dental contractors, or community organizations.

HHSC will track MCO performance on the PIPs. HHSC will also track other key facets of MCO performance through the use of the Performance Indicator Dashboards in **Chapter 10 of Exhibit B, UMCM**. HHSC will compile the Performance Indicator Dashboard based on MCO submissions, data from the EQRO, and other data available to HHSC. HHSC will share the Performance Indicator Dashboard results with the MCO annually.

### 2.6.22 UTILIZATION MANAGEMENT (UM)

This section provides the UM requirements of the MCO. The MCO must have a written UM program description, which includes, at a minimum:

1. Procedures to evaluate the need for Medically Necessary Covered Services;
2. The clinical review criteria used, the information sources, and the process used to review and approve the provision of Covered Services;
3. The method for conducting an annual review to ensure UM clinical criteria are based on accurate, up-to-date, evidence based, and peer-reviewed clinical criteria;
4. The procedure for amending the UM clinical review criteria; and
5. The staff position functionally responsible for the day-to-day management of the UM function.

#### 2.6.22.1 POLICIES AND PROCEDURES

The MCO and its Subcontractors must have in place and follow written UM policies and procedures for processing requests for initial and continuing authorizations of services. The UM policies and procedures must comply with 42 C.F.R. § 438.210 and include:

1. A list of staff positions responsible for the day-to-day management of the UM program and their functions.
2. The MCO's clinical review criteria used to determine medical necessity for Covered Services, the sources used to develop the clinical review criteria, and the method for periodically reviewing and amending the clinical review criteria.
3. The processes and rationale used to make coverage determinations, including partial approvals, partial denials and administrative determinations. For the

purposes of this section, administrative determinations means coverage determinations made without a medical necessity evaluation.

The MCO must also include in the UM policies and procedures the methods used to ensure:

1. Compliance with Tex. Ins. Code ch. 4201 and Tex. Gov't Code ch. 533;
2. Clinical PA determinations for outpatient pharmacy benefits are made by Texas-licensed pharmacists or pharmacists licensed in another state acting under the supervision of a Texas-licensed pharmacist, working under the direction of the Medical director;
3. PA determinations to deny or limit services are made by physicians licensed in Texas working under the direction of the Medical Director;
4. The PA process does not result in undue delays in services;
5. Qualified personnel are available to respond to UM inquiries 7:00 a.m. to 6:00 p.m. local time throughout the State, Monday through Friday, with a telephone system capable of accepting UM inquiries outside of these hours, and that the MCO responds to voice messages within one Business Day after the message is recorded;
6. Information is kept confidential and secure in accordance with **Article 9 of Exhibit A, STAR Health Uniform Terms and Conditions**, whether in the custody of the MCO, the MCO's Subcontractors, or when being transmitted by any means;
7. PA and concurrent review determinations are made and supervised by formally educated and currently licensed medical professionals with same or similar specialty as ordering Provider, such as physicians, nurses, or therapists, who have subject area knowledge and relevant patient care experience; and that these medical professionals work and supervise others only within the scope of their education and licensure;
8. The routine assessment of effectiveness and efficiency of the UM program;
9. Evaluation of the appropriate use of new and existing medical technologies, including medical procedures, drugs, and devices;
10. Members receive Medically Necessary and appropriate services, targeting areas of suspected inappropriate service utilization, including overutilization and underutilization;
11. Routine generation of Provider profiles regarding utilization patterns and compliance with UM criteria and policies;
12. Member and Provider utilization is compared with norms for comparable individuals;
13. Inpatient admissions, ER use, ancillary services, and out-of-state services are routinely monitored;
14. Peer-to-peer consultation is provided among the MCO's Providers and between Providers and the MCO's clinical staff;
15. The MCO uses the Texas Resilience and Recovery Utilization Management Guidelines for Targeted Case Management and Mental Health Rehabilitative Services;
16. Suspected cases of Provider, OON provider, or Member FWA are referred to the HHSC OIG as required by **Section 2.6.29 of this Exhibit H, SOW**; and
17. Inter-rater reliability is tested when making PA determinations.

In accordance with the requirements in **Chapter 16 of Exhibit B, UMCM**, the MCO must share UM data among all relevant MCO employees, including both physical and BH staff, or, if applicable, between the MCO and Subcontractor contracted with the MCO to manage BH Services.

#### 2.6.22.2 UM DETERMINATIONS

In making UM determinations, the MCO must make a reasonable effort to obtain all necessary information, including pertinent clinical information, and consult and communicate with the treating physician as appropriate. When making UM determinations, the MCO must comply with the requirements of 42 C.F.R. § 456.111 (Beneficiary Information for Hospitals) and 42 C.F.R. § 456.211 (Beneficiary Information for Mental Hospitals), as applicable.

UM should specifically assess prescribing patterns for psychotropic medications against the *Psychotropic Medication Utilization Parameters for Children and Youth in Texas Public Behavioral Health* found at the DFPS website. The MCO must maintain the ability to assess prescribing patterns for psychotropic medications through both an automated and manual process. UM that requires direct contact with the actual Provider must be scheduled at times convenient to the Provider's schedule, so as not to interrupt regular clinical care duties.

The MCO must issue coverage determinations in accordance with the requirements of 42 C.F.R. § 438.210(d), TDI requirements, and within the following timelines after receipt of a request for services or equipment:

1. Within one Business Day for concurrent hospitalization decisions;
2. Within one hour for post-stabilization or life-threatening conditions, except the MCO must not require PA for Emergency Medical Conditions and Emergency BH Conditions;
3. For a Member who is hospitalized at the time of the request, within one Business Day for services or equipment that will be necessary for the care of the Member immediately after Discharge, including if the request is submitted by an OON provider, Provider of Acute Care inpatient services, or a Member;
4. Within three Business Days for all other PA requests. For PA requests received with insufficient or inadequate documentation, the MCO must follow timeframes set forth in **Chapter 3 of Exhibit B, UMCM**.

The MCO must have a process in place that allows a Provider to submit a PA or service authorization request for services up to 60 Days prior to the expiration of the current authorization period. If practicable, the MCO must review the request and issue a determination prior to the expiration of the existing authorization. The MCO's process must consider if the request contains sufficient clinical information to justify reauthorization of services.

The MCO must ensure compensation to individuals or entities conducting UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services, as required by 42 C.F.R. § 438.210(e). The MCO

must also ensure that the quality of Covered Services is not adversely impacted by financial and reimbursement-related processes and decisions.

### 2.6.22.3 Criteria for Determining Medical Necessity

In accordance with 42 C.F.R. § 438.236, the MCO must adopt practice guidelines that meet the following requirements:

1. Are based on evidence-based guidelines or a consensus of providers in the particular field;
2. Consider the needs of the Members;
3. Are adopted in consultation with contracted healthcare professionals; and
4. Are reviewed and updated periodically as appropriate.

The criteria for determining Medically Necessary Covered Services must be no more restrictive than that used in the Medicaid State plan and must meet the requirements of said plan, **Exhibit E, TMPPM**, and applicable waiver handbooks, including quantitative and non-quantitative treatment limits.

The decisions for medical necessity must be consistent with the practice guidelines adopted by the MCO. The MCO must disseminate the guidelines to all affected Providers and, upon request, to Members, Medical Consenters, Caregivers, and DFPS Staff.

### 2.6.22.4 Medical Director

Any decision to deny a PA request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician under the direction of the Medical director, as defined in **Section 4.04 of Exhibit A, STAR Health Uniform Terms and Conditions**, who has appropriate expertise in addressing the Member's medical, BH, or LTSS needs.

The MCO must ensure that the Medical Director, or his or her designee:

1. Is available by telephone 24 hours a Day, 7 Days a week, for UM determinations;
2. Possesses expertise with BH Services, or has ready access to such expertise to ensure timely and appropriate BH medical decisions for Members, including after regular business hours;
3. Is authorized and empowered to represent the MCO regarding clinical issues, UM, and quality of care inquiries;
4. Exercises independent medical judgment in all decisions relating to medical necessity;
5. Makes all determinations involving denial or limitation of services in accordance with **Section 2.6.22.5 of this Exhibit H, SOW**; and
6. Makes all determinations regarding UM appeals, including appeals of PA denials for outpatient pharmacy benefits.

For purposes of this section, the MCO must ensure that the Medical director’s designee is:

1. A physician that meets the qualifications for a Medical director; or

2. For PA determinations for outpatient pharmacy benefits, is a Texas-licensed pharmacist working under the direction of the Medical director.

#### 2.6.22.5 Compliance with State and Federal Prior Authorization Requirements

The MCO must adopt PA requirements that comply with State and federal laws governing authorization of Covered Services and prescription drug benefits, including 42 U.S.C. § 1396r-8 and Tex. Gov't Code §§ 531.073 and 533.005(a)(23). In addition, the MCO must comply with Tex. Hum. Res. Code § 32.073 and Tex. Ins. Code §§ 1217.004 and 1369.256, which require the MCO to use national standards for electronic PA of prescription drug and Covered Services no later than two years after adoption and accept PA requests submitted using TDI's standard form.

In the case of service code, procedure code, or benefit change that affects a current PA issued to a provider, the MCO must provide guidance to the provider holding the PA no less than 45 Days prior to effective date of the change. If the change is a result of a service code, procedure code, or benefit change adopted by HHSC, the MCO must issue notice of the change by the later of:

1. 45 Days prior to the effective date of the change; or
2. Within 10 Business Days of receiving notice of the change from HHSC.

The MCO may choose to reissue PAs or publish guidance to providers on updating current PAs. Such PA information must be sufficient for providers to accurately bill for services. The MCO must establish and document a plan to inform all impacted providers of the changes. The MCO must be able to demonstrate that each impacted provider is notified of the changes within the prescribed timeframe through broadcast messages or individual notifications. The MCO must provide a copy of the plan and any associated notifications to HHSC upon request.

### 2.6.23 Special Supplemental Nutrition Program for Women, Infants, and Children

The MCO must, through its Provider Contract, require its Providers to coordinate with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to provide medical information necessary for WIC eligibility determinations. The MCO must make referrals to WIC for Members potentially eligible for WIC. The MCO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract.

### 2.6.24 Health Passport

The Health Passport application facilitates Service Coordination and Continuity of Care for Members, as well as streamlines data sharing and coordination between the Members' Providers and DFPS. The Health Passport functions as an accessible, paperless repository

of information related to each Member, his or her Providers, demographics, medical services rendered, and pertinent administrative documentation.

Chapter 2054 of the Texas Government Code requires that DIR maintain a statewide data center which consists of consolidated data services managed by contracted vendors, which is also referred to as Data Center Services (DCS). Currently, Health Passport does not operate in the DCS. HHSC is pursuing another exemption. The MCO must be prepared to offer a solution that operates in the DCS and one that is independent of the DCS in the event HHSC secures an exemption from DIR.

Please see http://dir.texas.gov/View-About-DIR/Data-Center/Landing.aspx for additional information concerning the DCS.

### 2.6.24.1 Health Passport Development

The MCO must develop and maintain a new web-based Health Passport system to provide health records for all Members. The MCO must maintain the current Health Passport application and features while development is occurring.

The MCO must design the Health Passport in such a way as to allow for electronic communication via the Health Passport among each Member's Providers for Service Coordination and service planning purposes. The MCO should explore making the Health Passport compatible with commonly used electronic health records systems and local health information exchanges to facilitate use.

The Health Passport must be structured in a manner to provide the data in a summarized, user-friendly, printable format and must employ hierarchical security measures to limit access to designated persons as defined by HHSC. The Health Passport must be maintained in a web-based electronic format with the minimum system functions and features set forth in **Exhibit F, Health Passport Overview and Requirements**.

### 2.6.24.2 Health Passport Mobile Accessibility

The MCO must develop and maintain accessibility and secure viewing of Health Passport Electronic Health Records on users' mobile devices. At a minimum, this mobile accessibility must meet requirements for usability, security, availability, and downtime described **Exhibit F, Health Passport Overview and Requirements** and the mobile access must be capable of displaying all data elements listed in **Exhibit F, Health Passport Overview and Requirements**. The mobile accessibility must be implemented by the Operational Start Date.

### 2.6.24.3 Health Passport Required Data Elements

The MCO is required to include the data elements set forth in **Exhibit F, Health Passport Overview and Requirements**. The Health Passport may contain additional information proposed by the MCO and approved by HHSC.

### 2.6.25 COORDINATION WITH TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

DFPS is responsible for the care of children and young adults in DFPS conservatorship who have been removed from the home because of abuse or neglect. It is essential that the MCO and DFPS coordinate and maintain a positive and productive relationship that will help ensure Members receive the best possible opportunity to achieve desired physical and BH outcomes.

The MCO must coordinate with DFPS regarding the healthcare of a Member who has entered DFPS conservatorship. MCO Service Coordinators must be available to provide information to and assist Members, Medical Consenters, and DFPS Staff with access to care and coordination of services as required in **Section 2.6.47 of this Exhibit H, SOW**, including development of the DFPS plan of care.

The MCO must also provide training opportunities, including web-based and in-person trainings, at the regional level to DFPS Staff, upon State request.

The MCO must coordinate with SSCC staff to improve the coordination and provision of Covered Services for Members in categories 1 and 2 of the Target Population. The MCO must ensure that its staff understand the roles and responsibilities of the SSCC staff and develop positive working relationships with these organizations.

The MCO, DFPS, and HHSC will meet on a schedule determined by HHSC to address issues and concerns that arise during the Transition Phase and Operations Phase. As a result of these meetings, and at HHSC's discretion and direction, the MCO must revise processes and procedures, modify trainings or educational materials, or make other Program changes. The meetings will provide an ongoing opportunity to improve communication and share information between HHSC, DFPS Staff, Members, Providers, Caregivers and Medical Consenters, and the MCO. These meetings may also serve to update Program requirements and streamline processes as necessary.

The MCO must use the DNF to determine whether a placement change has occurred by identifying if a Member's address or the Caregiver's name on the DNF has changed. The MCO must give notice to the PCP listed in the Health Passport before the end of the second Business Day after the Day the MCO receives this information on the DNF.

The MCO must require Service Coordinators, Member Advocates, STAR Health Representatives, and any other Member-facing staff positions pass background checks as a condition of hire and require passage of background checks every two years thereafter. The MCO must not place these staff members in contact with Members, or allow them to have access to Member information until DFPS has completed the initial background check. The MCO must remove all staff not having passed a DFPS background check, and all staff alleged to have committed a criminal offense that would prohibit him or her from having contact with Members pursuant to DFPS regulations in 26 Tex. Admin. Code pt. 1, ch. 745, subch. F, div. 3, from all Program functions in which direct contact with Members or access to Member information is expected.

The MCO must require Providers, through contract provisions, to testify in court as needed for child protection litigation.

### 2.6.25.1 SERVICES ORDERED BY THE COURT

Members in DFPS conservatorship are subject to the jurisdiction of a court. During the course of a case, a judge may issue a court order related to the delivery of Covered Services to the Member. The MCO must not deny, reduce, or controvert the medical necessity of any Covered Service included in such a court order. The MCO must comply with all provisions related to Covered Services included in a court order until such time as the court order is subsequently modified by the court having jurisdiction over the matter.

The MCO must provide covered Medicaid inpatient psychiatric services up to the court-ordered or annual limit, whichever is less, to Members birth through 20 years of age who have been ordered to receive the services by a court of competent jurisdiction, including services ordered pursuant to the Tex. Health & Safety Code chs. 573 or 574, and the Tex. Crim. Proc. Code ch. 46B, or as a condition of probation. For Members ages 21 through 22, the MCO may provide inpatient services for acute psychiatric conditions in a free-standing Psychiatric Hospital in lieu of an Acute Care inpatient Hospital setting.

The MCO must not deny, reduce, or controvert the medical necessity of inpatient mental health services provided pursuant to a Court-ordered Commitment for Members birth through age 20. Any modification or termination of services must be presented to the court having jurisdiction over the matter for determination.

A Member who has been ordered to receive treatment under a Court-ordered Commitment can only appeal the commitment through the court system.

The MCO must provide a Member Covered Services for SUD treatment services, if required as a condition of the Member's probation.

The MCO must have a process to accept the court order and must communicate in writing with DFPS and HHSC to acknowledge the receipt of any court order. If the MCO identifies any concern or disputes with the provisions included in a court order, the MCO must notify HHSC within one Business Day of receiving the court order. Relevant concerns or disputes include:

1. The service ordered is not a Covered Service; and
2. The service, if provided as ordered, could have a negative impact on the health or well-being of the Member.

### 2.6.25.2 TRAINING FOR LAW ENFORCEMENT OFFICIALS AND JUDGES

Upon request from HHSC or DFPS, the MCO must provide training for law enforcement officials, judges, district and county attorneys representing HHSC or DFPS, and attorneys and guardians ad litem regarding the relevant requirements of the Contract and special needs of Members. HHSC and DFPS may also participate in these trainings. The MCO must update training materials annually, at a minimum, and more often if a change in law or policy alters the content of the training materials.

The MCO must collaborate with the Supreme Court of Texas Children's Commission to ensure that training materials to be presented to the judiciary are appropriate and effective tools.

The MCO must include the following issues in its training materials:

1. Role of law enforcement officials, judges, district and county attorneys representing DFPS, and attorneys ad litem as it relates to the behavioral and healthcare needs of the Members;
2. Requirements for providing Covered Services to the population including:
    a. Required timelines for Covered Services and assessments as defined in the Contract and in the Texas Family Code;
    b. Legal review of Member needs, Service Plans, and healthcare progress as part of court hearings; and
    c. Other DFPS policies that govern the provision of Covered Services;
3. How to access resources available to the judiciary, such as:
    a. Requesting Health Passport records to obtain healthcare and assessment information;
    b. Requesting additional training from MCO trainers; and
    c. Emailing the MCO's dedicated judicial email box for questions about psychotropic medication utilization issues and other concerns.

#### 2.6.25.3 Liaisons

The MCO must employ a team of dedicated STAR Health Liaisons who are responsible for coordinating with regional DFPS well-being specialists to promptly resolve or escalate systemic or programmatic issues identified by the MCO, DFPS, or HHSC. Such issues may arise related to the individual healthcare of a Member.

STAR Health Liaisons must be housed regionally and be available to coordinate with DFPS to develop work flows and processes, including those related to the transmission of clinical and non-clinical Member information. STAR Health Liaisons must also take a leading role in identifying training needs for the MCO and DFPS Staff.

The STAR Health Liaison must assist DFPS Staff, upon request, with the process for submitting a Complaint or Inquiry to the MCO. If the MCO internal process did not satisfy the concern, the STAR Health Liaison must assist DFPS Staff, upon request, with the process for submitting a Complaint to HHSC.

STAR Health Liaisons must contact and assist Members who are transitioning into Target Population Category 3 and refer Members to the TYP as appropriate. STAR Health Liaisons must coordinate with DFPS transitioning services staff and with DFPS contracted transition centers listed on the DFPS website to develop work flows and processes that will ensure outreach to the Members is successful.

#### 2.6.25.4 Services and Supports for Members with Life Threatening Conditions

The MCO must provide additional supports described in this section for Members in categories 1 and 2 of the Target Population who cannot live without mechanical supports or the services of others because of one or more non-temporary, life-threatening conditions, including the inability to maintain an open airway without assistance, not including the use

of inhalers for asthma; the inability to be fed except through a feeding tube, gastric tube, or a parenteral route; a condition that requires the use of sterile techniques or specialized procedures to promote healing, or to prevent infection, cross-infection, contamination, or tissue breakdown; or multiple physical Disabilities, including sensory impairments. The MCO must:

1. Coordinate with DFPS and assist Members, described above, during a placement change or instances in which a Member is admitted to and discharged from an inpatient setting, to ensure a safe and timely transition to the Members new placement;
2. Arrange prior-authorized appropriate non-emergency transportation and supports to these Members, which may include the use of an ambulance and the provision of skilled nursing services for the duration of transportation;
3. Provide safe assembly and disassembly of the Member's DME in conjunction with the provision of these services; and
4. In the case of an unplanned or emergent placement change, provide up to a 48-hour observation stay in an inpatient setting when appropriate placement or supports are not immediately in place.

For the purposes of this section, a placement change includes, but is not limited to, a Member's initial transition into conservatorship, a Member's transition between residences while in conservatorship, or a Member's exit out of conservatorship to another residence.

### 2.6.26 FINANCIAL REQUIREMENTS FOR COVERED SERVICES

The MCO must pay for or reimburse Providers for all Covered Services provided to all Members. The MCO is not liable for costs incurred in connection with healthcare rendered prior to the Member's Effective Date of Coverage with the MCO.

#### 2.6.26.1 CAPITATION RATE PAYMENTS

Refer to **Section 2.8 of this Exhibit H, SOW**, and **Chapter 6 of Exhibit B, UMCM,** for information concerning Capitation Rate development, financial payment structure and provisions, and Capitation Payments, including the time and manner of payment and adjustments to Capitation Payments.

#### 2.6.26.2 THIRD PARTY LIABILITY AND RECOVERY AND COORDINATION OF BENEFITS

In the STAR Health Program, Medicaid coverage is primary when coordinating benefits with all other insurance coverage, with the exception of court-ordered insurance. TPR in the STAR Health Program should be sought only in cases where healthcare coverage is required of a biological parent by an order of the court; in these cases, the MCO must cost avoid and deny the claim for other insurance or, if the claim is already paid, pursue TPR.

A Member may receive collateral health benefits under a different type of insurance, including worker's compensation or personal injury protection under an automobile policy. If a Member is entitled to coverage for specific services payable under another insurance

plan and the MCO paid for such Covered Services, the MCO must obtain reimbursement from the responsible insurance entity not to exceed 100 percent (100%) of the value of any Covered Services paid by the MCO.

The MCO is responsible for establishing and documenting a plan and process, referred to as the "Third Party Liability (TPL) MCO Action Plan" in accordance with **Chapter 5.3.4 of Exhibit B, UMCM**, for avoiding and recovering costs for services that should have been paid through a third party (including health insurers, self-insured plans, group health plans as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1167(1).), service benefit plans, managed care organizations, PBMs, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

The TPL MCO Action Plan and process must be in accordance with State and federal law and regulations, including Sections 1902(a)(25)(E) and (F) of the Social Security Act, which require MCOs to first pay and later seek recovery from liable third parties for: (1) preventive pediatric care; and (2) services provided to a Member on whose behalf child support enforcement is being carried out by the State agency under Part D of Title IV of the Social Security Act.

The MCO must submit the TPL MCO Action Plan to the Office of Inspector General-Third Party Recoveries (OIG-TPR) email address at TPL_ManagedCare@hhs.texas.gov no later than September 1 for the upcoming SFY for review and approval. The MCO must submit any change requests to the TPL MCO Action Plan for review and approval no later than 90 Days prior to the date of the proposed changes.

The projected amount of TPR that the MCO is expected to recover may be factored into the rate setting process.

The MCO must provide financial reports to HHSC, as stated in **Section 2.6.27.2.2 of this Exhibit H, SOW,** and in accordance with **Chapters 5.3.4 of Exhibit B, UMCM**.

The MCO must provide all TPR reports to OIG-TPR at the frequency stated in and in accordance with **Chapter 5.3.4 of Exhibit B, UMCM**.

The MCO has 120 Days from the date of adjudication of a claim that is subject to TPR to attempt recovery of the costs for services that should have been paid through a third party.

The MCO must provide to HHSC, by the 10th Day of each month, a report indicating the claims for which the MCO has billed or made a recovery up to the 120th Day from adjudication of a claim that is subject to TPR. After 120 Days, HHSC will attempt recovery for any claims in which the MCO did not attempt recovery and will retain, in full, all funds received as a result of any HHSC-initiated TPR. The MCO is precluded from attempting to bill for any recovery after 120 Days from the claim adjudication date. Any collections by the MCO billed after 120 Days from the claim adjudication date must be sent to OIG-TPR in the format prescribed in **Chapter 5.3.4 of Exhibit B, UMCM**. The MCO must continue to cost avoid and cost recover where applicable.

After 365 Days from adjudication of a claim, the MCO loses all rights to pursue or collect any recoveries subject to TPR. HHSC has sole authority for recoveries of any claim subject to TPR after 365 Days from the date of adjudication of a claim. Should the MCO receive

payment on an HHSC-initiated recovery, the MCO must send the payment to OIG-TPR in the format prescribed in **Chapter 5.3.4 of Exhibit B, UMCM**.

HHSC retains the responsibility to pursue, collect, and retain recoveries of all non-health insurance resources such as casualty, liability, estate, child support, and personal injury claims, wherein payments have been made on behalf of a Member. The MCO must continue to pay all valid, non-health insurance claims and is not permitted to cost avoid or seek recovery of any non-health insurance resources. Should the MCO receive payment on a non-health insurance recovery, the MCO must send the payment to OIG-TPR in the format prescribed in **Chapter 5.3.4 of Exhibit B, UMCM**. Members with these other resources will remain enrolled in the MCO.

The MCO is subject to the requirements related to coordination of benefits for secondary payors in the Tex. Ins. Code §§ 843.349(e) and (f).

Nothing in this section authorizes MCO to proceed with litigation or file suit on behalf of or in the name of HHSC or the State.

### 2.6.27 REPORTING REQUIREMENTS

The following sections provide reporting requirements required of the MCO.

#### 2.6.27.1 GENERAL REPORTING REQUIREMENTS

The MCO must provide and must require its Material Subcontractors to provide at no cost to HHSC:

1. All information required under the Contract, including the reporting requirements or other information related to the performance of its responsibilities as reasonably requested by HHSC;
2. Any information in its possession sufficient to permit HHSC to comply with the Federal Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997), or other federal or State laws, rules, and regulations; and
3. Ad hoc reports requested by HHSC.

All information must be provided in accordance with the timelines, definitions, formats, and instructions as specified by HHSC. Where practicable, HHSC may consult with the MCO to establish timeframes and formats reasonably acceptable to both Parties.

The MCO must provide the reports specified in **Chapter 5.0.1 of Exhibit B, UMCM**. This chapter includes a list of required reports and a description of the format, content, file layout, and submission deadlines for each report.

Any Deliverable or report not listed in **Chapter 5.0.1 of Exhibit B, UMCM,** but referenced in the Contract without a specified due date, is due quarterly on the last Day of the month following the end of the reporting period. Where the due date states 30 Days, the MCO is to provide the Deliverable by the last Day of the month following the end of the reporting period. Where the due date states 45 Days, the MCO is to provide the Deliverable by the 15th Day of the second month following the end of the reporting period.

The MCO's chief executive and chief financial officers, or persons in equivalent positions, must certify that the financial data, Encounter Data, and other measurement data has been reviewed and is true and accurate to the best of the certifying person's knowledge. Such certification may not be delegated.

#### 2.6.27.1.1 Managed Care Organization Deliverables Related to Management Information System Requirements

The MCO must comply with all applicable JIPs, as modified or amended, and all required file submissions for HHSC or its designee, EQRO, EB, or other business partners. The JIPs are posted in a centralized secure file transfer site designated by HHSC. See **Chapter 7 of Exhibit B, UMCM**.

The MCO must submit plans and checklists related to MIS to HHSC according to the format and schedule identified in **Chapter 5.0.1 of Exhibit B, UMCM**. Additionally, if a systems Readiness Review is triggered by one of the events described in **Section 2.6.28 of this Exhibit H, SOW**, the MCO must submit all of the plans identified in **Chapter 5.0.1 of Exhibit B, UMCM,** in accordance with an HHSC approved timeline.

### 2.6.27.2 Accounting and Reporting Requirements

The MCO's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with FAR, Generally Accepted Accounting Principles (GAAP), **Section 2.8 of this Exhibit H, SOW**, and the cost principles contained in the HHSC Cost Principles document in **Chapter 6 of Exhibit B, UMCM**. If HHSC guidelines, rules, regulations and provisions of this SOW are in conflict with GAAP, HHSC guidelines, rules, regulations or provisions, then FAR will prevail. HHSC will not recognize or pay services that cannot be properly substantiated by the MCO and verified by HHSC. The MCO must:

1. Maintain accounting records for STAR Health and the resulting Contract separate and apart from other corporate accounting records;
2. Maintain records for all claims payments, refunds, and adjustment payments to Providers and OON providers, Capitation Payments, interest income, and payments for Administrative Services or functions, and must maintain separate records for medical and administrative fees, charges, and payments;
3. Ensure and provide access to HHSC and its auditors and agents to the detailed records and supporting documentation for all costs incurred by the MCO. The MCO must ensure such access to its Subcontractors, including Affiliates, for any costs billed to or passed to the MCO with respect to an MCO Program; and
4. Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts.

The MCO will reimburse HHSC if HHSC seeks reimbursement from the MCO for reasonable costs incurred by HHSC to perform examinations, investigations, audits, or other types of attestations that HHSC determines are necessary to ensure MCO compliance

with this Contract. The use of and selection of any external parties to conduct examinations, investigations, audits, or other types of attestations, as well as the scope of work of examinations, investigations, audits, or other types of attestations are also at HHSC's sole discretion.

#### 2.6.27.2.1 General Access to Accounting Records

The MCO must provide authorized representatives of the State and federal governments full access to all financial records, subcontracts, and accounting records related to the performance of the Contract. See **Article 8 of Exhibit A, STAR Health Uniform Terms and Conditions,** for additional requirements.

The MCO and its Subcontractors and Affiliates must:

1. Cooperate with the State and federal governments in their evaluation, inspection, audit, or review of accounting records and any necessary supporting information.
2. Permit authorized representatives of the State and federal government full access, during normal business hours, to the accounting records that the State and the federal governments determine are relevant to the Contract. Such access is guaranteed at all times during the performance and retention period of the Contract, and will include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the MCO.
3. Make copies, at no cost to HHSC, of any accounting records or supporting documentation relevant to the Contract, including Provider Contracts, available to State and federal governments or their agents within seven Business Days, or as otherwise specified, of receiving a written request for specified records or information. If such documentation is not made available as requested, the MCO must reimburse the requesting party for all costs, including transportation, lodging, and subsistence for all State and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, and reproduction functions at the locations of such accounting records.
4. Pay any and all additional costs incurred by the State and federal governments that are the result of the MCO's failure to provide the requested accounting records or financial information within ten Business Days of receiving a written request from the State or federal government. Failure to provide such required documentation and information in a timely manner may be deemed to be a material breach of the Contract's terms.

#### 2.6.27.2.2 Financial Reporting Requirements

At HHSC's request and pursuant to the Contract, the MCO must provide financial reports to support Contract monitoring as well as State and federal reporting requirements. All financial information and reports submitted by the MCO become property of HHSC. HHSC may, at its discretion, release such information and reports to the public at any time and without notice to the MCO.  In accordance with State and federal laws regarding Member confidentiality, HHSC will not release any Member-identifying information contained in such reports.

Any required data submitted by the MCO in a Portable Document Format (PDF) must be in a text-searchable version. Joint Photographic Experts Group (JPEG) and Graphics Interchange Format (GIF) formats are not permitted. All data submitted by the MCO must be text-searchable. Where expressly permitted by HHSC, signature pages may be submitted in a non-text-searchable format.

The MCO must submit all required financial reports as detailed in **Chapter 5.3 of Exhibit B, UMCM,** and the Contract using the templates in **Chapter 5.3 of Exhibit B, UMCM**.

### 2.6.28 MANAGEMENT INFORMATION SYSTEM (MIS) REQUIREMENTS

The MCO must maintain an MIS and subsystems, located in the United States, including the hardware, Software, network, interfaces, and communications systems with the capability and capacity to support the following operational and administrative areas for the performance of the Services and Deliverables. If the MCO subcontracts a MIS function, the MCO must ensure that the Subcontractor's MIS complies with the following requirements of this section:

1. Eligibility management;
2. Enrollment management;
3. Provider management;
4. Member management;
5. Prior Authorization processing;
6. Claims processing;
7. Encounters processing;
8. Financial processing;
9. Telephony management;
10. Utilization management;
11. Quality management;
12. Third Party Recovery management;
13. Deliverables management;
14. Health Passport management;
15. Audit function management; and
16. Ad hoc and standard reporting management.

The MCO's MIS must meet the Contract requirements, including all applicable State and federal laws, rules, regulations, standards, and guidelines. The MIS must have the capacity and capability to capture and utilize various data elements required for MCO administration and to interface with the Information Management Protecting Adults and Children in Texas' (IMPACT) subsystem, which is the DFPS system that will transmit data to the MCO.

The MCO must have an MIS that can be adapted to changes in business practices or policies within the timeframes negotiated by the Parties. The MCO is required to cover the cost of such MIS modifications through the Contract Term.

The MCO must use an address verification and standardization Software when contracting with Providers. The Software must standardize Provider addresses by fixing spelling errors,

correcting abbreviations and fixing capitalization so that the address matches the format preferred by the USPS. The MCO must validate addresses to the master Provider file provided by HHSC through the Provider Management and Enrollment System (PMES).

The MCO must provide HHSC's staff prior written notice via email of Major Systems Changes to its MIS and implementations no later than 180 Days prior to the planned change or implementation, including any changes relating to Material Subcontractors, in accordance with the requirements of the Contract and **Section 4.08 of Exhibit A, STAR Health Uniform Terms and Conditions.**

The email notification must detail the following:

1. The aspects of the MIS that will be changed and date of implementation;
2. How these changes will affect the provider and Member community, if applicable;
3. The communication channels that will be used to notify these communities, if applicable;
4. A detailed implementation plan and schedule of proposed changes; and
5. A contingency plan in the event of downtime of the MIS or substantial non-performance of the MIS.

These Major Systems Changes are subject to HHSC desk review and onsite review of the MCO’s facilities as determined by HHSC and as specified in **Section 2.6.3 of this Exhibit H, SOW**, to test readiness and functionality prior to implementation. If HHSC notifies the MCO that a desk and/or onsite review is required, HHSC-approval must be received of the Major Systems Change prior to implementation of the changes to its MIS or supporting systems. HHSC has sole discretion to modify or waive the notification requirement.

The MCO must provide HHSC any updates to the MCO’s organizational chart relating to the MIS and the description of MIS responsibilities at least 30 Days prior to the effective date of the approved change. The MCO must provide HHSC with the names of official points of contact for MIS issues on an ongoing basis.

Additionally, the MCO’s MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.

The MCO is required to participate in work groups and regular calls related to MIS and convened by HHSC.

In accordance with **Chapter 16 of Exhibit B, UMCM**, the MCO must share and integrate service authorization data among all relevant MCO employees, including both physical and BH staff, or, if applicable, between the MCO and the BHO.

#### 2.6.28.1 SYSTEM-WIDE FUNCTIONS

The MCO’s MIS must include the following key business processing functions and features, which must apply across all subsystems:

1. Process secure electronic data transmission or media to add, delete, or modify Member records with accurate begin and end dates;

2. Track Covered Services received by Members through the MIS and accurately and fully maintain those Covered Services as HIPAA compliant Encounter Data transactions;
3. Transmit or transfer Encounter Data transactions on electronic media in the HIPAA format to HHSC or its designee to receive the Encounter Data;
4. Maintain a history of changes and adjustments and audit trails for current and retroactive data;
5. Maintain procedures and processes for accumulating, archiving, and restoring data in the event of an MIS or subsystem failure;
6. Employ industry standard medical billing taxonomies, procedure codes, and diagnosis codes, to describe services delivered and Encounter Data transactions produced;
7. Accommodate the coordination of benefits;
8. Produce standard Explanation of Benefits (EOBs);
9. Pay financial transactions to Providers in compliance with federal and State laws, rules and regulations;
10. Ensure that all financial transactions are auditable according to GAAP guidelines;
11. Ensure that FSRs comply with **Chapter 6 of Exhibit B, UMCM,** with respect to segregating costs that are allowable for inclusion in HHSC-designed financial reports;
12. Relate and extract data elements to produce report formats in **Exhibit B, UMCM,** or as required by HHSC;
13. Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;
14. Maintain and cross-reference all Member-related information with the most current Medicaid Provider number; and
15. Ensure that the MIS is able to integrate pharmacy data from HHSC's VDP files, available through the Virtual Private Network (VPN), into the MCO's Member data.

### 2.6.28.2 ENCOUNTER DATA

The MCO must provide complete Encounter Data that accurately reflects information received on claims for all Covered Services. The MCO must submit Encounter Data in accordance with:

1. The requirements in 42 C.F.R. §§ 438.242, and 438.818; and
2. The format and data elements as described in the most current version of HIPAA-compliant 837 Companion Guides, NCPDP format for pharmacy, and Encounters Submission Guidelines.

The MCO must adhere to the method of transmission, the submission schedule, and any other requirements specified in **Chapter 5.0.1 of Exhibit B, UMCM**. The MCO must submit Encounter Data transmissions no less than monthly and include all Encounter Data and Encounter Data adjustments processed by the MCO within the preceding month. The MCO must ensure that HHSC receives complete and accurate Encounter Data no later than 30 Days after the month in which the claim was adjudicated. The MCO must submit

pharmacy Encounter Data no later than 25 Days after the date of adjudication and include all Encounter Data and Encounter Data adjustments processed by the MCO.

For reporting Encounter Data to HHSC, the MCO must use the procedure codes, diagnosis codes, and other codes as directed by HHSC. Any exceptions will be considered on a code-by-code basis after HHSC receives written notice from the MCO requesting an exception. The MCO must also use the Provider numbers obtained from the master Provider file or as directed by HHSC for Encounter Data submissions.

The MCO must ensure Encounter Data quality validation incorporates assessment standards developed jointly by the MCO and HHSC. The MCO must make original records and data available for inspection by HHSC for validation purposes upon HHSC request. The MCO must correct and resubmit Encounter Data that does not meet quality standards within a time period specified by HHSC.

At HHSC's request, the MCO must submit an Encounter Data file to HHSC's EQRO, in the format provided in **Chapter 5.0.1 of Exhibit B, UMCM**.

#### 2.6.28.3 CLAIMS PROCESSING REQUIREMENTS

The MCO must administer an effective, accurate, and efficient claims payment process in compliance with State and federal laws, rules and regulations, and the Contract, including the claims processing procedures contained in **Chapter 2 of Exhibit B, UMCM**. The MCO must process and Adjudicate all claims for Covered Services that are filed within the timeframe specified in **Chapter 2 of Exhibit B, UMCM,** and pharmacy claims that are filed in accordance with the time frames specified in **Chapter 2 of Exhibit B, UMCM**.

The MCO must employ a fully automated claims processing system where a minimum of 60 percent (60%) of claims are auto-adjudicated (adjudicated with no manual intervention). If the MCO is not able to achieve this performance standard, it must submit a plan and a corresponding timeline that improves the MCO's claims processing system to a level that achieves the standard. The MCO must maintain and follow the HHSC-approved plan and corresponding timeline.

The claims processing system must:

1. Register the date a claim is received by the MCO;
2. Register the detail of each claim transaction or action, including date of service, at the time the transaction occurs;
3. Have the capability to report each claim transaction by date and type to include interest payments;
4. Maintain information at the claim and line detail level;
5. Maintain adequate audit trails;
6. Report accurate claims performance measures to HHSC; and
7. Maintain online and archived files.

The MCO must keep online automated claims payment history for the most recent 18 months. The MCO must retain other financial information and records, including all original claims forms, for the time period established in **Section 8.01 of Exhibit A, STAR Health Uniform Terms and Conditions**. The MCO must ensure all claims data can be

easily sorted and are produced in formats as requested by HHSC. Claim transactions for pharmacy services must be in the NCPDP B1/B2 formats and all claim transactions must be in the 837/835 format.

#### 2.6.28.4 ELECTRONIC DATA INTERCHANGE

The MCO must offer its Providers and Subcontractors the option of submitting and receiving claims information through a HIPAA compliant Electronic Data Interchange (EDI) that allows for automated processing and adjudication of claims. The MCO must offer EDI processing as an alternative to the filing of paper claims. The MCO must use HIPAA-compliant electronic formats.

The MCO may not require a physician or provider to submit documentation that conflicts with the requirements of 28 Tex. Admin. Code pt.1, ch. 21, subchs. C and T.

HHSC may require the MCO to receive electronic claims through an HHSC-contracted vendor. The MCO must allow Providers to send claims to this vendor, who will then redirect the claims to the appropriate payor. The MCO's interface must allow receipt of these electronic submissions. The MCO must provide and maintain a system to receive claims from an HHSC designated claims portal. The MCO must also allow Providers to send claims directly to the MCO or its Subcontractor.

The MCO must be able to receive, load, and read Enrollment Files received from HHSC in the 834 format. Eligibility inquiries must be in the 270/271 format with the exception of pharmacy services. Pharmacies may submit eligibility inquiries in the NCPDP E1 format.

### 2.6.29 FWA

An MCO is subject to all State and federal laws and regulations relating to FWA in health care and the Medicaid and CHIP programs. The MCO must cooperate and assist the HHSC Office of Inspector General (HHSC OIG) and any State or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected FWA.

1. The MCO is subject to and must meet all requirements in Tex. Gov't Code §§ 531.113, 531.1131, and 533.012 and 1 Tex. Admin. Code pt. 15, ch. 353, subch F, ch. 370, subch. F as well as all laws specified in the Contract.
2. The MCO must require all employees who process Medicaid claims, including Subcontractors, to attend annual training as provided by HHSC in accordance with Tex. Gov't Code § 531.105.
3. The MCO must perform pre-payment review for identified providers as directed by HHSC OIG.
4. When requested by the HHSC OIG, the MCO will be required to provide employees to participate in administrative proceedings pursued by the HHSC OIG. Such employees must be knowledgeable about the subject matter on which they are called to testify and must be available for preparatory activities and for formal testimony. The MCO must provide the employees at no cost to the State and the HHSC OIG.

5. For the purposes of nursing facility and Hospital Utilization Reviews, **Section 2.6.29.4 of this Exhibit H, SOW,** also applies to HHSC requests.
6. Failure to comply with any requirement of **Section 2.6.29 of this Exhibit H, SOW,** may subject the MCO to liquidated damages and/or administrative enforcement pursuant to 1 Tex. Admin. Code pt. 15, ch. 371, subch. G, in addition to any other legal remedy available by law to HHSC or HHSC OIG.

### 2.6.29.1 Special Investigative Units

In order to facilitate cooperation with HHSC OIG, the MCO must establish and maintain a SIU, either in-house or by contract with another entity, to investigate possible acts of FWA for all services provided under the Contract, including those that the MCO subcontracts to outside entities.

1. The MCO's SIU does not have to be physically located in Texas but must be adequately staffed to handle Texas volume. The SIU must have adequate staff and resources apportioned at the levels and experience sufficient to effectively work Texas cases based on objective criteria considering, but not necessarily limited to, the MCO's total Member population, claims processes, risk exposure, current caseload, and other duties as described in 1 Tex. Admin. Code pt. 15, ch. 353, subch. F and ch. 370, subch. F.
2. The MCO must submit a written FWA compliance plan to HHSC OIG for approval each year 90 Days prior to the start of the SFY. See **Section 2.5.3.7 of this Exhibit H, SOW,** for requirements regarding timeframes for submitting the original plan.
3. The MCO must maintain a full-time SIU manager dedicated solely to the Texas Medicaid program to direct oversight of the SIU and FWA activities.
4. The MCO SIU must employ or Subcontract, at minimum, one full-time investigator, in addition to the SIU manager, who is dedicated solely to the services provided under the Texas Medicaid contract. The investigator must hold credentials such as certification from the Association of Certified Fraud Examiners, an accreditation from the National Health Care Anti-Fraud Association, or have a minimum of three years Medicaid or CHIP FWA investigatory experience.

### 2.6.29.2 General Requests for and Access to Data, Records, and Other Information

The MCO and its Subcontractors must allow access to all premises and provide originals or copies of all records and information requested free of charge to the HHSC OIG, HHSC or its authorized agent(s), CMS, the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, the Office of the Texas Attorney General, TDI, or other units of State government.

1. Each MCO must designate one primary and one secondary contact person for all HHSC OIG records requests. Each MCO must also identify a central group email inbox that will receive all HHSC OIG records requests. HHSC OIG records requests will be sent to the central group email inbox and also may be sent to the

designated MCO contact person(s) in writing by e-mail, fax, or mail, and will provide the specifics of the information being requested (see below).

2. The MCO must respond to the appropriate HHSC OIG staff member within the timeframe designated in the request. If the MCO is unable to provide all of the requested information within the designated timeframe, the MCO may request an extension in writing (e-mail) to the HHSC OIG requestor no less than two Business Days prior to the due date.
3. The MCO's response must include data for all data fields, as available. The data must be provided in the order and format requested. If any data field is left blank, an explanation must accompany the response. The MCO must not add or delete any additional data fields in its response. All requested information must be accompanied by a notarized business records affidavit unless indicated otherwise in HHSC OIG's record request.
4. The MCO must retain records in accordance with **Chapter 18 of Exhibit B, UMCM**.

The most common requests include, but are not limited to:

1. 1099 data and other financial information – three Business Days;
2. Claims data for sampling and recipient investigations – ten Business Days;
3. Urgent claims data requests – three Business Days (with HHSC OIG manager's approval);
4. Provider education information – ten Business Days;
5. Files associated with an investigation conducted by an MCO – 15 Business Days;
6. Provider profile, UR summary reports, and associated provider education activities and outcomes – as indicated in the request;
7. Member and/or pharmacy data as required by HHSC OIG;
8. Requests submitted to the MCO/dental contractor for interpretations or clarifications of the MCO/dental contractor policy and procedure – five Business Days;
9. The basis for providing specific authorized services, including Case-by-case Services, VAS, and CCP services provided through THSteps – as needed; and
10. Other time-sensitive requests – as needed.

#### 2.6.29.3 CLAIMS DATA SUBMISSION REQUIREMENTS

The MCO and its Subcontractors must submit Adjudicated Claims data per the frequency and scope prescribed by the HHSC OIG. This data must include submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats. In the event that the MCO denies provider claims, either as Adjudicated-Denied Claims or Deficient-Denied Claims, the MCO must submit all available claims data, for such denied claims, to the HHSC OIG without alteration or omission. The MCO and its Subcontractors shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with HHSC OIG data quality standards and requirements as originally defined or subsequently amended.

1. The MCO and its Subcontractors shall comply with industry-accepted clean claim standards for all data submissions to HHSC OIG, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of all paid and denied claims. In the event that the MCO or its Subcontractors denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the MCO and its Subcontractors are required to submit all available claims data, for such denied claims, to HHSC OIG without alteration or omission.
2. The MCO and its Subcontractors shall submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by HHSC OIG, in order to support comprehensive financial reporting, utilization analysis, and investigative efforts.
3. The MCO and its Subcontractors shall submit processed claims data according to standards and formats as defined by HHSC OIG, complying with standard code sets and maintaining integrity with all reference data sources including provider and Member data. All data submissions by the MCO and its Subcontractors will be subjected to systematic data quality edits and audits on submission to verify not only the data content, but also the accuracy of claims processing.
4. Any batch submission from an MCO or its Subcontractors which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the MCO and its Subcontractors for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted shall be completed within five Business Days. Due to the need for timely data and to maintain integrity of processing sequence, should the MCO or its Subcontractors fail to respond in accordance with this **Section 2.6.29.4**, the MCO and its Subcontractors shall address any issues that prevent processing of a claims batch in accordance with procedures specified and defined by HHSC OIG.
5. The MCO and its Subcontractors shall supply electronic funds transfer (EFT) account numbers on a monthly basis in a format defined by HHSC OIG for all Medicaid providers who have elected to receive payments via EFT and who are participating in their plans.
6. Failure by the MCO or its Subcontractor to submit data as described in this section may result in administrative enforcement by HHSC OIG as specified in 1 Tex. Admin. Code pt. 15, ch. 371, subch. G or liquidated damages as specified in **Exhibit C, Deliverables Liquidated Damages Matrix**.

### 2.6.29.4 PAYMENT HOLDS AND SETTLEMENTS

Title 42 C.F.R. § 455.23 requires the State Medicaid agency to suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of Fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or suspend payment only in part. The rules governing payment suspensions based upon pending investigations of credible allegations of Fraud apply to Medicaid managed care entities. Managed care Capitation Payments may be included in a suspension when an individual Provider is under

investigation based upon credible allegations of Fraud, depending on the allegations at issue.

The MCO must cooperate with HHSC OIG when HHSC OIG imposes payment suspensions or lifts a payment hold. When HHSC OIG sends notice that payments to a Provider have been suspended, the MCO must also suspend payments to the Provider within one Business Day of receipt of HHSC OIG notice. When notice of a payment hold or a payment hold lift is received, the MCO must respond to the notice within three Business Days and inform HHSC OIG of action taken.

The MCO must also report all of the following information to HHSC OIG after it suspends payments to the Provider:

1. Date the suspension was imposed;
2. Date the suspension was discontinued;
3. Reason for discontinuing the suspension;
4. Outcome of any appeals;
5. Amount of adjudicated Medicaid payments held, and, if applicable,
6. The good cause rationale for not suspending payment (for example, the provider is not enrolled in the MCO's network) or imposing a partial payment suspension.

If the MCO does not suspend payments to the Provider, or if the MCO does not correctly report the amount of adjudicated payments on hold, HHSC may impose contractual or other remedies.

The MCO must report the fully adjudicated hold amount on the monthly open case list report required by **Chapter 5.5 of Exhibit B, UMCM,** and provide this information to HHSC OIG upon request.

The MCO must follow the requirements set forth in a settlement agreement involving an MCO's Provider and HHSC OIG. The MCO must withhold the designated percentage of funds to be paid toward an identified overpayment. Upon HHSC OIG request, the MCO must forward the held funds to HHSC OIG, Attn: Chief Counsel Accounting, along with an itemized spreadsheet detailing the Provider's claims paid so that the claims data can be reconciled with the monthly Remittance & Status statements.

For payment suspensions initiated by the MCO, the MCO must report the following information to HHSC OIG:

1. The nature of the suspected Fraud;
2. Basis for the suspension;
3. Date the suspension was imposed;
4. Date the suspension was discontinued;
5. Reason for discontinuing the suspension;
6. Outcome of any appeals;
7. The amount of payments held;
8. The percentage of the hold, and, if applicable;
9. The good cause rationale for imposing a partial payment suspension.

MCOs must maintain all documents and claims data on Providers who are under HHSC OIG investigation or any internal investigations that are referred to HHSC OIG for

recoupment. The MCO's failure to comply with **Section 2.6.29 of this Exhibit H, SOW,** and all State and federal laws and regulations relating to FWA in healthcare and the Medicaid and CHIP programs are subject to administrative enforcement by HHSC OIG as specified in 1 Tex. Admin. Code pt. 15, ch. 371, subch. G.

### 2.6.29.5 Treatment of Recoveries by the MCO for Fraud, Waste, and Abuse

Pursuant to 42 C.F.R. § 438.608(d)(1), the MCO must comply with all State and federal laws pertaining to provider recoveries including Tex. Gov't Code § 531.1131.

The MCO must have internal policies and procedures for the documentation, retention, and recovery of all overpayments, specifically for the recovery of overpayments due to FWA.

In cases identified by the HHSC OIG, the HHSC OIG has the right to recover any identified Overpayment directly from the Provider or to require the MCO to recover the identified Overpayment and distribute funds to the State.

The MCO will have no claim to any funds that are recovered by the State of Texas or the United States Government from a provider through an action under the Federal False Claims Act, 31 U.S.C. §§ 3729-3733, Texas Medicaid Fraud Prevention Act, Tex. Hum. Res. Code ch. 36, or similar laws. The recovery of an Overpayment by an MCO from a provider does not preclude the prosecution of non-recovery from a provider under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws.

Upon discovery of FWA the MCO shall:

1. Submit a referral using the Fraud referral form through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS); and
2. Proceed with recovery efforts if the recovery amount is less than $100,000 or, if the recovery amount exceeds $100,000 and the HHSC OIG has notified the MCO it is authorized to, proceed with recovery efforts.

The MCO may retain recovery amounts pursuant to Tex. Gov't Code § 531.1131(c) and (c-1).

Pursuant to Tex. Gov't Code § 531.1131(c-3), the MCO is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services, or claims upon which the recoupment or withhold are based meet one or more of the following criteria:

1. Upon written notice from HHSC OIG that it has begun recovery efforts, the MCO is prohibited from taking any actions to recoup or withhold improperly paid funds.
    a. The prohibition described in this subsection shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims. The MCO must not engage in any reprocessing, recoupments, and other payment recovery efforts or claims adjustments of any kind based on the parameters set by HHSC OIG.
    b. The prohibition does not impact any current MCO contractual obligations, as well as any reprocessing, recoupment, other payment recovery efforts or

claims adjustments for claims that fall outside those identified in the written notice from HHSC OIG.

2. The improperly paid funds have already been recovered by HHSC OIG.

The MCO must report at least annually, or at the request of the HHSC OIG, the status of its recoveries of overpayments in the manner specified by the HHSC OIG.

#### 2.6.29.6 False Claims Act and Whistleblowing

In accordance with 42 U.S.C. § 1396a(a)(68), an MCO that receives or makes annual Medicaid payments of at least $5 million must:

1. Establish written policies for all employees, managers, officers, contractors, Subcontractors, and agents of the MCO or Subcontractor, that provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, as described in 42 U.S.C. § 1396a(a)(68)(A);
2. Include in the MCO's or Subcontractor's written policies detailed provisions regarding the MCO's or Subcontractor's policies and procedures for detecting and preventing FWA; and
3. Include in any employee handbook, a specific discussion of the laws described in 42 U.S.C. § 1396a(a)(68)(A), the rights of employees to be protected as whistleblowers, and the MCO's or Subcontractor's policies and procedures for detecting and preventing FWA.

#### 2.6.29.7 Lock-in Actions

The HHSC OIG's Lock-In Program restricts or "locks in" a Medicaid Member to a designated Provider or pharmacy if it finds that the Member used Medicaid services, including drugs, at a frequency or amount that is duplicative, excessive, contraindicated, or conflicting, or that the Member's actions indicate abuse, misuse, or Fraud.

The MCO is required to maintain written policies for all employees, managers, officers, contractors, Subcontractors, and agents of the MCO or Subcontractor. The policies must provide detailed information related to the HHSC OIG's Lock-In Program and the MCO's policies and procedures about overutilization of prescription medications. The MCO must submit documentation on an annual basis demonstrating how the MCO complies with HHSC OIG's Lock-In Program policies and procedure requirements. The MCO must submit the information 90 Days prior to the start of each SFY in conjunction with its FWA compliance plan.

### 2.6.30 Complaints and Managed Care Organization Internal Appeals Process for Providers

The following sections outline minimum requirements for the Complaints and MCO Internal Appeals process for Providers. The MCO must provide information, including the

information specified in 42 C.F.R. § 438.10(g)(2)(xi), about the Complaint and MCO Internal Appeals process to all Providers and Material Subcontractors at the time they enter into a contract with the MCO. This process must be reviewed and approved in writing by HHSC or its designee.

#### 2.6.30.1 PROVIDER COMPLAINTS

The MCO must develop, implement, and maintain a system for tracking and resolving all Provider Complaints. The MCO's tracking system must include the status and final disposition of each Provider Complaint.

The MCO must resolve 98% of Provider Complaints within 30 Days from the date the Complaint is received.

The MCO must also resolve Provider Complaints received by HHSC in accordance with **Chapter 3 of Exhibit B, UMCM**.

#### 2.6.30.2 PROVIDER APPEAL OF MANAGED CARE ORGANIZATION CLAIMS DETERMINATIONS

The MCO must develop, implement, and maintain a system for tracking and resolving all Provider claims payment appeals, as required by Tex. Gov't Code § 533.005(a)(15). Within this process, the MCO must respond completely to each Provider's claims payment appeal and:

1. Establish a tracking mechanism to document the status and final disposition of each Provider's claims payment appeal; and
2. Provide written notice to the Provider of the outcome of the appeal.

In addition, the MCO's process must comply with the requirements of Tex. Gov't Code § 533.005(a)(19).

The MCO must resolve 98% of Provider claims payment appeals within 30 Days from the date the appeal is received.

The MCO must enter into agreements with OON physicians to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a Provider appeals. The physician resolving the dispute must not be an employee of the MCO's Medicaid or CHIP lines of business but may be an employee in the MCO's Medicare or commercial lines of business. The MCO must ensure the determination of the physician resolving the dispute is binding on the MCO and the Provider. The MCO must ensure the physician resolving the dispute is licensed to practice medicine in the State of Texas and holds the same specialty or a related specialty as the appealing Provider. If required by HHSC, the MCO must submit to and comply with the decision of an independent review process established by HHSC for final determination on these disputes.

### 2.6.31 MEMBER COMPLAINT AND APPEAL SYSTEM

The MCO must develop, implement, and maintain a system for tracking, resolving, and reporting all Member Complaints and MCO Internal Appeals regarding its services, processes, procedures, staff, and the denial or limited authorization of a requested service. This requirement includes tracking, resolving, and reporting the type or level of service and the denial, in whole or in part, of payment for services. The system must comply with the requirements in applicable federal and State laws and regulations, including 42 C.F.R. pt. 431, subpt. E, and pt. 438, subpt. F and the provisions of 1 Tex. Admin. Code pt. 15, ch. 357 relating to the STAR Health MCO. For the purposes of this section, Member communications meeting the definition of a Complaint must not be categorized by the MCO as any form of Inquiry or request. The MCO must acknowledge the Member's Complaint, in writing, within five Business Days after the MCO receives the Complaint, unless the Complaint is an Initial Contact Complaint.

The Complaint and MCO Internal Appeal process must include a Complaint process, an appeal process, and access to HHSC's State Fair Hearing system. The procedures must be the same for all Members, DFPS Staff, Medical Consenters, and attorneys or guardians ad litem, and must be reviewed and approved in writing by HHSC or its designee.

The MCO must accept Complaints or appeals filed by Providers and Caregivers on behalf of a Member if authorized by the Medical Consenter.

Modifications and amendments to the Complaint and MCO Internal Appeal process must be submitted for HHSC's approval at least 60 Days prior to implementation.

The MCO must ensure that 98% of Member Complaints are resolved within 30 Days from the date the Complaint is received by the MCO. HHSC will refer Member Complaints that it receives to the MCO for resolution.

The MCO must resolve Member Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will provide the MCO up to 10 Business Days to resolve such Complaints, depending on the severity and urgency of the Complaint and no more than the maximum days allowed as stated in **Chapter 3 of Exhibit B, UMCM**, unless an extension has been granted. MCO must provide a reason for the extension request prior to the due date and the request must include the requirements in **Chapter 3 of Exhibit B, UMCM**. HHSC may, in its discretion, grant a written extension if the MCO demonstrates good cause.

The MCO must ensure that standard appeals and Expedited MCO Internal Appeals are resolved within the specified timeframes, unless the MCO can document that the Member requested an extension or the MCO shows there is a need for additional information and the delay is in the Member's interest. The MCO must respond fully and completely to each Expedited MCO Internal Appeal and establish a tracking mechanism to document the status and final disposition of each such appeal.

The MCO must designate an officer of the MCO who has primary responsibility for ensuring that Complaints are resolved in compliance with written policy and within the required timeframe. For purposes of this section, an officer of the MCO means a president, vice president, secretary, treasurer, or chairperson of the board for a corporation, the sole

proprietor, the managing general partner of a partnership, or a person having similar executive authority in the organization.

The MCO must have a routine process to detect patterns of Complaints. The MCO's management, supervisory, and Quality Improvement staff must be involved in developing policy and procedure improvements to address the Complaints.

The MCO's Complaint procedures must be provided to Members in writing and through oral interpretive services. A written description of the MCO's Complaint procedures must be available in all Prevalent Languages identified by HHSC, at no more than a sixth-grade reading level.

The MCO must include a written description of the Complaint process in the Member handbook. The MCO must maintain and publish in the Member handbook at least one toll-free telephone number with TTY/TDD and interpreter capabilities for making Complaints. The MCO must provide such oral interpretive service to callers free of charge.

The MCO's process must require that every Complaint received in-person, by telephone, or in writing, be acknowledged and recorded in a written record and logged with the following details:

1. A description of the reason for the Complaint;
2. The date received;
3. The date of each review or, if applicable, review meeting;
4. Resolution at each level of the Complaint, if applicable;
5. Date of resolution at each level, if applicable; and
6. Name of the Member for whom the Complaint was filed.

In accordance with 42 C.F.R. § 438.416, the MCO must accurately maintain the records in a manner accessible to HHSC and available upon HHSC's request.

For Complaints that are received in-person or by telephone, the MCO must provide Members, Medical Consenter, DFPS Staff, attorneys, or guardians ad litem with written notice of resolution if the Complaint cannot be resolved within one Business Day of receipt. As TDI does not require the reporting of issues described in 28 Tex. Admin. Code pt. 1, ch. 3, subch. KK, § 3.9202(2)), the MCO must report this subcategory of Complaints to HHSC as "Initial Contact Complaints."

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for filing a Complaint.

The MCO must cooperate with HHSC to resolve all Member Complaints. Such cooperation may include providing information or assistance to HHSC Complaint staff at no cost to HHSC.

The MCO must provide designated Member Advocates, as described in **Section 2.6.17.4 of this Exhibit H, SOW**, to assist Members in understanding and using the MCO's Complaint system. The MCO's Member Advocates must assist Members in writing or filing a Complaint and monitoring the Complaint through the MCO's Complaint process until the issue is resolved.

### 2.6.31.1 MANAGED CARE ORGANIZATION INTERNAL APPEAL PROCESS FOR MEMBERS

The MCO must develop, implement, and maintain an MCO Internal Appeal procedure that complies with State and federal laws and regulations, including 42 C.F.R. pt. 431, subpt. E and pt. 438, subpt. F, as well as comply with provisions of Tex. Ins. Code chs. 843 and 4201, except as set forth herein. An MCO Internal Appeal is a disagreement with an Adverse Benefit Determination, as defined in **Section 1.4 of this Exhibit H, SOW**. The MCO Internal Appeal procedure must be the same for all Members, DFPS Staff, Medical Consenters, attorneys, and guardians at litem. When a Member, Medical Consenter, DFPS Staff, attorney, or guardian ad litem expresses orally or in writing any dissatisfaction or disagreement with an Adverse Benefit Determination, the MCO must regard the expression of dissatisfaction or disagreement as a request to appeal an Adverse Benefit Determination.

The provisions of Tex. Ins. Code ch. 4201, relating to an appeal to an IRO, do not apply to a Medicaid recipient. Texas Medicaid is using the EMR process provided in 42 C.F.R. § 438.408(f)(1)(ii).

Except for the resolution of an Expedited MCO Internal Appeal as provided in **Section 2.6.31.2 of this Exhibit H, SOW**, the MCO must complete the entire standard appeal process within 30 Days after receipt of the initial written or oral request for MCO Internal Appeal. The timeframe for an MCO Internal Appeal may be extended up to 14 Days if the Member, DFPS Staff, Medical Consenters, attorneys, or guardians at litem requests an extension, or the MCO shows that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the MCO must give the Member written notice of the reason for delay if the Member had not requested the delay.

The MCO must have policies and procedures in place outlining the Medical Director's role in an MCO Internal Appeal of an Adverse Benefit Determination. The Medical Director must have a significant role in monitoring, investigating, and hearing MCO Internal Appeals. In accordance with 42 C.F.R. § 438.406, the MCO's policies and procedures must require that individuals who make decisions on appeals are not involved in any previous level of review or decision-making, nor a subordinate of any such individual, and are healthcare professionals who have the appropriate clinical expertise in treating the Member's condition or disease.

The MCO must provide designated Member Advocates, as described in **Section 2.6.17.4 of this Exhibit H, SOW**, to assist Members, DFPS Staff, and Medical Consenters in understanding and using the MCO Internal Appeal process. The MCO's Member Advocates must assist Members, DFPS Staff, and Medical Consenters in writing or filing an MCO Internal Appeal and monitoring the MCO Internal appeal through the MCO's appeal process until the issue is resolved.

During the MCO Internal Appeal process, the MCO must provide the Member, DFPS Staff, and Medical Consenter a reasonable opportunity to present evidence and any allegations of fact or law in-person as well as in writing. The MCO must inform the Member, DFPS Staff, and Medical Consenter of the time available for providing this information and that, in the case of an expedited resolution, limited time will be available.

The MCO must provide the Member, DFPS Staff, and Medical Consenter opportunity, before and during the MCO Internal Appeal process, to examine the Member's case file, including medical records and any other documents considered during the MCO Internal Appeal process. The MCO must include, as parties to the MCO Internal Appeal, the Member, DFPS Staff, and Medical Consenter, or the legal representative of a deceased Member's estate.

In accordance with 42 C.F.R. § 438.420, the MCO must continue the benefits currently being received by the Member, including the benefit that is the subject of the MCO Internal Appeal, if all of the following criteria are met:

1. The Member, Medical Consenter, or DFPS Staff, as applicable, files the MCO Internal Appeal in a timely manner, as defined in the Contract and in accordance with 42 C.F.R. § 438.402;
2. The appeal involves the termination, suspension, or reduction of a previously authorized service;
3. The Covered Services were ordered by an authorized Provider;
4. The original period covered by the original authorization has not expired; and
5. The Member, DFPS Staff, or Medical Consenter timely requests an extension of the benefits.

If, at the Member's, DFPS Staff, or Medical Consenter's request, the MCO continues or reinstates the Member's benefits while the MCO Internal Appeal is pending, the benefits must be continued until one of the following occurs:

1. The Member, DFPS Staff, or Medical Consenter withdraws the MCO Internal Appeal or request for State Fair Hearing;
2. Ten Days pass after the MCO mails the notice resolving the MCO Internal Appeal against the Member, unless the Member, within the ten-Day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is issued; or
3. A State Fair Hearing officer issues a hearing decision adverse to the Member or the time period or service limits of a previously authorized service have been met.

In accordance with State and federal regulations, if the final resolution of the MCO Internal Appeal is adverse to the Member and upholds the MCO's Adverse Benefit Determination, then, to the extent that the services were furnished to comply with the Contract, the MCO must not recover such costs from the Member without written permission from HHSC.

If the MCO, IRO, or State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the MCO Internal Appeal was pending, the MCO must authorize or provide the disputed services as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

If the MCO, IRO, or State Fair Hearing officer reverses a decision to deny authorization of services and the Member received the disputed services while the MCO Internal Appeal was pending, the MCO is responsible for the payment of services.

If the IRO or a State Fair Hearing officer reverses an MCO's denial of a PA for a DME service/equipment after the Member has enrolled with a second MCO, the original MCO must pay for the DME service/equipment from the date it denied the authorization until the date the Member enrolled with the second MCO. In the case of custom DME, the original MCO must pay for the custom DME if the denial is reversed.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for appealing an Adverse Benefit Determination.

### 2.6.31.2 EXPEDITED MANAGED CARE ORGANIZATION INTERNAL APPEALS

In accordance with 42 C.F.R. § 438.410, the MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from a Member, DFPS Staff, or Medical Consenter) or the Provider indicates (in making the request on the Member's behalf or supporting the Member's, DFPS Staff's or Medical Consenter's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The MCO must follow all appeal requirements for the Member MCO Internal Appeals as set forth in **Sections 2.6.31.1 of this Exhibit H, SOW,** except where differences are specifically noted herein. The MCO must accept oral or written requests for Expedited MCO Internal Appeals. An MCO must provide the Member, DFPS Staff, and Medical Consenter access to the Member's case file free of charge and sufficiently in advance of the standard timeframe for MCO Internal Appeals.

In instances where a Provider indicates, or the MCO determines, that the standard timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the MCO must approve, modify, or deny a provider's PA or concurrent request for Covered Services, and send the appropriate notice of the Adverse Benefit Determination, in a timeframe which is appropriate for the nature of the Member's condition. However, in no circumstance can such be more than 72 hours from the receipt of the request, except where the MCO must complete the investigation and resolution of an MCO Internal Appeal relating to an ongoing emergency or denial of continued hospitalization:

1. In accordance with the medical or dental immediacy of the case; and
2. Not later than one Business Day after receiving the Member's request for Expedited MCO Internal Appeal.

Except for an appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member, DFPS Staff, and Medical Consenter of the outcome of the Expedited MCO Internal Appeal may be extended up to 14 Days if the Member, DFPS Staff, or Medical Consenter requests an extension or the MCO shows (to the satisfaction of HHSC, upon HHSC's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the MCO must give the Member, DFPS Staff, and Medical Consenter written notice of the reason for delay if the Member, DFPS Staff, or Medical Consenter did not request the delay.

If the decision is adverse to the Member, the MCO must follow the procedures relating to the notice in **Section 2.6.31.4 of this Exhibit H, SOW.** The MCO is responsible for notifying the Member, DFPS Staff, and Medical Consenter of his or her right to access an EMR and/or an expedited State Fair Hearing from HHSC. The MCO will be responsible for providing documentation to HHSC, the Member, DFPS Staff, and Medical Consenter, indicating how the decision was made, prior to HHSC's expedited State Fair Hearing and/or EMR. If the MCO fails to render a decision within the required timeframe, the Member is deemed to have exhausted the Expedited MCO Internal Appeals process. The Member may initiate a State Fair Hearing.

The MCO is prohibited from discriminating or taking punitive action against a Member, DFPS Staff, or Medical Consenter for requesting an Expedited MCO Internal Appeal. The MCO must ensure that punitive action is not taken against a Provider who requests an Expedited MCO Internal Appeal or supports a Member's, DFPS Staff's, or Medical Consenter's request.

If the MCO denies a request for an Expedited MCO Internal Appeal, it must:

1. Transfer the MCO Internal Appeal to the timeframe for standard resolution, and
2. Make a reasonable effort to give the Member prompt oral notice of the denial and follow up within two Days with a written notice.

### 2.6.31.3 ACCESS TO STATE FAIR HEARING AND EXTERNAL MEDICAL REVIEW FOR MEDICAID MEMBERS

The MCO must inform Members, DFPS Staff, and Medical Consenters that, after exhausting the MCO's Internal Appeal process, they can access the State Fair Hearing process, with or without an EMR. The Member may request an EMR and/or State Fair Hearing if the MCO fails to respond to the Member's appeal within the timeframe in 42 C.F.R. § 438.408. The MCO must notify Members and Medical Consenters that they may be represented in the State Fair Hearing by an Authorized Representative such as DFPS Staff or Medical Consenter.

The EMR is an optional, extra step a Member may request to further review the MCO's Adverse Benefit Determination. The EMR will not consider new evidence. The EMRs will be conducted by IROs contracted by HHSC. The role of the IRO is to act as an objective arbiter and decide whether the MCO's original Adverse Benefit Determination must be reversed or affirmed. The EMR will take place between the MCO Internal Appeal and the State Fair Hearing. The MCO will send a copy of the EMR decision to the Member, HHSC Intake Team, and State Fair Hearings office as directed by HHSC.

If a Member requests a State Fair Hearing, the MCO must complete and submit the request via Texas Integrated Eligibility Redesign System (TIERS) to the appropriate State Fair Hearings office, within five Days of the Member's request for a State Fair Hearing. If the Member requests an EMR, the MCO will complete and submit the request via TIERS to the HHSC Intake Team within five Days of the Member's request for an EMR.

Within five Days of notification that the State Fair Hearing is set, the MCO must prepare an evidence packet for submission to the HHSC State Fair Hearings staff and send a copy

of the packet to the Member. The evidence packet must comply with HHSC's State Fair Hearings requirements.

The MCO must ensure that the appropriate staff members who have firsthand knowledge of the Member's appeal to be able to speak and provide relevant information on the case attend all State Fair Hearings as scheduled.

### 2.6.31.4 NOTICES OF ADVERSE BENEFIT DETERMINATION AND DISPOSITION OF APPEALS FOR MEDICAID MEMBERS

The MCO must notify the Member, HHSC, DFPS Staff, and Medical Consenter, in accordance with 1 Tex. Admin. Code pt.15, ch. 357, whenever the MCO makes an Adverse Benefit Determination. The notice must, at a minimum, include any information required by **Chapter 3 of Exhibit B, UMCM,** regarding notices of Adverse Benefit Determinations and incomplete PA requests.

### 2.6.31.5 TIMEFRAME FOR NOTICE OF ADVERSE BENEFIT DETERMINATION

In accordance with 42 C.F.R. § 438.404(c), the MCO must mail a notice of Adverse Benefit Determination within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid-Covered Services, at least 10 Business Days before the termination, suspension, or reduction of previously authorized services, or within the timeframes specified in 42 C.F.R. §§ 431.213, and 431.214, if applicable;
2. For denial of payment, at the time of any Adverse Benefit Determination affecting the claim;
3. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R. § 438.210(d)(1);
4. If the MCO extends the timeframe for making a decision, in accordance with 42 C.F.R. § 438.210(d)(1), it must:
    a. Give the Member, DFPS Staff, and Medical Consenter written notice of the reason for the decision to extend the timeframe and inform the Member, DFPS Staff, and Medical Consenter of the right to file an appeal if he or she disagrees with that decision; and
    b. Issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.
5. For PA decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) and not subject to an extension, which constitutes a denial and is thus an Adverse Benefit Determination, on the date that the timeframes expire; and
6. For expedited MCO Internal Appeals of PA decisions, within the timeframes specified in 42 C.F.R. § 438.210(d).

#### 2.6.31.6 NOTICE OF DISPOSITION OF APPEAL

The MCO must provide written notice of disposition of all appeals, including Expedited MCO Internal Appeals, to the Member and Authorized Representative acting on behalf of the Member to ensure the Member has an adequate opportunity to request a State Fair Hearing/EMR within 10 Days. The notice must include the results and date of the appeal resolution. For decisions not wholly in the Member's favor, in accordance with 42 C.F.R. § 438.408(e), the notice must also contain:

1. The right to request a State Fair Hearing/EMR;
2. How to request a State Fair Hearing/EMR;
3. The circumstances under which the Member may continue to receive benefits pending a State Fair Hearing/EMR;
4. How to request the continuation of benefits; and
5. Any other information required by 1 Tex. Admin. Code pt.15, ch. 357 that relates to an MCO's notice of disposition of an appeal.

#### 2.6.31.7 TIMEFRAME FOR NOTICE OF RESOLUTION OF APPEALS

In accordance with 42 C.F.R. § 438.408, the MCO must provide written notice of the resolution of appeals, including Expedited MCO Internal Appeals, as expeditiously as the Member's health condition requires, but the notice must not exceed the timelines as provided in this section for MCO Internal Appeals or Expedited MCO Internal Appeals. For expedited resolution of appeals, the MCO must make reasonable efforts to give the Member, DFPS Staff, and Medical Consenter prompt oral notice of the resolution of the appeal and follow up with a written notice within the timeframes set forth in this section for Expedited MCO Internal Appeals. If the MCO denies a request for expedited resolution of an appeal, the MCO must transfer the appeal to the timeframe for standard resolution as provided in this section, and make reasonable efforts to give the Member, DFPS Staff, or Medical Consenter prompt oral notice of the denial and follow up within two Days with a written notice.

### 2.6.32 COVERED SERVICES

The MCO is responsible for assessing, authorizing, arranging, coordinating, and providing the following non-exhaustive, high-level listing of Covered Services, including community-based LTSS, in accordance with the requirements of the Contract and subject to modification due to changes in federal and State law or regulation. Covered Services include the following:

1. Emergency and non-emergency ambulance services;
2. Audiology services, including hearing aids, for adults and children;
3. BH Services, including:
    a. Inpatient mental health services. The MCO may provide these services in a free-standing Psychiatric Hospital in lieu of an Acute Care Hospital inpatient setting for Members age 21 through the month of their 22nd birthday, limited to no more than 15 Days per month, as described in

**Chapter 16 of Exhibit B, UMCM**. Inpatient Psychiatric Hospital services provided in a free standing Psychiatric Hospital to Members under age 21 or ages 65 and older are a covered Medicaid benefit and are not provided "in lieu of" and there is no day limitation for services;

b. Outpatient mental health services;
c. Psychiatry services;
d. Mental Health Rehabilitative Services;
e. Mental Health TCM;
f. Residential and outpatient SUD treatment services, including:
    i. Assessment;
    ii. Detoxification services;
    iii. Counseling treatment; and
    iv. Medication assisted therapy;
g. Crisis stabilization and hospitalization diversion program for children with acute BH needs. In areas where this service is available, the MCO must:
    i. Utilize Trauma Informed Mobile Crisis Outreach Teams (MCOTs) to provide assistance, education, and training to Members, and their Medical Consenters, and Caregivers; and
    ii. Provide residential crisis stabilization services and enhanced wraparound services to Members who qualify.

4. Birthing services provided by a physician and Certified Nurse Midwife (CNM) in a licensed birthing center;
5. Birthing services provided by a licensed birthing center;
6. Cancer screening, diagnostic, and treatment services;
7. Chiropractic services;
8. CFC services, including:
    a. Personal assistance services;
    b. Habilitation;
    c. Emergency response services; and
    d. Support consultation;
9. Dental services, including:
    a. Diagnostic and preventive, including support of the First Dental Home strategic initiative for THSteps children 6 through 35 months of age;
    b. Therapeutic;
    c. Restorative;
    d. Endodontic;
    e. Periodontal;
    f. Prosthodontic (removable and fixed);
    g. Implant and oral and maxillofacial surgery;
    h. Orthodontic; and
    i. Adjunctive general;
10. Dialysis;
11. DME and supplies;
12. ECI services
13. Emergency Services;
14. Family planning services;

15. Home Healthcare Services provided in accordance with 42 C.F.R. § 440.70, and as directed by HHSC;
16. Hospital services, including inpatient and outpatient;
    a. The MCO may provide inpatient services for acute psychiatric conditions in a freestanding Psychiatric Hospital in lieu of an Acute Care inpatient Hospital setting; and
    b. The MCO may provide SUD treatment services in a chemical dependency treatment facility in lieu of an Acute Care inpatient Hospital setting;
17. Laboratory;
18. Mastectomy, breast reconstruction, and related follow-up procedures, including inpatient services; outpatient services provided at an outpatient hospital and ambulatory healthcare center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    a. All stages of reconstruction on the breast(s) on which Medically Necessary mastectomy procedure(s) have been performed;
    b. Surgery and reconstruction on the other breast to produce symmetrical appearance;
    c. Treatment of physical complications from the mastectomy and treatment of lymphedemas;
    d. Prophylactic mastectomy to prevent the development of breast cancer; and
    e. External breast prosthesis for the breast(s) on which Medically Necessary mastectomy procedure(s) have been performed;
19. Medical checkups and CCP Services (for children birth through age 20) through the THSteps Program EPSDT services;
20. Oral evaluation and fluoride varnish in the Medical Home in conjunction with THSteps medical checkup for children 6 months through 35 months of age;
21. Optometry, glasses, and contact lenses;
22. Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals;
23. Drugs and biologicals provided in an inpatient setting;
24. Podiatry;
25. PCS;
26. Prenatal care;
27. Prenatal care provided by a physician, CNM, Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), and physician assistant in a licensed birthing center;
28. PPECC;
29. Primary care services;
30. PDN;
31. Radiology, imaging, and X-rays;
32. Specialty physician services;
33. Therapies: physical, occupational, and speech; and
34. Transplantation of organs and tissues.

The following is a list of Covered Services for Members who qualify for MDCP services. The MCO must provide Medically and Functionally Necessary services to Members who meet the functional eligibility for MDCP:

1. Respite care;
2. Supported Employment;
3. Financial Management Services;
4. Adaptive Aids;
5. Employment Assistance;
6. Flexible family support services;
7. Minor Home Modifications; and
8. Transition assistance services.

The MCO must provide full coverage for Covered Services to all Members beginning on the Member's Effective Date of Coverage without regard to the Member's:

1. Previous coverage, if any, or the reason for termination of the coverage;
2. Health status;
3. Confinement in a healthcare facility; or
4. Any other reason.

The MCO must not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any Member.

The MCO must not practice discriminatory selection or encourage segregation among the total group of Members by excluding, seeking to exclude, or otherwise discriminating against any group or class of individuals.

The MCO must begin providing STAR Health services to the Member upon receipt of the DNF. The DNF is not an official eligibility file and does not contain information concerning Members included in Category 3, 4, and 5 of the Target Population.

The MCO must also comply with DFPS requirements related to Covered Services in laws, rules and regulations, including requirements for assessments and Court Ordered services, as amended or modified during the Contract Term. Information on these requirements is available at the DFPS website https://www.dfps.state.tx.us/.

The MCO is responsible for providing Members all Covered Services available to clients of the FFS program in no less than the amount, duration, and scope as is available through FFS as reflected in the following sources:

1. Texas Medicaid State Plan under Title XIX of the Social Security Act State plans for medical assistance, 42 U.S.C. § 1396a;
2. 42 C.F.R. § 438.210, with the exception of Non-capitated Services described in **Section 2.6.60.7 of this Exhibit H, SOW**;
3. 42 C.F.R. § 440.230;
4. 42 C.F.R. pt. 441, subpt. B; and
5. **Exhibit E, TMPPM.**

The MCO must allow Covered Services to be provided by an OON provider if a Provider is not available within the time and distance standards to provide the services for that specialty.

Covered Services are subject to changes in federal and State laws, rules, or regulations, Medicaid policy, and medical practice, clinical protocols, or technology.

The MCO must have a process in place to monitor a Member's claims history for acute and community-based LTSS that receive a PA to ensure that these services are being delivered.

On an ongoing basis, or at every placement change, the MCO must monitor claims data for all approved PAs for delivery of the services. The MCO must research and resolve any services not received as a result of the lack of claims data. At the request of HHSC, the MCO must be able to demonstrate that Members' services requiring PAs were delivered.

In the development of medical policies and medical necessity determinations, the MCO must adopt practice guidelines that:

1. Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field;
2. Consider the needs of Members;
3. Are adopted in consultation with contracting healthcare professionals; and
4. Are reviewed and updated periodically as appropriate.

The Covered Services included within **Sections 2.6.33 through 2.6.60 of this Exhibit H, SOW**, must be provided by the MCO as part of the Capitated Payment it received under this Contract.

### 2.6.33 ACCESS TO CARE

The MCO must ensure all Covered Services are available to Members on a timely basis, in accordance with the Contract's requirements and medically appropriate guidelines, and consistent with generally accepted practice parameters. The MCO must ensure all Members have access to a choice of Providers for all Covered Services. If the MCO is unable to meet this standard, the MCO must request an exception from HHSC as discussed in **Section 2.6.33.3 of this Exhibit H, SOW**.

The MCO must comply with the access requirements as established by TDI in 28 Tex. Admin. Code pt. 1, ch. 3, subch. KK, § 3.9208 and ch. 11, subch. Q, § 11.1607, for all MCOs doing business in Texas, except as otherwise required by the Contract. Where conflicts exist between TDI access requirements and the Contract, the shortest mileage and timeframe requirements apply.

The MCO must require PCPs to have Call Coverage and accessibility for Members 24 hours a Day, 7 Days a week and Network PCPs to have after-hours telephone availability consistent with **Section 2.6.35.14 of this Exhibit H, SOW**.

The MCO must ensure that Providers offer office hours to Members that are at least equal to those offered to the MCO's commercial lines of business or Medicaid FFS participants, if the Provider accepts only Medicaid Members.

If Covered Services are not available through Providers, the MCO must allow referral to an OON provider upon the request of DFPS Staff, the Medical Consenter, or a Provider. The MCO must ensure the referral is made within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but in no event may the making of the referral exceed five Business Days after receipt of the request. The

MCO must fully reimburse the OON provider in accordance with the OON methodology for Medicaid as defined by HHSC in 1 Tex. Admin. Code pt. 15, ch. 353, subch. A, § 353.4. The MCO must ensure access to these services within the timeframes specified in **Section 2.6.33.1 of this Exhibit H, SOW**, and within the time appropriate to the circumstances and Member's need.

The MCO must ensure the provision of Covered Services meet the specific preventive, Acute Care, Community-Based Services, LTSS, and specialty healthcare needs appropriate for treatment of the Member's condition(s).

The MCO may not make a Member, the Medical Consenter, or the Caregiver responsible for any payment for Covered Services or functionally necessary Covered Services.

### 2.6.33.1 APPOINTMENT ACCESSIBILITY

The MCO must meet the specific standards for appointment accessibility through its Provider Network composition and management. The following standards are measured from the date of presentation or request, whichever occurs first, unless another date is noted, such as the Day the Member enters conservatorship:

1. Emergency Services must be provided upon Member's presentation at the service delivery site, including OON and out-of-state facilities;
2. Services to address an Urgent Condition, including urgent specialty care and BH Services, must be provided within 24 hours. Treatment for BH Services may be provided by a licensed BH clinician;
3. An initial medical exam must be provided within three Business Days of the Member entering DFPS conservatorship. The Day of removal is Day zero;
4. Primary Routine Care, including annual adult well checks for Members 21 years of age or older, must be provided within 14 Days;
5. Specialty Routine Care must be provided within 21 Days;
6. Initial outpatient BH visits must be provided within 14 Days;
7. Specialty Therapy evaluations must be provided within 21 Days of submission of a signed referral. If an additional evaluation or assessment is required (e.g. audiology testing) as a condition for authorization of therapy evaluation, the additional required evaluation or assessment must be scheduled to allow the Specialty Therapy evaluation to occur within 21 Days from date of submission of a signed referral;
8. Initial outpatient BH visits following Discharge from an inpatient psychiatric setting must be provided within seven Days;
9. Community-Based Services for Members must be initiated within seven Days from the authorization;
10. For Members receiving MDCP services, services must be initiated by the start date of the ISP tracker;
11. Prenatal care must be provided within five Days for initial appointments for any pregnant Member, or immediately, if an emergency exists. Appointments for ongoing care must be available in accordance to the treatment plan as developed by the Provider;

12. The Texas CANS 2.0 assessment must be provided within 30 Days of the Member entering DFPS conservatorship for Members ages 3 through 17, or within 30 Days of the Member's third birthday. Subsequent annual Texas CANS 2.0 assessments must be provided within 14 Days of the annual due date;
13. An initial THSteps medical exam must be provided within 30 Days of the Member entering DFPS conservatorship, unless the periodicity schedule requires an exam sooner. The periodicity schedule can be found at: https://www.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers;
14. A THSteps medical exam that occurs subsequent to the initial THSteps medical checkup must be provided within 14 Days; and
15. THSteps preventive dental services must be provided within 14 Days.

### 2.6.33.2 ACCESS TO PROVIDERS

The MCO's Network must include all the provider types listed below and in **Chapter 5.28 of Exhibit B, UMCM**, to provide timely access to all Covered Services in accordance with the appointment accessibility standards in **Section 2.6.33.1 of this Exhibit H, SOW**. The MCO's Network must provide timely access to regular and preventive care to all Members and THSteps services to all Members, from birth through age 20.

The MCO must allow each Member to choose his or her Provider to the extent possible and appropriate, in accordance with federal and State law and policy, including 42 C.F.R. §§ 438.3(l) and 457.1201(j). The MCO must also ensure that access is consistent with 1 Tex. Admin. Code pt. 15, ch. 353 subch. E, § 353.411.

For each provider type, the MCO must provide access to a choice of Providers that are not closed to new Members for at least 90% of Members within the prescribed distance or travel time standard. Counties will be designated as "Metro," "Micro," or "Rural," as defined in **Exhibit D, Access Standard Map**. The county designation is based on population and density parameters is available in **Exhibit D, Access Standard Map**. Members' residences identified in Enrollment Files will be used to assess distance and travel times. The MCO must comply with the requirements set forth in **Chapter 5.28 of Exhibit B, UMCM**.

HHSC will track MCO performance. HHSC will use the MCO Provider files to run geo-mapping reports that will measure provider choice and distance and travel time from the Member to the Provider. HHSC will share identified deficiencies with the MCO. This sharing of identified deficiencies does not remove the MCO's obligation to self-identify any deficiencies.

#### 2.6.33.2.1 EMERGENCY SERVICES ACCESS

The MCO must provide coverage for Emergency Services to Members 24 hours a Day and 7 Days a week, without regard to PA or the Emergency Service provider's contractual relationship with the MCO. The MCO's policy and procedures, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must

comply with all applicable State and federal laws and regulations, regardless of whether the provider is in Network or OON.

The MCO is not responsible for payment for unauthorized non-emergency services provided to a Member by OON providers, except when that provider is an IHCP enrolled as a FQHC, as provided in **Section 2.6.35.5 of this Exhibit H, SOW**.

The MCO must have a BH Crisis Services Hotline that meets all requirements described in **Sections 2.6.16** and **2.6.50.3 of this Exhibit H, SOW**.

The MCO must provide coverage for Emergency Services in compliance with 42 C.F.R. § 438.114 and as described in more detail in **Section 2.6.60.1 of this Exhibit H, SOW**. The MCO may arrange Emergency Services and crisis BH Services through mobile crisis teams.

#### 2.6.33.2.2 PRIMARY CARE PROVIDER AND TEXAS HEALTH STEPS PROVIDER

The MCO must ensure all Members have access to a choice of age-appropriate Network PCPs, including THSteps Providers, accepting new patients in its Network.

For the purpose of assessing compliance with this section, an internist who provides primary care only to adults is not considered an age-appropriate PCP choice for Members birth through age 17, and a pediatrician is not considered an age-appropriate choice for Members age 18 and older, unless a specific condition warrants it.

#### 2.6.33.2.3 DENTAL

The dental Subcontractor's Network must comply with the accessibility standards set forth in 1 Tex. Admin. Code pt. 15, ch. 353, subch. E, § 353.411(b)-(d). At the minimum, the MCO must ensure that Members have access to a choice of Main Dentists with an open practice.

As appropriate, this access must include arranging for services from Providers who are able to accommodate the Member's special needs.

The MCO must ensure its dental Subcontractor provides Members with access to a choice of pediatric dentists, endodontists, orthodontists, and prosthodontist specialty providers.

#### 2.6.33.2.4 OBSTETRICIAN/GYNECOLOGIST

At a minimum, the MCO must ensure all female Members have access to a choice of OB/GYN Providers accepting new patients.

If the OB/GYN Provider is acting as the Member's PCP, the MCO must follow the access requirements for the PCP in **Section 2.6.33.2.2 of this Exhibit H, SOW**. A female Member who has selected an OB/GYN, or whose Medical Consenter has selected an OB/GYN, must be allowed direct access to the OB/GYN's Covered Services without a referral from the Member's PCP or a PA.

#### 2.6.33.2.5 Prenatal

The MCO must ensure Members who are pregnant have access to a choice of Network Providers for prenatal care that are accepting new patients.

The MCO must allow a pregnant Member who is past the 24th week of pregnancy to remain under the Member's current OB/GYN provider's care through the Member's postpartum checkup, even if the OB/GYN Provider is, or becomes, OON.

#### 2.6.33.2.6 Mental Health - Outpatient

The MCO must ensure that all Members have access to a choice of covered outpatient mental health service Providers accepting new patients in the Network.

The MCO must follow Network requirements for outpatient mental health as set forth in **Section 2.6.35.17 of this Exhibit H, SOW**.

#### 2.6.33.2.7 Outpatient Substance Use Disorder Treatment

The MCO must ensure all Members have access to a choice of outpatient SUD service Providers accepting new patients in the Network.

The MCO must follow the Network requirements for outpatient SUD providers as set forth in **Section 2.6.35.19 of this Exhibit H, SOW**.

#### 2.6.33.2.8 Mental Health Targeted Case Management and Mental Health Rehabilitative Services

The MCO must ensure the Members have access to a choice of Network Providers of Mental Health TCM and Mental Health Rehabilitative Services accepting new patients in the Network.

#### 2.6.33.2.9 Specialist Provider Access

The MCO must ensure all Members have access to a choice of Network specialist Providers for all Covered Services. The MCO must ensure PCPs make referrals for the following Providers on a timely basis, based on the urgency of the Member's medical condition, but no later than five Days after the PCP identifies the need for specialty care:

1. Audiologist;
2. Cardiology/cardiovascular disease;
3. Otolaryngology;
4. General surgeon;
5. Ophthalmologist;
6. Orthopedic/orthopedic surgeon;
7. Pediatric sub-specialty;
8. Psychiatrist (including child and adult psychiatrists);
9. Urologist; and

10. All other specialists not listed above.

#### 2.6.33.2.10 THERAPIES - OCCUPATIONAL, PHYSICAL, AND SPEECH THERAPY

For therapies provided in an outpatient clinic or facility, the MCO must ensure Members have access to a choice of Providers accepting new patients for Occupational Therapy (OT) , Physical Therapy (PT), and Speech Therapy (ST).

For in-home therapies, the MCO must ensure that Members have access to a Provider accepting new patients and able to provide in-home therapy services.

#### 2.6.33.2.11 NURSING SERVICES, ATTENDANT CARE, AND HABILITATION

The MCO must ensure Members have access to a choice of at least two qualified Providers for the following:

1. Nursing services, such as skilled nursing and PDN – licensed HCSSAs;
2. PCS – licensed HCSSAs;
3. CFC services (including CFC personal assistance services and CFC Habilitation) – licensed HCSSAs or providers who are contracted with HHSC to provide services under the Home and Community-Based Services (HCS) or Texas Home Living (TxHmL) waiver programs;
4. MDCP services (including Respite, Supported Employment and Employment Assistance) – licensed HCSSAs; and
5. Consumer Directed Services (CDS) delivery option – FMSAs able to provide Financial Management Services for Members who elect to receive services through CDS.

#### 2.6.33.2.12 LONG TERM SERVICES AND SUPPORT PROVIDERS

At a minimum, the MCO must ensure that all Members have access to a choice of the following LTSS providers for all Covered Services: Assisted Living Facility; Attendant Care; CFC Habilitation Services; CDS; In-Home Therapies – OT, PT, and ST; In-Home Skilled Nursing; and PDN.

#### 2.6.33.2.13 ACUTE CARE HOSPITAL

The MCO must ensure all Members have access to a choice of Acute Care Hospitals with a staff or on-call pediatrician in the Network.

#### 2.6.33.2.14 PHARMACY

At the minimum, the MCO must ensure that all Members have access to a pharmacy. The MCO must ensure that access is consistent with 1 Tex. Admin. Code pt. 15, ch. 353, subch. J, § 353.915.

#### 2.6.33.2.15 PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS

If there is a licensed, Medicaid-enrolled PPECC within the SA, the MCO must ensure the Member has access to the PPECC's services.

#### 2.6.33.2.16 ACCESS TO ALL OTHER PROVIDERS FOR SERVICES PROVIDED IN THE MEMBER'S RESIDENCE

The MCO must ensure all Members have access to a choice of Providers for all other Covered Services. This in residence access requirement includes, but is not limited to:

1. Specialists not previously referenced in this section;
2. Oncology, including surgical and radiation;
3. Special Hospitals;
4. Hospitals with specialized children's services;
5. Children's Hospitals;
6. Psychiatric Hospitals;
7. Diagnostic services;
8. Vision services; and
9. Single or limited service healthcare physicians or Providers as applicable to the Program.

The MCO may make arrangements with Providers outside the State for Members to receive a Medically Necessary higher level of skill or specialty than the level available within the State.

### 2.6.33.3 EXCEPTION PROCESS

If the MCO cannot meet any of the above access requirements, the MCO must submit an exception request to HHSC. HHSC will consider requests for exceptions to the access standards for all provider types under limited circumstances.

The MCO must support each exception request with information and documentation as specified in the template provided by MCCO. HHSC may grant exceptions when the MCO has established, through utilization data, that a normal pattern for securing Covered Services within an area does not meet these standards, or when the MCO is providing care of a higher skill level or specialty than the level available within an area. Exceptions may be granted only for a specific amount of time at HHSC's discretion.

### 2.6.33.4 MONITORING ACCESS

The MCO must verify that Covered Services furnished by Providers are available and accessible to Members in compliance with the standards described in **Sections 2.6.33** and **2.6.35 of this Exhibit H, SOW**.

The MCO must design, develop, and implement a Provider directory verification report to verify that the Provider information maintained by the MCO is correct and in alignment with the Provider information maintained by HHSC or its designee. The MCO must

complete a report annually each SFY and provide to HHSC in accordance with **Chapter 5.0.1 of Exhibit B, UMCM**.

The Provider directory verification report must include the following elements:

1. Provider name;
2. Practice physical address;
3. Phone number;
4. Office hours;
5. Days of operation;
6. Practice limitations;
7. Languages spoken;
8. Provider type/specialty;
9. Length of time a Member must wait between scheduling an appointment and receiving treatment;
10. For PCPs, whether the Provider is accepting new patients;
11. For PCPs, whether the Provider is a THSteps enrolled Provider;
12. Accessibility of Provider offices, per ADA requirements as referenced in 42 U.S.C. § 12101, et seq.;
13. Whether the Provider offers Telemedicine, Telehealth, or Telemonitoring; and
14. Whether the Provider has certifications or training in EBPs or promising practices such as:
    a. TIC;
    b. TF-CBT;
    c. PCIT;
    d. TBRI; and
    e. CPP.

### 2.6.34 TELEMEDICINE AND TELEHEALTH ACCESS

Telemedicine, Telehealth, and Telemonitoring are Covered Services and are benefits of Texas Medicaid as provided in **Exhibit E, TMPPM**. The MCO is encouraged to contract with Providers offering these services to provide better access to healthcare for its Members. The MCO may not require a service be provided to a Member through Telemedicine services or Telehealth services when the service can reasonably be delivered by a provider through a face-to-face consultation with the Member in the community. This requirement does not prohibit the authorization of the provision of any eligible service to a Member through Telemedicine or Telehealth at the Member's request. The MCO is required to comply with the various reimbursement related requirements of Tex. Gov't Code § 531.0216.

The MCO may not limit a physician's choice of platform for providing Telemedicine or Telehealth services by requiring the physician to use a particular platform to receive reimbursement for the service. The MCO must allow Members to receive Telemedicine or Telehealth services from providers other than the Member's PCP if the provider complies with the applicable standard of care requirements for providing that service in an in-person

setting, gives the PCP notice of the teleservice including a summary of the service provided, and the recipient or legal guardian consents to the notice.

#### 2.6.34.1 SCHOOL-BASED TELEMEDICINE AND TELEHEALTH SERVICES

School-based Telemedicine medical services are a Covered Service for Members in accordance with Tex. Gov't Code § 531.0217. The MCO must reimburse the distant site physician providing treatment even if the physician is not the Member's PCP. To be eligible for reimbursement, distant site physicians providing treatment must meet the service requirements outlined in Tex. Gov't Code § 531.0217(c-4). The MCO may not request PA for school-based Telemedicine medical services. School-based Telehealth services are a Covered Service for Members pursuant to Tex. Gov't Code § 531.02171. The MCO must reimburse an eligible distant site provider providing treatment even if the provider is not the Member's PCP. To be eligible for reimbursement, the distant site provider providing treatment must meet the service requirements outlined in Tex. Gov't Code § 531.02171(b).

### 2.6.35 PROVIDER NETWORK

The MCO must enter into written Provider Contracts with credentialed providers. The Provider Contracts must comply with requirements in **Section 2.6.35.15 of this Exhibit H, SOW,** and include reasonable administrative and professional terms as necessary.

The MCO must maintain a Network sufficient to provide all Members with access to the full range of Covered Services required under the Contract. The MCO must ensure its Providers and Subcontractors meet all State and federal eligibility criteria, reporting requirements, and any other applicable rules or regulations. The MCO must seek to obtain participation, in its Network, of qualified providers currently serving the Medicaid Members throughout the State.

The MCO must provide an updated Provider Network development plan that fully describes all programs and incentives the MCO will develop to increase the Network's expertise in child welfare, TIC, and TF-CBT on a fixed schedule, and in a format determined by HHSC.

MCOs utilizing OON providers to render services to Members must not exceed the utilization standards established in 1 Tex. Admin. Code pt. 15, ch. 353, subch. A, § 353.4. HHSC may modify this requirement for an MCO that demonstrates good cause for noncompliance, in accordance with 1 Tex. Admin. Code pt. 15, ch. 353, subch. A, § 353.4(g)(3). Each exception request must be supported by information and documentation as specified in **Chapter 5.15 of Exhibit B, UMCM**.

The Provider Network must be responsive to the linguistic, cultural, and other unique needs of any Members who are a minority or have a physical, intellectual, or cognitive disability, or other special population in the State served by the MCO, including the capacity to communicate with Members in languages other than English, when necessary, as well as with those who are blind, deaf-blind, deaf, or hearing impaired.

The MCO must seek participation in the Network from the following types of entities that may serve American Indian and Alaskan Native Members:

1. Health clinics operated by a federally recognized tribe in the SA;
2. FQHCs operated by a federally recognized tribe in the SA; and
3. Urban Indian organizations in the SA.

#### 2.6.35.1 ALL PROVIDERS

If licensure or certification is required to provide a Covered Service, the MCO must ensure, through its Provider Contracts, the Provider is licensed or certified in the State of Texas, except as provided in **Section 2.6.36 of Exhibit H, SOW**.

The Provider Contract must ensure all Providers required to have a license or certification, including HHSC enrolled pharmacies, have a NPI in accordance with 45 C.F.R. pt. 162, subpt. D, and are enrolled with HHSC as Medicaid Providers under that NPI. The MCO must ensure that all non-pharmacy Acute Care Providers have a TPI number.

The MCO is prohibited from employing, contracting with, or entering into a Provider Contract with Providers whose license or certification is expired or cancelled or who are excluded, suspended, or terminated from participation in the Texas Medicaid and CHIP programs. The MCO must reconcile its list of credentialed Providers to the master Provider file as often as the HHSC or its designee makes it available.

#### 2.6.35.2 PROVIDER CONTRACT REQUIREMENTS

The MCO's Provider Contracts must be in writing, must be in compliance with applicable federal and State laws and regulations, and must include the minimum requirements specified in Chapter 8 of Exhibit B, UMCM. The Provider Contract must require the Provider to be credentialed, and the Provider and MCO must both sign the contract. The MCO must provide each Provider with the Provider's copy of the executed contract within 45 Days of execution.

The MCO is prohibited from requiring a Provider or Provider group to enter into an exclusive contracting arrangement with the MCO as a condition for participation in its Network.

The MCO must resubmit the model Provider Contracts to HHSC any time it makes modifications to such agreements. HHSC retains the right to reject or require changes to any Provider Contract that does not comply with Program requirements or the STAR Health Contract.

#### 2.6.35.3 INPATIENT HOSPITAL AND MEDICAL SERVICES

The MCO must ensure, through Provider Contracts, that Acute Care Hospitals and Special Hospitals in the Network are available and accessible 24 hours per Day, 7 Days per week to provide Covered Services to Members throughout the SA.

In addition, the MCO must have Hospitals in Network to serve Members whose severity of substance use withdrawal, comorbid medical conditions, or comorbid psychiatric conditions requires a Hospital level of care for withdrawal management.

### 2.6.35.4 ANY WILLING PROVIDER

The MCO must enter into a Provider Contract with any willing provider listed below and operating in the State of Texas or serving a Member of any STAR Health Target Populations, who meets the MCO's Credentialing requirements and agrees to the Provider Contract rates and terms:

1. State Hospitals;
2. Hospitals receiving funds as a Disproportionate Share Hospital;
3. Pharmacy providers;
4. Ambulance providers;
5. LMHA or LBHA;
6. Public Health Entity;
7. Optometrists, ophthalmologists, therapeutic optometrists, and institutions of higher education that provide an accredited program for training as a Doctor of Optometry or an optometrist residency or training as an ophthalmologist or an ophthalmologist residency;
8. HHSC-contracted ECI providers;
9. DFPS-contracted family-based services providers and SSCC providers;
10. SUD service providers; and
11. Residential SUD service providers.

### 2.6.35.5 SIGNIFICANT TRADITIONAL PROVIDERS

Upon HHSC's request, the MCO must offer STPs the opportunity to participate in its Network for at least three years from the start of HHSC's request to include STPs. However, the STP must:

1. Agree to accept the MCO's Provider reimbursement rate for the provider type; and
2. Meet the standard Credentialing requirements of the MCO, provided that lack of board certification or accreditation by The Joint Commission is not the sole grounds for exclusion from the Network.

The MCO may terminate a Provider Contract with a STP after demonstrating, to the satisfaction of HHSC, good cause for the termination.

If the MCO has so terminated an STP for cause within the past 12 months, the MCO does not have to extend a contracting opportunity.

### 2.6.35.6 INDIAN HEALTH CARE PROVIDERS

The MCO must demonstrate that a sufficient number of IHCPs are participating in its Network to ensure that Indian Members who are eligible to receive services have timely access to services available from a Network IHCP. The MCO must allow an Indian

Member to designate a Network IHCP as a PCP, as long as that Provider has capacity to provide the services. The MCO must allow an Indian Member to receive Covered Services from an OON IHCP from whom the Indian Member is otherwise eligible to receive such services.

If the MCO cannot ensure timely access to Covered Services because of few or no Network IHCPs, the MCO will be considered as compliant with the Contract in accordance with 42 C.F.R. § 438.14(b)(1) if Indian Members are allowed to access IHCPs out-of-state or if the circumstance is deemed good cause for disenrollment from managed care in accordance with 42 C.F.R. § 438.56(c). The MCO must permit an OON IHCP to refer an Indian Member to a Provider.

The MCO must pay for Covered Services provided by an IHCP to an Indian Member, regardless of whether the IHCP is part of the MCO Network. The MCO must:

1. Pay the IHCP an agreed to, negotiated rate, or in the absence of a negotiated rate, pay a rate not less than the level and amount that would be paid to a Provider that is not an IHCP; and
2. Make payment to all IHCPs in its Network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. §§ 447.45 and 447.46.

If an IHCP is not enrolled in Medicaid as an FQHC and regardless of whether an IHCP is a Network Provider, for services provided to Indian Members, the IHCP must be paid the applicable Encounter rate published annually in the federal register by the Indian Health Service, or, in the absence of a published Encounter rate, the amount the IHCP would be paid if services were provided under the Medicaid state plan in FFS. If an IHCP is enrolled in Medicaid as an FQHC, the IHCP must be reimbursed as described in **Section 2.6.10.7 of this Exhibit H, SOW**.

#### 2.6.35.7 SPECIALIZED SERVICES

If the MCO does not have Provider Contracts with the following providers, the MCO must maintain a written OON reimbursement agreement with the providers listed below:

1. Children's Hospital or Hospital with specialized pediatric services so that these services are available and accessible 24 hours per Day, 7 Days per week to provide Covered Services to Members throughout the State;
2. DSHS designated Level I and Level II trauma centers or Hospitals meeting the equivalent level of trauma care within the State;
3. HHSC-designated transplant centers or centers meeting equivalent levels of care (HHSC utilizes the CMS list for the HHSC-designated transplant centers list, which may be found on the CMS website https://www.cms.gov/); and
4. Hemophilia centers supported by the Centers for Disease Control and Prevention (CDC), which include pharmacy services provided by the centers (a list of these hemophilia centers is maintained by the CDC).

### 2.6.35.8 PHYSICIAN SERVICES

The MCO must contract with a sufficient number of participating physicians and specialists within the State to comply with the access requirements described in **Section 2.6.33 of this Exhibit H, SOW,** and meet Members' needs for all Covered Services. The MCO must ensure all Members are allowed to:

1. Select a Network ophthalmologist or therapeutic optometrist to provide eye Covered Services, other than surgery; and
2. Select, without a PCP referral or PA, eye Covered Services from a Network specialist who is an ophthalmologist or therapeutic optometrist for non-surgical services.

The MCO must ensure that an adequate number of physicians have admitting privileges at one or more participating Acute Care Hospitals in the Network to ensure that necessary admissions are made.

There must always be at least one Network PCP with admitting privileges available and accessible 24 hours per Day, 7 Days per week for each Acute Care Hospital in the Network. The MCO must require that all physicians who admit to Hospitals maintain Hospital access for their Members through appropriate Call Coverage.

### 2.6.35.9 URGENT CARE CLINIC SERVICES

The MCO must ensure urgent care clinics, including multi-specialty clinics serving in this capacity, are included within the Network.

### 2.6.35.10 PHARMACY PROVIDER SERVICES

The MCO must have a retail pharmacy Network and have the option to implement an additional Network for specialty pharmacy services. Except for selective arrangements for drugs on the HHSC Specialty Drug List, the MCO must not have preferred pharmacy or selective pharmacy Networks. The MCO must allow pharmacies in the retail pharmacy Network to dispense any drug listed on the VDP formulary, with the exception of drugs listed on the HHSC Specialty Drug List. The MCO may limit the dispensing of drugs on the HHSC Specialty Drug List to pharmacies enrolled in the MCO's specialty pharmacy Network.

The MCO must ensure that all pharmacy Network Providers meet all requirements under 1 Tex. Admin. Code pt. 15, ch. 353, subch. J, § 353.909.

The MCO must enter into a Provider Contract with any willing pharmacy provider that meets the MCO's Credentialing requirements and agrees to the MCO's contract rates and terms for participation in the MCO's retail pharmacy Network.

The MCO may also enter into selective contracts for drugs listed on the HHSC Specialty Drug List (published on the Medicaid Vendor Drug Program website in accordance with 1 Tex. Admin. Code pt. 15, ch. 354, subch. F, div. 3, § 354.1853) with one or more pharmacy providers, but any selective arrangement must comply with Tex. Gov't Code §

533.005(a)(23)(G) and 1 Tex. Admin. Code pt. 15, ch. 353, subch. J, § 353.905(e) and ch. 370, subch. H, § 370.701.

### 2.6.35.11 Diagnostic Imaging Services

The MCO must ensure diagnostic imaging services are available and accessible to all Members in the SA in accordance with the access standards in **Section 2.6.33 of this Exhibit H, SOW.** The MCO must ensure diagnostic imaging procedures that require the injection or ingestion of radiopaque chemicals are performed only under the direction of physicians qualified to perform those procedures.

### 2.6.35.12 Community-Based Service Providers

The MCO must ensure that all Members have access to at least two Providers of each category of Community-Based Services. If the MCO determines it is unable to provide Member access to more than one Provider of Community-Based Services, the MCO must submit and receive an exception as described in **Section 2.6.33.3 of this Exhibit H, SOW**.

### 2.6.35.13 Home Health Services and Durable Medical Equipment and Supplies

The MCO must have a sufficient number of contracts with home health Providers to ensure all Members have access to a choice of Providers for home health Covered Services. The MCO must ensure delivery of DME and supplies occur within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but in no event to exceed five Business Days after receipt of the request.

### 2.6.35.14 Prescribed Pediatric Extended Care Centers

The MCO must contract with qualified PPECCs within the SA, if available. Qualified PPECCs include those with a temporary, initial, or renewal license.

### 2.6.35.15 Primary Care Providers

The MCO must provide Medical Home services for Members through PCPs or specialty care Providers. The MCO must promote, monitor, document, and ensure that PCPs and specialty care Providers comply with the use of the Medical Home Services Model.

The MCO, through Provider Contracts, must ensure that Medical Homes deliver BH and physical health services in a manner that supports integrated care. Ideally, integration of care means the BH Provider is seeing the Member in tandem with the PCP. The MCO must regularly measure Member BH improvement using psychometrically-sound instruments.

As a Medical Home, the PCP works with Members, Medical Consenters, Caregivers, Providers, Service Coordinators, DFPS Staff, SSCC staff, and other state and non-state entities to assure that all the Member's medical and BH needs are met. This includes

screening and assessment, identification, and referral to Covered Services, and assessment and coordination of non-Covered Services that impact the Member's health.

Specialists who serve as PCPs are encouraged, but not required, to be THSteps providers. The MCO must contractually require PCPs to upload forms and documents related to the Member's THSteps checkup to the Health Passport, as well as complete the THSteps checkup steps and bill appropriately. The MCO must require through contract provisions that PCPs comply with the periodicity requirements for children and young adults.

The MCO's PCP Network may include Providers from any of the following practice areas:

1. General practice;
2. Family practice;
3. Internal medicine;
4. Pediatrics;
5. OB/GYN;
6. APRNs and physician assistants, when APRNs and physician assistants are practicing under the supervision of a physician who also qualifies as a PCP under the Contract, even if the supervising physician is not in the MCO's Network;
7. FQHCs, RHCs, and similar community clinics; and
8. Specialist physicians who are willing to provide a Medical Home to selected Members with special needs and conditions.

The MCO must treat APRNs and physician assistants in the same manner as other Network PCPs with regard to:

1. Selection and assignment as PCPs,
2. Inclusion as PCPs in the MCO's Network, and
3. Inclusion as a PCP in any Provider directory maintained by the MCO.

A pediatrician is not considered an age-appropriate choice for a Member aged 18 and over, unless a specific condition or situation warrants it. An internist or other Provider who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member birth through age 17, unless a specific condition or situation warrants it.

An internist or other Provider who provides primary care to adults and children may be a PCP for children if:

1. The Provider assumes all MCO PCP responsibilities for such child Members in the specific age range from birth through age 18;
2. The Provider has a history of practicing as a PCP for the specified age range, as evidenced by the Provider's primary care practice, including an established Member population within the specified age range; and
3. The Provider has admitting privileges to a local Children's Hospital or a local Hospital that includes admissions to pediatric units.

The MCO must allow a PCP or specialist physician providing PCP services the ability to choose to use an interdisciplinary team approach to managing a Member's care. The PCP and other Providers that agree to function as an interdisciplinary team would constitute a PCP Team. If requested by the PCP Team, the MCO must assign a Service Coordinator to assist the PCP Team. The PCP Team must include the Medical Consenter, and, if

appropriate, a young adult Member. If requested by the Member's Medical Consenter, the Member's Caregiver may be included in the PCP Team. The PCP Team may also include the Member's DFPS caseworker and SSCC staff.

The PCP Team must:

1. Develop specialty care and support service recommendations to be incorporated into the Member's ISP, including evaluation, and coordination of prescriptions ordered by the PCP Team and other Providers;
2. Participate in Hospital Discharge planning;
3. Participate in pre-admission Hospital planning for non-emergency hospitalizations; and
4. Provide information to the Medical Consenter, Caregiver, DFPS caseworker, SSCC staff, and (if applicable) the young adult Member concerning the specialty care recommendations.

The PCP for a Member with Disabilities, MSHCN, or a Member with Chronic or Complex Conditions may be a specialist physician who agrees to provide PCP services to the Member. The Provider Contract must ensure that the specialist physician agrees to perform all PCP duties required in the Contract and that PCP duties are within the scope of the specialist's license. The Provider Contract must ensure that any Member or Medical Consenter may initiate the request through the MCO for a specialist to serve as a PCP for Members with Disabilities, MSHCN, or Chronic or Complex Conditions. The MCO must process such requests in accordance with 28 Tex. Admin. Code pt. 1, ch. 11, subch. J. Specialists may limit the number of Members for which they will serve as a PCP.

The Provider Contract must ensure PCPs either have admitting privileges at a Network Hospital or make referral arrangements with a Provider who has admitting privileges to a Network Hospital. The MCO must ensure Members have a choice of PCPs with admitting privileges who are available and accessible 24 hours per Day, 7 Days per week, for each Acute Care Hospital in the Network.

The MCO must require, through its Provider Contract, that PCPs are accessible to Members 24 hours a Day, 7 Days a week. The MCO must include, in its Network, sites that offer primary care services during evening and weekend hours.

The MCO must require PCPs, through contract provisions, to assess the medical and BH needs of Members for referral to specialty care Providers, and to provide referrals as needed. The MCO must allow Members and Medical Consenters to access BH treatment without prior approval from the PCP. PCPs must coordinate Members' care with specialty care Providers after referral. The MCO must make best efforts to ensure that PCPs are capable of appropriately assessing Member needs for referrals and that the PCP is making such referrals. Best efforts must include, but are not limited to, Provider education activities centered on TIC, child welfare, and review of Provider referral patterns.

The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours:

Acceptable non-business-hours coverage includes all of the following:

1. The office telephone is answered during non-business hours by an answering service, which meets the language requirements of each of the Prevalent Languages and can contact the PCP or another designated medical practitioner, who returns the call within 30 minutes;
2. The office telephone is answered during non-business hours by a recording in the language of each of the Prevalent Languages, directing the Member to call another number to reach the PCP or another Provider designated by the PCP and who will answer the Members call. Another recording is not acceptable; or
3. The office telephone is transferred during non-business hours to another location where an individual answers the telephone and contacts the PCP or another Provider who returns the call within 30 minutes.

Unacceptable non-business hours coverage:

1. The office telephone is only answered during office hours;
2. The office telephone is answered during non-business hours by a recording that tells Members to leave a message;
3. The office telephone is answered during non-business hours by a recording that directs Member to go to an ER for any services needed; and
4. Returning non-business hours calls outside of 30 minutes.

#### 2.6.35.16 PRIMARY CARE PROVIDER AND SPECIALIST NOTIFICATIONS

The MCO must furnish each PCP with a current list of enrolled Members assigned to that Provider no later than five Business Days after the MCO receives the Enrollment File from the HHSC EB each month. The MCO may offer and provide such enrollment information in alternative formats when such format is acceptable to the PCP. The MCO must also notify a Member's PCP, in accordance with Tex. Fam. Code § 264.018, within two Business Days of receiving notification from DFPS that a placement change has occurred.

The MCO, in accordance with Tex. Gov't Code § 533.0056, must ensure the Continuity of Care following a placement change by notifying each specialty Provider treating the Member that a placement change has occurred. The MCO is responsible for coordinating the transition of care from the previous treating PCP and specialists to the new treating PCP and specialists, if applicable.

#### 2.6.35.17 OUTPATIENT MENTAL HEALTH SERVICE PROVIDERS

The MCO must ensure that all Members have access to outpatient mental health service Providers in the Network including master's and doctorate-level trained practitioners practicing independently or at clinics/group practices, or at outpatient Hospital departments as detailed in the **Chapter 5.28 of Exhibit B, UMCM**. The outpatient mental health Service Provider should be the appropriate Provider type to meet each individual Member's needs, including outpatient mental health service Provider who serve children and adolescents. The MCO must ensure Member access to a choice of outpatient mental health Providers who are trained and certified in the administration of the Texas CANS 2.0 assessment.

### 2.6.35.18 MENTAL HEALTH REHABILITATIVE AND TARGETED CASE MANAGEMENT SERVICE PROVIDERS

The MCO must ensure Members have access to Mental Health Rehabilitative Services and Mental Health TCM services provided by Comprehensive Provider Agencies, including LMHAs and non-LMHA Providers.

### 2.6.35.19 OUTPATIENT SUBSTANCE USE DISORDER SERVICE PROVIDERS

The MCO must make reasonable efforts to contract with outpatient SUD service providers. The MCO's Network for outpatient SUD service Providers must include chemical dependency treatment facilities, including facilities licensed by HHSC to serve adolescents. The Network must also include the following for Medication Assisted Treatment:

1. Licensed narcotic (opioid) treatment programs;
2. Chemical dependency treatment facilities licensed by HHSC; and
3. Appropriately trained physicians and other qualified prescribers as specified in the TMPPM.

The MCO must include STPs of this benefit in its Network and provide such STPs with expedited Credentialing. The MCO must enter into Provider Contracts with any willing STP of these benefits that meets the Medicaid enrollment requirements, MCO Credentialing requirements, and agrees to the MCO's contract terms and rates. For purposes of this section, STPs are providers who meet the Medicaid enrollment requirements and have a contract with HHSC to receive funding for treatment under the Federal Substance Abuse Prevention and Treatment block grant. The STP requirements described herein apply to the SA, and unlike other STP requirements are not limited to the first three years of operation.

### 2.6.35.20 RESIDENTIAL SUBSTANCE USE DISORDER SERVICE PROVIDERS

The MCO must make reasonable effort to contract with residential SUD service providers. The MCO's Network for residential outpatient SUD service Providers must include chemical dependency treatment facilities licensed by HHSC to provide residential services, including facilities licensed by HHSC to serve adolescents in a residential setting. The MCO must ensure access to Providers who offer residential treatment services and Providers who offer residential withdrawal management services.

The MCO must include STPs of this benefit in its Network and provide such STPs with expedited Credentialing. The MCO must enter into Provider Contracts with any willing STP of these benefits that meets the Medicaid enrollment requirements, MCO Credentialing requirements, and agrees to the MCO's contract terms and rates. For purposes of this section, STPs are providers who meet the Medicaid enrollment requirements and have a contract with HHSC to receive funding for treatment under the Federal Substance Abuse Prevention and Treatment block grant. The STP requirements

described herein apply to the SA, and unlike other STP requirements are not limited to the first three years of operation.

### 2.6.36 Out-of-State Providers

The MCO must ensure that the out of state providers it chooses to enroll in its Network are enrolled as a Medicaid provider with HHSC.

The MCO may enroll out-of-state providers in its Network in accordance with 1 Tex. Admin. Code pt. 15, ch. 352, § 352.17 and pharmacy providers in accordance with 1 Tex. Admin. Code pt. 15, ch. 353, subch. J, § 353.909. The MCO may enroll out-of-state diagnostic laboratories in its Network under the circumstances described in Tex. Gov't Code § 531.066.

### 2.6.37 Value-added Services

The MCO may offer additional services for coverage which are VAS. VAS may be services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles, health literacy, service access, and improved health outcomes among Members. These may include family or Community-Based Services. VAS must not be Covered Services or Non-capitated Services. Best practice approaches to delivering Covered Services are not considered VAS.

If the MCO offers any VAS, then MCO must offer VAS to all Members for whom the services are appropriate. VAS that are approved by HHSC during the contracting process will be included in this SOW.

Any VAS that the MCO elects to provide must be provided at no additional cost to HHSC. The MCO must not report the costs of VAS as allowable costs on the FSR for either medical or administrative expenses and are not factored into the rate-setting process. The MCO must not pass on the cost of the VAS to Members or providers. HHSC may collect data on VAS costs for informational purposes.

The MCO may offer discounts on non-Covered Services to Members as VAS, provided that the MCO complies with applicable Texas Insurance Code provisions. The MCO must ensure that Providers do not charge Members for any other cost-sharing for a VAS, including copayments or deductibles.

The MCO must specify the conditions and parameters regarding the delivery of each VAS and must clearly describe any limitations specific to each VAS in the MCO's Member handbook. The MCO must also include a disclaimer in its Marketing Materials and Provider directory indicating that restrictions and limitations may apply for each VAS.

The MCO will be given the opportunity to add, enhance, delete, or reduce VAS once per SFY with changes to be effective September 1. HHSC may, but is not required to, allow additional modifications to VAS if Covered Services are amended by HHSC during a SFY. The MCO must submit requests to add, enhance, delete, or reduce a VAS to HHSC by April 1 of each SFY to be effective September 1of that SFY. The MCO must use HHSC's

template for submitting proposed VAS found in **Chapter 4 of Exhibit B, UMCM**. Once approved by HHSC, this document will be incorporated by reference into the Contract.

Once requests are approved, the MCO cannot reduce or delete any VAS until September 1 of the following SFY. When the MCO requests deletion or reduction of a VAS, the MCO must include information regarding the processes by which the MCO will notify Members, Medical Consenters, and DFPS Staff and revise Member Materials and Marketing Materials in accordance with **Chapter 4 of Exhibit B, UMCM.**

The MCO must not include a VAS in any Member Materials until the MCO obtains HHSC's approval, as outlined in **Section 2.6.15.1 of this Exhibit H, SOW**.

### 2.6.38 CASE-BY-CASE SERVICES

The MCO may offer additional benefits that are outside the Capitation Rate and SOW to individual Members on a case-by-case basis, based on medical necessity, functional necessity, cost-effectiveness, the wishes of the Member or Medical Consenter, and the potential for improved health status of the Member. The MCO does not have to receive HHSC approval for Case-by-case Services and does not have to provide such services to all MCO Members. The MCO must maintain documentation of each authorized Case-by-case Service provided to each Member. Case-by-case Services authorized by the MCO are not considered in the rate-setting process; are provided by the MCO at no cost to HHSC, the Member, or provider; and must be appropriately reported in the MCO's FSR as may be provided by HHSC, but not within medical expenses or administrative expenses.

### 2.6.39 COVERED COMMUNITY-BASED LONG-TERM SERVICES AND SUPPORTS

Community-Based Services include home and community-based LTSS for MDCP Members and home health Covered Services, including PCS and CFC, for all Members. The MCO must ensure that Members needing community-based LTSS are identified and that services are referred and authorized in a timely manner. The MCO must ensure that Providers of Community-Based Services are appropriately licensed to deliver the service they provide. MDCP services must be provided in a manner consistent with CMS home and community-based settings requirements. See 42 C.F.R. § 441.301(c)(4).

The MCO must provide Community-Based Services when necessary for preventative reasons to avoid more expensive hospitalizations, ER visits, or institutionalizations. The MCO must make Community-Based Services available to Members to assure maintenance of the highest level of functioning possible in the least restrictive setting. The MCO must consider the Member's need for Community-Based Services to assist with ADLs and IADLs as important as needs related to a medical condition.

The MCO must authorize Covered Services to support Members with ongoing or Chronic Conditions or Members who require these services in a manner that reflects the Member's ongoing need for such services and supports. The MCO must ensure Members receiving community-based LTSS have access to the benefits of community living to achieve Person-Centered outcomes and live and work in the setting of their choice.

#### 2.6.39.1 ATTENDANT CARE BILLING

The MCO must require agencies that provide attendant care to conduct unannounced home visits to validate services are being rendered and billed correctly. The MCO must maintain written documentation of these requirements and make available upon request by HHSC.

### 2.6.40 COMMUNITY FIRST CHOICE SERVICES

CFC provides community-based LTSS as an alternative to living in an institution to eligible Members with physical or cognitive Disabilities, SPMI, or SED. The MCO must make the array of services allowable under CFC available to Members who meet eligibility requirements. The MCO must provide CFC services in accordance with 1 Tex. Admin. Code pt. 15, ch. 354, subch. A, div. 27.

Members with physical Disabilities must meet the medical necessity level of care requirements for nursing facility care to be eligible for CFC services. The MCO must complete the SAI, as amended or modified, and submit the form to HHSC or its designee. The MCO must also complete the assessment documentation and prepare a CFC Service Plan identifying the needed CFC services and include it in the Member's ISP and in the Health Passport. The MCO must complete these activities within 45 Business Days of the identified need for or request for services, or within an alternate timeframe as determined solely by HHSC. The MCO must reassess the Member annually, at each placement change, or if the Member experiences a Change in Condition. The MCO must complete and submit the re-assessment electronically via HHSC or its designee's portal in the specified format no later than 45 Days prior to the annual CFC Service Plan expiration date.

Members with cognitive Disabilities must meet the institutional level of care for an ICF/IID or related conditions to be eligible for CFC services. The MCO must review and consider the assessment and Service Plan completed by the Local Intellectual and Developmental Disability Authority (LIDDA) when determining eligibility and finalizing the Member's ISP. The MCO must also include the CFC Service Plan in the Member's ISP and in the Health Passport. The MCO must complete these activities within 45 Days of the identified need for or request for services, or within an alternate timeframe as determined solely by HHSC.

Members with SPMI or SED must meet an Institutions for Mental Disease (IMD) level of care, which is determined by receiving a Texas CANS 2.0 or ANSA with a level of care 4, to be eligible for CFC services.

The MCO must coordinate with a provider of Mental Health Rehabilitative Services and Mental Health TCM to determine whether the Member meets an IMD level of care. The MCO must prepare a CFC Service Plan identifying the needed CFC services and include the CFS Service Plan in the Member's ISP and in the Health Passport. The MCO must complete these activities within 45 Days of the identified need for or request for services, or within an alternate timeframe as determined solely by HHSC. The MCO must reassess the Member annually, at each placement change, if the Member experiences a Change in Condition, or at the request of the Member.

The MCO must notify Members and Medical Consenters of the eligibility determination. If the Member is eligible for CFC services, the MCO will notify the Member and Medical Consenter of the effective date of eligibility. If the Member is not eligible for CFC services, the MCO will provide the Member and Medical Consenter information on the right to appeal the determination, including access to HHSC's State Fair Hearing process as described in **Section 2.6.31 of this Exhibit H, SOW**. The MCO must prepare any requested documentation regarding its assessments and CFC Service Plans and attend the State Fair Hearing as referenced in 42 C.F.R. pt. 431, subpt. E, Fair Hearings for Applicants and Beneficiaries.

As part of any CFC service assessment, the MCO must inform the Member and Medical Consenter about service delivery options, as outlined in **Section 2.6.42 of this Exhibit H, SOW**.

The MCO must contract with Providers of CFC services to ensure access to these services for all qualified Members. The MCO must ensure CFC services are provided in manner consistent with CMS home and community-based settings requirements. See 42 C.F.R.§ 441.301(c)(4). At a minimum, the MCO must ensure these Providers meet all of the following State licensure and certification requirements for providing the services. CFC Providers, with the exception of emergency response services Providers, must be licensed by HHSC as a HCSSA or certified as a HCS or Texas Home Living agency. See more information about CFC in **Exhibit E, TMPPM.**

### 2.6.41 PERSONAL CARE SERVICES

PCS provides Medically Necessary assistance with ADLs and IADLs to eligible Members with physical, cognitive or BH Disabilities, when the ADLs or IADLs are related to the Disability or Chronic Condition. The MCO must make the array of services allowable under PCS available to Members who meet eligibility requirements. The MCO must provide PCS services in accordance with 1 Tex. Admin. Code pt. 15, ch. 363, subch. F.

The MCO must complete the SAI and prepare a PCS Service Plan identifying the needed PCS and include it in the Member's ISP and in the Health Passport. The MCO must complete these activities within 30 Business Days of the identified need for or request for services, or within an alternate timeframe as determined solely by HHSC. The MCO must reassess the Members annually, at each placement change, or if the Member experiences a Change in Condition. The MCO must complete and submit the re-assessment electronically via HHSC or its designee’s 's portal in the specified format no later than 45 Business Days prior to the PCS Service Plan expiration date.

The MCO must notify Members and Medical Consenters of their eligibility determination. If the Member is eligible for PCS, the MCO will notify the Member and Medical Consenter of the effective date of eligibility. If the Member is not eligible for PCS, the MCO will provide the Member and Medical Consenter information on the right to appeal the determination and HHSC's State Fair Hearing process as described in **Section 2.6.31 of this Exhibit H, SOW**. The MCO must prepare and produce any requested documentation regarding its assessments and PCS Service Plans and attend the State Fair Hearing as referenced in 42 C.F.R. pt. 431, subpt. E, Fair Hearings for Applicants and Beneficiaries.

As part of any PCS service assessment, the MCO must inform the Member and Medical Consenter about service delivery options, as outlined in **Section 2.6.42 of this Exhibit H, SOW**.

The MCO must contract with Providers of PCS to ensure access to these services for all qualified Members. At a minimum, the MCO must ensure these Providers meet all of the state licensure and certification requirements for providing the services. The MCO must ensure, through Provider Contracts, that an organization that employs attendants who provide PCS must meet the licensing standards set out in 40 Tex. Admin. Code pt. 1, ch. 41 and 26 Tex. Admin. Code pt. 1, ch. 558.

The MCO must ensure an organization serving as a FMSA, providing Financial Management Services and other employer support services to a Member receiving PCS through the CDS option, meets the FMSA contracting requirements specified in 40 Tex. Admin. Code pt. 1, chs. 41 and 49, relating to CDS option and contracting for community services.

The MCO must allow PCS to be provided in an individual or group setting. See information about PCS in **Exhibit E, TMPPM**.

### 2.6.42 SERVICE DELIVERY OPTIONS

Three options are available to Members desiring to self-direct the delivery of PCS, attendant care services, Habilitation in CFC, MDCP in-home or out-of-home Respite, Supported Employment, and Employment Assistance. The three options, which are set forth in more detail below, are:

1. CDS option;
2. Service responsibility option; and
3. Agency option.

The MCO must provide information, including the risks and benefits about the three options to all eligible Members and their Caregivers and Medical Consenters. The MCO must also provide orientation in the option selected to the Member, Caregiver, and Medical Consenter. The MCO must provide information regarding all available options:

1. At initial assessment;
2. At annual reassessment or placement change;
3. At any time when a Member requests the information; and
4. In the Member handbook.

#### 2.6.42.1 CONSUMER DIRECTED SERVICES OPTION

CDS is a service delivery option in which a Member or the Member’s Medical Consenter employs and retains service providers and directs the delivery of PCS, personal assistance services and/or Habilitation in CFC, MDCP Respite, Supported Employment, Employment Assistance Services, flexible family support services, Adaptive Aids, and Minor Home Modifications.

In the CDS option, the Member or Medical Consenter is the employer of record and retains control over the hiring, management, and termination of an individual providing these services.

The Member or Medical Consenter is responsible for assuring that the employee meets the qualifications and requirements for these services. The Member or Medical Consenter is required to select an FMSA to handle functions including processing payroll, withholding taxes, and filing tax-related reports to the IRS and the Texas Workforce Commission for these services.

The FMSA is also responsible for providing training to the Member or Medical Consenter on being an employer, verifying provider qualifications (including criminal history and registry checks), and approving the budget. The FMSA must be qualified to perform these services by completing the mandatory FMSA enrollment training and becoming part of the MCO's Network.

The MCO may not negotiate the "Consumer Payment Rates" that are used to determine the Member's budget and Service Plan for services delivered through the CDS option. The MCO must calculate the Member's budget and Service Plan using the "Consumer Payment Rates for Determining the Consumer's Budget" proxy rates adopted by HHSC and multiply the rate by the number of units authorized during the budget year.

#### 2.6.42.2 Service Responsibility Option

In the service responsibility option, the Member or their Medical Consenter is actively involved in choosing his/her personal attendant or Respite Provider but is not the employer of record. The HCSSA in the MCO's Network is the employer of record for the personal attendant employee and Respite Provider. The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of these services.

In this model, the Member or Medical Consenter selects the personal attendant or Respite Provider from the HCSSA's employees. The personal attendant or Respite Provider's schedule is set up based on the Member's or Medical Consenter's input, and the Member or Medical Consenter manages the PCS, attendant care services and Habilitation in CFC, MDCP in-home or out-of-home Respite, Supported Employment, and Employment Assistance Services. The Member or Medical Consenter retains the right to supervise and train the personal attendant. The Member or Medical Consenter may request a different personal attendant, and the HCSSA is expected to honor the request as long as the new attendant is an eligible Provider.

#### 2.6.42.3 Agency Option

In the agency option, the MCO contracts with a HCSSA or a certified home and community-based LTSS or Texas Home Living agency for the delivery of services. The HCSSA is the employer of record for the personal attendant, Respite Provider, or nurse. The HCSSA establishes the payment rate, benefits, and provides all administrative

functions such as payroll, substitute (back-up), and filing tax-related reports for the service Provider.

### 2.6.43 FACILITY BASED CARE

A Member who enters a community-based ICF/IID will remain a Member.

The MCO is not responsible for the cost of services provided in a community-based ICF/IID, maintaining ICFs/IID in its Provider Network, or reimbursing ICFs/IID for Covered Services.

During a Member's stay in a community-based ICF/IID, the MCO must provide Service Coordination as well as any Covered Services that occur outside of the ICF/IID. Members residing in a community-based ICF/IID must receive at least level two Service Coordination.

The MCO must also coordinate with the Member, Medical Consenter, and DFPS Staff to identify community-based LTSS and programs that may help the Member return to the community.

### 2.6.44 EARLY CHILDHOOD INTERVENTION

This section provides ECI requirements of the MCO.

#### 2.6.44.1 REFERRALS

The MCO must ensure Providers are educated regarding the federal laws and regulations on child find and referral procedures, including 20 U.S.C. § 1435 (a)(5) and 34 C.F.R. § 303.303. The MCO must require Providers to identify and provide ECI referral information to the Medical Consenter of any Member under the age of three suspected of having a developmental delay or Disability or otherwise meeting eligibility criteria for ECI services in accordance with 26 Tex. Admin. Code pt. 1, ch. 350 within seven Days from the Day the Provider identifies the Member.

The MCO must permit Members to self-refer to local ECI Providers without requiring a referral from the Member's PCP. The MCO's policies and procedures, including its Provider manual and Member handbook, must include written policies and procedures for allowing a self-referral to ECI providers. The MCO must use written educational materials developed or approved by HHSC ECI for these child find activities.

The MCO must inform the Member's Medical Consenter that ECI participation is voluntary. The MCO is required to provide Covered Services to a Member regardless of whether the Member's Medical Consenter chooses to participate in ECI.

#### 2.6.44.2 ELIGIBILITY

The local ECI program will determine eligibility for ECI services using the criteria in 26 Tex. Admin. Code pt. 1, ch. 350, subch. H.

The MCO must cover medical diagnostic procedures required by ECI to determine eligibility, including discipline specific evaluations, so that ECI can meet the 45-Day timeline established in 34 C.F.R. § 303.342(a). The MCO must require compliance with these requirements through Provider Contract provisions. The MCO must not withhold authorization for the provision of such medical diagnostic procedures. Further, the MCO must promptly provide relevant medical records to the ECI Provider upon request. The MCO must ensure compliance with HIPAA in the sharing of any Member medical records with the ECI Provider.

#### 2.6.44.3 PROVIDERS

The MCO must contract with all qualified ECI Providers to provide ECI Covered Services to Members younger than 3 who are eligible for ECI services. The MCO must allow an OON provider to provide ECI Covered Services if a Provider is not available to provide the Covered Services in the amount, duration, scope, and service setting as required by the IFSP.

#### 2.6.44.4 INDIVIDUAL FAMILY SERVICE PLAN

The IFSP identifies the Member's present level of development based on assessment, describes the services to be provided to the Member to meet the needs of the Member and the family, and identifies the person or persons responsible for each service required by the plan. The IFSP is developed by an interdisciplinary team that includes the Member's Medical Consenter, Caregivers, DFPS Staff, ECI service coordinator, ECI professionals directly involved in the eligibility determination and Member assessment, ECI Providers, other family members, advocates, or other persons as requested by the Member's Medical Consenter or DFPS Staff. If the Member's Medical Consenter provides written consent, the Member's PCP or MCO staff may be included in IFSP meetings.

The IFSP is a contract between the ECI provider and Member's Medical Consenter. The Member's Medical Consenter signs the IFSP to consent to receive the services established by the IFSP. The IFSP contains information specific to the Member, as well as information related to family needs and concerns. If the Medical Consenter provides written consent, the ECI program may share a copy of IFSP sections relevant only to the Member with the MCO and PCP to enhance coordination of the plan of care. When shared, these sections must be included in the Member's ISP and the Health Passport.

Members in ECI will receive Level 2 Service Coordination as described in **Section 2.6.47.2 of this Exhibit H, SOW**. The MCO must offer Service Coordination and develop an ISP for these Members.

#### 2.6.44.5 COVERED SERVICES AND REIMBURSEMENT

The ECI interdisciplinary team, including a LPHA, as defined in 26 Tex. Admin. Code pt. 1, ch. 350, subch. C, § 350.312, practicing within the scope of their licenses, determines medical necessity for ECI Covered Services established by the IFSP. As the IFSP serves as authorization for program-provided services, the MCO must require, through contract

provisions with the Provider, that all Medically Necessary program-provided services contained in the Member's IFSP are provided to the Member in the amount, duration, scope and service setting established by the IFSP. For purposes of this section "program-provided services" refers to services that are provided by the local ECI provider.

The MCO cannot create unnecessary barriers for the Member to obtain IFSP program-provided services, including requiring PA for the ECI assessment or additional authorization for services or establishing insufficient authorization periods for prior authorized services.

The MCO must, through its Provider Contract, require ECI Providers to submit claims to the MCO for all ECI program-provided services included in the IFSP. The MCO must pay claims for all ECI program-provided Covered Services submitted by ECI Providers in the amount, duration, and scope and service setting established by the IFSP. ECI program-provided Mental Health TCM services and ECI specialized skills training are Non-capitated Services, as described in **Section 2.6.60.7 of this Exhibit H, SOW**.

### 2.6.45 MEMBERS WITH SPECIAL HEALTHCARE NEEDS

All Members are considered MSHCN.

The MCO must provide access to PCPs and specialty care Providers with demonstrated experience serving MSHCN, including SED or SPMI, and Members who have experienced trauma, abuse, or neglect. The MCO must ensure that the Providers are board-qualified or board-eligible in their specialty and meet MCO Credentialing requirements. The MCO may request exceptions from HHSC for approval of STPs who are not board-qualified or board-eligible, but who otherwise meet the MCO's Credentialing requirements.

The MCO must also provide access to Network PCPs and specialty care Providers that have demonstrated experience with MSHCN, including SED or SPMI, and who are certified in TIC or TF-CBT in pediatric specialty centers such as Children's Hospitals, teaching Hospitals, tertiary care centers, and in community mental health centers or other venues for treatment of SED or SPMI.

The MCO must have a mechanism in place to allow MSHCN to have direct access to specialists as appropriate for the Members' conditions and identified needs, such as a standing referral to a specialty physician or BH Provider. The MCO must also provide MSHCN with access to non-PCP specialists as PCPs, as required by 28 Tex. Admin. Code pt.1, ch. 11, subch. J, § 11.900 and **Section 2.6.35.14 of this Exhibit H, SOW**.

### 2.6.46 SCREENINGS AND ASSESSMENTS

The MCO is responsible for authorizing, arranging, coordinating, and providing timely all screenings and assessments required by laws, rules, and regulations as amended or modified during the Contract Term, and in accordance with the requirements of the Contract. All screenings and assessments must be used to inform the MCO of the level of Service Coordination each Member requires and to complete the ISP.

The MCO must assist in coordinating and scheduling screenings and assessments. The MCO must have methods to ensure that any required documentation or information needed to perform the screening or assessment is timely gathered and does not impede or delay the authorization or initiation of a Member's services. The MCO may not require any additional information or documentation that has the effect of creating a delay in, or barrier to, the Member receiving timely and appropriate care or has the effect of depriving any Member of access to such care.

Members who meet the criteria for treatment services, outlined in 40 Tex. Admin. Code pt. 19, ch. 700, subch. W, may require expedited screenings or assessments, as determined by DFPS Staff. The MCO must work with DFPS Staff, as appropriate, to schedule the required screening or assessment within three Business Days of notification such screenings or assessments are needed. The MCO must provide the resulting diagnosis and recommendations from the Provider performing the screening or assessment to DFPS staff within two Business Days of MCO's receipt of the results. Expedited assessments may include the Texas CANS 2.0, psychosocial, psychological, psychiatric, neurological, physical, or any other assessment that is a Covered Service and assists DFPS or its agent in identifying needed treatment services for a Member.

#### 2.6.46.1 Initial Telephonic Member Screening

The purpose of the initial telephonic Member screening is to gather all relevant health status information from the Member or Medical Consenter upon enrollment, to notify the Member and Medical Consenter about the availability of Service Coordination, and to provide the Medical Consenter with any additional education related to Program services and supports.

The MCO must conduct an initial telephonic Member screening for all new Members as soon as possible, but no later than within 10 Days of receiving Member on DNF, unless notified by the Member, Medical Consenter, or DFPS Staff of a more urgent need. The MCO must ensure that the initial telephonic Member screening includes HHSC-approved questions designed to determine a Member's general healthcare needs.

The MCO must use the results of the initial telephonic Member screening together with claims data to help the MCO prioritize which Members require the most immediate attention and to ensure correct assessments are performed and critical services are in place for those Members immediately upon enrollment.

The MCO must also use this information to determine which Members should be assessed using the SAI and which level of Service Coordination is appropriate for the Member. If the Member has historical or potential nursing needs that would necessitate assignment of a Service Coordinator that is an RN or NP, the MCO must ensure the SAI is conducted by an RN or NP.

The MCO must make at least three efforts to contact new Members or Medical Consenters telephonically. If an MCO is unable to reach a Member or Medical Consenter by telephone, the MCO must mail written correspondence to the Member and Medical Consenter explaining the need to contact the MCO as soon as possible. The MCO must also make at

least three efforts to contact the DFPS caseworker and any other Medical Consenters listed in the Member's file. The MCO must document in the Member's case file all attempts to contact or locate a Member, Medical Consenter, or DFPS Caseworker.

The MCO must encourage Member or Medical Consenter participation in the telephonic screening and explain that refusal to participate may impair the MCO's ability to identify and provide necessary Covered Services. If the Member or Medical Consenter declines to participate in the initial telephonic Member screening, the MCO must document this in the Member's case file.

The MCO will not be required to meet timelines and requirements for development of the ISP for Members with a documented refusal to participate, or documentation of the MCO's inability to reach the Member. However, the MCO must make every effort to work directly with a Member's PCP to obtain enough information to develop an ISP. The MCO must document unsuccessful efforts. A Member is determined unable to reach when an MCO has completed all required attempts to contact or locate a Member or Medical Consenter, including the DFPS caseworker, but has been unsuccessful.

During these telephonic efforts, or through written materials provided by the MCO to the Member or Medical Consenter, the MCO must:

1. Document in the Member's file the name and contact information of any other individual with whom a Medical Consenter provides permission to discuss the case;
2. Provide information on the purpose and goals of the screening and assessment process;
3. Estimate the timeframe it will take to complete each screening and assessment;
4. Provide information the Member or Medical Consenter should be prepared to discuss as a part of the screening and assessment process including medication information, diagnoses, current services, and general questions and concerns.

During the initial telephonic Member screening, the MCO must:

1. Ensure that the Member and Medical Consenter are aware that Members in Category 1 of the Target Population age three through 17 must receive the Texas CANS 2.0 assessment within 30 Days of entry into conservatorship, and assist the Member or Medical Consenter, as applicable, in the timely scheduling of the assessment;
2. Ensure that the Member and Medical Consenter are aware that all Members through age 20 must receive a THSteps medical checkup within 30 Days of enrollment, unless periodicity requires the checkup sooner; and
3. When the initial telephonic Member screening indicates the Member may qualify for MDCP, CFC, or PCS, assist in scheduling the SAI for further evaluation.

The MCO must complete a new telephonic Member screening each time a Member experiences a placement change, Change in Condition, or upon request of the Medical Consenter or DFPS Staff. If the telephonic screening indicates the need for a change in the Member's level of Service Coordination, the ISP must be updated by the MCO within 30 Days of notification of the change or date of request.

#### 2.6.46.2 Initial Medical Exam

The purpose of the initial medical exam required in Tex. Fam. Code § 264.1076 is to provide a baseline of each Member's physical health, to address any urgent initial health issues and to address the Member's medication regimen.

The MCO must ensure that each Member in Category 1 of the Target Population receives an initial medical exam within three Business Days of entering DFPS conservatorship. This requirement does not apply to Members who are in a Hospital or an ER setting at the time of enrollment. The MCO must not require PA for the initial medical exam within the first 14 Days of the Member entering DFPS conservatorship.

The MCO must ensure that the results of the initial medical exam are used to inform the Member's ISP.

#### 2.6.46.3 Texas Comprehensive Child and Adolescent Needs and Strengths 2.0 Assessment

The Texas CANS 2.0 is a tool used to provide a comprehensive, trauma-informed assessment of each Member's needs and strengths and to assist in treatment planning.

The MCO must ensure that, to comply with Tex. Fam. Code § 266.012, all Members in category 1 of the Target Population age 3 through 17 are assessed by a CANS-certified and licensed clinician using the Texas CANS 2.0 tool within 30 Days of enrollment. The MCO must also ensure that all Members in Category 1 of the Target Population age three and older are assessed using the Texas CANS 2.0 annually. For Members turning age three, the Texas CANS 2.0 must be completed within 30 Days after the Member turns three years of age.

The MCO must ensure that the Texas CANS 2.0 is completed annually and the results of the Texas CANS 2.0 are used to inform the Member's ISP.

The MCO must not require PA for the initial or annual Texas CANS 2.0 but may require PA for annual Texas CANS 2.0 assessments completed early.

The MCO must contractually require Providers administering the Texas CANS 2.0 to:

1. Complete the Texas CANS 2.0 web-based training and receive certification;
2. Maintain certification by completing the web-based training annually prior to the expiration date on the certification;
3. Follow all policies and procedures set forth in the Texas CANS 2.0 manual, https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/local-mental-health-authorities/child-adolescent-needs-strengths-assessment , pertaining to administering the assessment to the Population; and
4. Enter all Members' Texas CANS 2.0 assessment results into the eCANS portal within three Business Days of performing the assessment.

The MCO must establish a process to ensure that the results of the Texas CANS 2.0 assessment tool are communicated to the Member's PCP, PCP Teams, BH Providers, Caregivers, Medical Consenters, and DFPS Staff.

To ensure coordination and tracking of the Texas CANS 2.0 assessment, the MCO must send a weekly report to HHSC and DFPS that contains information as required by HHSC.

#### 2.6.46.4 TEXAS HEALTH STEPS INITIAL CHECKUPS

The MCO must follow all requirements for THSteps medical and dental checkups named in **Sections 2.6.58.1 and 2.6.58.2 of this Exhibit H, SOW,** and in accordance with the appointment accessibility standards set forth in **Section 2.6.33.1 of this Exhibit H, SOW**.

### 2.6.47 SERVICE COORDINATION

Service Coordination provides every Member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using Covered Services and other supports to enhance a Member's well-being, independence, integration in the community, and potential for productivity.

The MCO must ensure that Service Coordination is used to:

1. Provide a holistic evaluation that identifies the Member's individual physical, behavioral, functional, and psychosocial needs and preferences, using the screening and assessment process, and claims and medical history data;
2. Educate and help provide health-related information to the Member, Medical Consenter, and DFPS Staff, and Providers, as appropriate;
3. Facilitate the provision of integrated Covered Services to meet the special preventive, primary Acute Care, Community-Based Services, LTSS, and specialty healthcare needs appropriate for treatment of the individual Member’s condition(s), which includes but is not limited to activities such as the MCO scheduling appointments for their Members and identifying appropriate Providers, when requested;
4. Engage the Member, Medical Consenter, DFPS Staff, Providers, and others in designing an ISP that addresses the Member's needs and preferences and outlines the services that will be provided;
5. Connect the Member to, and coordinate, Covered and non-Covered Services necessary to meet the Member's identified needs; and
6. Monitor to ensure the Member's access to Covered Services, screenings, and assessments, including those required by **Section 2.6.46 of this Exhibit H, SOW,** is timely and appropriate.

The MCO must provide the following to all Members, Medical Consenters, and Caregivers:

1. A description of Service Coordination that effectively communicates its benefits and encourages the Member and Medical Consenter’s participation;

2. A phone number to contact if the Member needs to access Service Coordination or is experiencing problems with Service Coordination and does not have a named Service Coordinator;
3. The name, phone number and electronic method of contact, such as via portal or secure email, of the Member’s named Service Coordinator, if applicable;
4. The minimum number of face-to-face or telephonic contacts the Member will receive every year;
5. Instructions on how to request additional Service Coordination assistance at any time; and
6. Instructions on how to access a Member Advocate to report Complaints about a Service Coordinator.

The MCO must have a systematic process for generating and receiving referrals and sharing confidential medical, treatment, and planning information across Providers.

#### 2.6.47.1 SERVICE COORDINATOR ROLES AND RESPONSIBILITIES

The purpose of a Service Coordinator is to maximize a Member's health, well-being, and independence. Service Coordination must consider and address the Member’s situation as a whole, including his or her medical, behavioral, psychosocial, and educational needs.

The MCO must ensure the Service Coordinator works with the Member’s PCP and specialty Providers to coordinate all Covered Services, Non-capitated Services, and non-Covered Services available in the community and through other sources. To ensure robust coordination between all types of available resources, the Service Coordinator must be familiar with and seek to establish relationships with staff at state and local programs and community organizations, such as those listed below, to make referrals for Members and establish services of any type:

1. Community Resource Coordination Groups (CRCGs);
2. ECI program;
3. Local school districts (special education);
4. HHSC NEMT;
5. DFPS forensic assessment centers;
6. HHSC Health, Developmental, and Independence Services (HDIS) Department Blind Children’s Vocational Discovery and Development program;
7. HHSC HDIS Title V Maternal and Child Health and Children with Special Health Care Needs Programs;
8. Other state and local agencies and programs such as food stamps, the WIC program, and Case Management for Children and Pregnant Women;
9. Staff responsible for overseeing Members' waiver services;
10. SSCC case managers;
11. Health Home coordinators;
12. Civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy, which also work on behalf of the MSHCN population; and
13. DFPS Medical Services Staff.

The MCO must ensure Service Coordinators are responsible for assisting Members, Medical Consenters, Caregivers, and DFPS Staff with:

1. Facilitating access to Covered Services, including scheduling appointments;
2. Expediting the scheduling of screenings and assessments used to determine residential placements as required in **Section 2.6.25 of this Exhibit H, SOW;**
3. Clarifying information regarding navigating the PA, Complaints, appeals, and State Fair Hearings processes;
4. Ensuring Providers timely respond to requests for medical information or supporting documentation needed for court hearings, PA, or to populate Health Passport records;
5. Facilitating the inclusion of updated information in Member's Health Passport from healthcare providers demonstrating adherence to services listed on the ISP.
6. Coordinating the sharing of health information between Providers, specialists, and other programs, such as ECI;
7. Identification of Members suspected of having an SED/SPMI and arranging for a Texas CANS 2.0 assessment by a comprehensive Provider;
8. Provision of information as requested by DFPS Staff to facilitate development of the DFPS plan of care, preparation for court hearings, and participation upon request in DFPS Family Group Conferences (FGCs);
9. Encouraging BH Providers to use EBPs and promising practices and confirming that a Member's BH Providers and PCPs are sharing information as required in **Section 2.6.50.4 of this Exhibit H, SOW**;
10. Serving as a Member Advocate as indicated in **Section 2.6.17.4 of this Exhibit H, SOW**; and
11. Conducting outreach to Members transitioning into Target Population category 3, referring these Members to the TYP and developing a Transition Plan, as needed.

The MCO must ensure Service Coordinators are solely dedicated to serving the Members. The MCO must pair a Member with a Service Coordinator who has appropriate experience relating to the individual Member's needs. The MCO must ensure Service Coordinators provide additional assistance and outreach to Caregivers and Medical Consenters of Members in relative placements.

The MCO must ensure Service Coordinators are responsible for maintaining a centralized record related to Member contacts, assessments, and service authorizations. The MCO must ensure that the centralized Member record meets all applicable professional standards ensuring confidentiality of Member records, referrals, organization, and documentation of information.

The MCO Service Coordinators may request and review DFPS plans of care, safety plans, and permanency plans during the ISP development and monitoring process.

To ensure Continuity of Care for Members receiving services authorized in an ISP or treatment plan by their prior health plan, the MCO must ensure the Service Coordinator works with the Member's current PCP and specialists to ensure the Member's condition remains stable and services are consistent to meet the Member's ongoing needs. The MCO must ensure the Service Coordinator authorizes the transitioning Member's OON providers to continue with the treatment plan authorized by the Member's prior health plan until the

new ISP is completed or the MCO can transition the Member to a Provider who can provide comparable services to address the Member's Complex Needs.

For Dual Eligible Members, the Service Coordinator must work with the Member's PCP to coordinate all Covered Services and any applicable Non-capitated Services. Dual Eligible Members receive most Acute Care Services through Medicare, rather than Medicaid. Service Coordinators must coordinate all Medicare and Medicaid Services for Dual Eligible Members and document when efforts have been made to coordinate Medicare covered services.

The MCO must maintain a sufficient number of Service Coordination staff and management to ensure the timely completion of assessments and ISPs, and successful Continuity of Care as required by **Section 2.6.51 of this Exhibit H, SOW**. The MCO must ensure that Service Coordinator-to-Member ratios are clinically appropriate and evidence-based.

The MCO must offer specialized Service Coordination teams having additional expertise to assist Members experiencing acute episodes or severe complex conditions.

The MCO must comply with the requirements in **Chapter 16 of Exhibit B, UMCM**. The MCO must share and integrate Service Coordination and PA data internally and, if applicable, between the MCO and the BHO. The MCO must implement joint rounds for physical health and BH Services or implement another effective means for sharing clinical information. The MCO must co-locate physical health and BH Service Coordination staff and ensure warm transfers between physical health and BH Service Coordination staff.

The MCO must ensure a Member's named Service Coordinator returns the Member's phone calls and e-mails by the next Business Day. If the Member's named Service Coordinator is unavailable due to illness or personal leave, the MCO must ensure the Member who attempts to contact the named Service Coordinator is provided with the name and contact information of an alternate Service Coordinator, and calls continue to be returned within required timeframes. Members without a named Service Coordinator must have their calls returned by a Member representative by the next Business Day. A named Service Coordinator must attend at least 75 percent (75%) of face-to-face meetings between the MCO and the Member, including the SAI annual reassessment.

The MCO must continuously monitor Service Coordinator staff's ability to complete these functions and take corrective action as necessary. Member and Provider feedback must be measured and considered by the MCO when reviewing Service Coordination outcomes.

The MCO must maintain a sufficient number of regional offices in which Service Coordinators will be housed to maximize a Member's health, well-being, and independence. Regional offices will be located in areas throughout the State that are determined by agreement between the MCO and HHSC to have the greatest Member density or the closest proximity to DFPS Staff offices.

#### 2.6.47.2 SERVICE COORDINATION LEVELS

The MCO must determine the appropriate level of Service Coordination for each Member based on findings from the screening and assessment process described in **Section 2.6.46**

**of this Exhibit H, SOW**, communication with the Member, Medical Consenter, DFPS Staff, and key service Providers, and in accordance with the guidelines in **Section 2.6.47.1 of this Exhibit H, SOW**.

#### 2.6.47.2.1 LEVEL 1 MEMBERS

Level 1 Members include the following Member types:

1. MDCP recipients;
2. Members served by one of the following waivers: Youth Empowerment Services (YES), Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), HCS, or TxHmL;
3. Members having a history of multiple ER visits, Acute Care or psychiatric hospitalizations within the past year;
4. Members with SED or SPMI;
5. Members with a serious ongoing illness or Chronic or Complex Condition;
6. Members enrolled in the hospice program; and
7. Members eligible for both Medicaid and Medicare.

The MCO must provide all Level 1 Members with a named Service Coordinator and provide a minimum of four face-to-face Service Coordination contacts annually at least once per quarter. As a best practice, visits should be spaced not fewer than 2 months or greater than 3 months apart. In addition, Service Coordinators must conduct once monthly phone calls in months where no face-to face contact occurred, or in the same month as a face-to-face visit when an unmet need was identified. Variance in this schedule must be approved by the Member or Medical Consenter and documented on the ISP. The MCO must work with the Medical Consenter and Member to modify the amount of Service Coordination contacts to the Member's needs. Face-to-face contacts may be coordinated with required updates to the SAI, if appropriate. If a named Service Coordinator changes, the MCO must notify the Member and Medical Consenter in writing, within five Business Days, of the name and phone number of the Member's new Service Coordinator.

The MCO must ensure Service Coordinators make every effort to work together with YES, CLASS, DBMD, HCS, or TxHmL Service Coordinators. These efforts must be documented.

If a Member receiving MDCP services does not utilize an MDCP service during a calendar month, the MCO must ensure the named Service Coordinator makes face-to-face or telephonic contact with the Member or Medical Consenter by the end of the following month to ensure the Member is receiving any Medically Necessary services. This contact can count toward the minimum utilization of an MDCP service required for that Member to maintain MDCP eligibility. The MCO must document the contact and any action taken with regard to either waiver or State Plan Medicaid services including referrals, service changes, or other follow-up resulting from the contact in the Member's case file.

#### 2.6.47.2.2 LEVEL 2 MEMBERS

Level 2 Members include the following Member types:

1. Members who do not meet the characteristics for Level 1 but receive PCS, CFC, or nursing services, including PDN and PPECC;
2. Members residing in a community-based ICF/IID;
3. Members with a history of SUD (multiple outpatient visits, hospitalization, or institutionalization within the past year);
4. Members without SED or SPMI but who have another mental health condition that significantly impairs function;
5. ECI program participants; and
6. Pregnant Members.

The MCO must provide all Level 2 Members with a named Service Coordinator and provide a minimum of two face-to-face contacts annually, in addition to six telephone visits annually, unless otherwise requested by the Member or Medical Consenter and documented on the ISP. Visits must be as evenly spaced as possible during the year. As a best practice visits should be spaced not fewer than 4 months or greater than 6 months apart. The MCO must work with the Medical Consenter and Member to modify the amount of Service Coordination contacts to meet the Member's needs. The annual face-to-face contact may be coordinated with required updates to the SAI, if appropriate.

#### 2.6.47.2.3 LEVEL 3 MEMBERS

Level 3 Members include those who do not meet the characteristics of Level 1 or Level 2. The MCO is required to provide Level 3 members with one face-to-face visit and make three telephonic contacts annually, at a minimum. The required visit and contacts must be as evenly spaced as possible during the year. As a best practice the MCO should make contact once every quarter. The MCO must provide Level 3 Members with access to all Service Coordination services. The MCO must ensure Level 3 Members receive a minimum of once quarterly telephonic Service Coordination contacts. The MCO must provide a named Service Coordinator to any Level 3 Member only upon the request of the Member, Medical Consenter, or DFPS caseworker.

All face-to-face and telephonic contacts must be counted from the date the MCO completes the initial telephonic Member screening. The MCO Service Coordinators must use the screening and assessment process and claims and medical history data to identify the level of Service Coordination to offer each Member. The MCO must contact the identified Member, Medical Consenter, Caregiver, or DFPS Staff and effectively communicate the benefits of Service Coordination. The MCO must make best efforts to encourage a Member and Medical Consenter's participation in Service Coordination.

During face-to-face or telephonic contacts, the Service Coordinator must:

1. Review the Member's short-term and long-term goals and objectives, as documented in the ISP;
2. Document the Member's progress and achievements or adjust the ISP as needed;
3. Develop new goals and objectives with input from the Member and Medical Consenter;
4. Update the Member's ISP;

5. Ask if the Member is receiving all Medically Necessary services and take action if the Member is not, such as scheduling appointments and initiating referrals;
6. Review Member rights regarding acts that constitute ANE; and
7. Review MCO processes for service authorization, appeals, and Complaints.

### 2.6.47.3 SERVICE COORDINATOR REQUIREMENTS AND TRAINING

The MCO must ensure the Service Coordinator for Level 1 Members is an RN, NP, or a physician assistant if the Member's needs are primarily for physical health. If the Member's needs are primarily for BH, the MCO must ensure the Service Coordinator is a licensed clinical social worker or licensed professional counselor.

The MCO must ensure the Service Coordinator for Level 2 Members has an undergraduate or graduate degree in social work or a related field or is a LVN with previous Service Coordination, case management, or child welfare experience.

The MCO must ensure the Service Coordinator for Level 3 Members has a minimum of a high school diploma or General Educational Development (GED) and direct experience working with children and young adults with similar conditions or behaviors in three of the last five years.

The MCO must provide access to ongoing training and continuing education to Service Coordinators that focuses on EBPs and promising practices related to case management for children and young adults with experiences in trauma, Person-Centered planning, and Cultural Competency. The MCO must ensure Service Coordinators complete a minimum of 16 hours of Service Coordination training every two years. The MCO must administer the training, which must include:

1. Principles of most integrated settings, including federal and state requirements;
2. How to assess Members' medical, BH, and social or environmental needs and strengths;
3. How to provide information, based on results from screenings and assessments, to Members related to needed Services and supports, such as:
    a. The full continuum of BH Services and supports available, including Mental Health TCM and Mental Health Rehabilitative Services;
    b. CDS;
    c. Person-Centered planning;
    d. TIC;
    e. Permanency planning;
    f. Non-capitated Services, non-covered services and community services;
    g. SUD services;
    h. LTSS and Community-Based Services;
    i. Support services for families; and
    j. Transition Planning.
4. Identifying and reporting Critical Events or Incidents such as ANE and educating Members regarding protections;
5. Cultural Competency based on CLAS;

6. Refresher of the standards of documentation and licensure requirements per the Texas Occupational Code, Texas Administrative Code, and scope of practice requirements as applicable to the LTSS setting;
7. How to complete all components of the SAI, as prescribed by HHSC, and per instructions located in **Chapter 16 of Exhibit B, UMCM**; and
8. How to determine Medicare versus Medicaid coverage and how to access internal MCO resources to assist.

The MCO must ensure Service Coordinators who provide services to Members enrolled in MDCP are trained and knowledgeable of the following:

1. The full STAR Health and MDCP Service array;
2. Provider requirements for each service;
3. The three service delivery options described in **Section 2.6.42 of this Exhibit H, SOW**;
4. Eligibility and assessment requirements; and
5. Monitoring and reporting requirements.

The MCO must ensure Service Coordinators working with Members receiving Community-Based Services, including CFC and MDCP services, complete within six months of hire date, an HHSC-approved training on Person-Centered practices and Person-Centered plan facilitation to meet federal requirements on Person-Centered planning for LTSS. The MCO must use a trainer certified by the learning community for Person-Centered practices or an HHSC-approved curriculum and trainer. This training is in addition to other Service Coordinator training requirements. Service Coordinators must also receive an HHSC-approved or HHSC-offered Person-Centered training refresher course every two years.

Annually, all MCO Service Coordination staff must complete the THSteps online module at https://www.txhealthsteps.com/ titled *Case Management Services in Texas* and maintain proof of completion.

### 2.6.47.4 SERVICE COORDINATION TEAMS

Service Coordination teams are Member-centered support networks designed to enhance services provided by the named Service Coordinator. The MCO must provide a Service Coordination team when the MCO or a Provider determines the Member could benefit from a multidisciplinary approach to Service Coordination or determines specific expertise is necessary to address needs identified in the Member's ISP. The MCO must ensure Service Coordination team member selection is based on the subject matter expertise they can provide and the needs of the Member. If a Member has a named Service Coordinator, the named Service Coordinator must lead the Service Coordination team. The leader of the Service Coordination team is responsible for ensuring the team addresses objectives identified in the Member's ISP.

All Members who receive LTSS must be offered access to a Service Coordination team, including at least one Coordinator with expertise in non-capitated LTSS.

#### 2.6.47.5 TRANSITION PLANNING

The MCO must employ Transition Specialists who are responsible for assisting Members and their Service Coordinators with Transition Planning for adulthood. The MCO must ensure that young adult Members receive early and comprehensive Transition Planning to prepare them for changes to services or benefits that occur as they transition to adulthood.

The MCO must ensure Transition Planning services are provided using a team approach and in coordination with the assigned Service Coordinator. The MCO must employ Transition Specialists and ensure the Transition Specialists are wholly dedicated to counseling and educating Members, Medical Consenters, and others in the Member's support system about resources for transitioning to adulthood.

For Members receiving Community-Based Services or LTSS, the MCO must ensure Transition Planning begins no later than the Member's 15th birthday. Transition Planning for these Members must include the following activities:

1. Develop a Continuity of Care plan for transitioning Medicaid services and benefits from STAR Health to another Medicaid managed care model without a break in service;
2. Identify adult healthcare providers;
3. Ensure the Member, Medical Consenter, Caregiver, and DFPS Staff are aware of available State and local programs, services, and supports the Member may utilize to improve their well-being as an adult;
4. Provide health and wellness education to assist Members with self-management of their own Covered Services;
5. Regularly update the ISP with goals related to the Member's transition;
6. Inform the Member and Medical Consenter of LTSS and waiver programs offered, such as CLASS, DBMD, TxHmL, and HCS, and assist with application to those programs, if appropriate;
7. Coordinate with the Member's school and Individual Education Plan (IEP) to ensure consistency of goals, if desired by the Member or Medical Consenter; and
8. Coordinate with the Texas Workforce Commission (TWC) to identify future employment and employment training opportunities, if desired by the Member or Medical Consenter.

For Members not receiving Community-Based Services or LTSS, the MCO must ensure the above listed Transition Planning activities begins no later than the Member's 17th birthday.

The MCO must ensure Transition Specialists are trained on other Medicaid managed care programs and must maintain current information on local and State resources to assist Members and Medical Consenters during the transition process.

The MCO must coordinate with DFPS transitioning services staff and with DFPS contracted transition centers listed at https://www.dfps.state.tx.us/Child_Protection/Youth_and_Young_Adults/Transitional_Living/transition_centers.asp to develop work flows and processes that will ensure outreach to this population is successful.

### 2.6.47.6 DISCHARGE PLANNING

The MCO must have a protocol for quickly assessing the needs of Members discharged from a Hospital or other care or treatment facility, including inpatient psychiatric facilities. The MCO must provide its protocol, Discharge planning, transition care, and other education programs to Providers regarding all available long-term care settings and options.

On behalf of Members who are hospitalized, the MCO's Service Coordinator must work with the Member's PCP, the Hospital or inpatient psychiatric facility discharge planner(s), the attending physician, the Member, and the Member's Medical Consenter to assess and plan for the Member's discharge. The MCO must ensure that the Member's physical and BH needs, including SUD Treatment, and the Member's needs prior to Discharge or placement are included in this assessment.

Unless the MCO receives notification of a Member's Discharge from a Hospital or other care or treatment facility, including an inpatient psychiatric facility, less than 24 hours before the Member is discharged, the MCO must ensure that Discharge planning begins before the Member is discharged. Discharge planning must include needed assessments and establishing appropriate service authorizations. When long-term care is needed, the MCO must ensure that the Member's Discharge plan includes arrangements for receiving Community-Based Services as appropriate. The MCO must ensure that the Member, the Member's Medical Consenter, and the Member's PCP are well-informed of all service options available to meet the Member's needs in the community. Within one Business Day of receipt of notice of a Member's Discharge from an inpatient psychiatric facility, the Service Coordinator must contact the Member.

For Member in a Nursing Facility or ICF/IDD, the MCO must also have a protocol for quickly assessing the needs of Members who have or will soon be discharged. The MCO's assessment must include both physical and BH needs, including SUD Treatment. The MCO must assure timely access to Service Coordination and arrange for Medically Necessary or functionally necessary PCS or Nursing Services immediately upon the Member's transition from a Nursing Facility or ICF/IID to the community.

### 2.6.48 INDIVIDUAL SERVICE PLAN DESCRIPTION

The purpose of the ISP is to articulate assessment findings, short- and long-term goals, service needs, and Member preferences. The MCO must use the ISP to communicate and help align expectations between the Member, Medical Consenter, DFPS Staff, MCO, and key Providers. The MCO must use the ISP to measure Member outcomes over time.

### 2.6.48.1 ISP REQUIREMENTS

The MCO must develop a Person-Centered ISP, also known as the Healthcare Service Plan, for each Member within 45 Days of the Member's enrollment unless the Member or Medical Consenter declines assistance through Service Coordination. If a Member or Medical Consenter declines the assistance, the Service Coordinator must document the

efforts made in accordance with section **2.6.46 of this Exhibit H, SOW**. The MCO must write the ISP in plain language that is clear to the Member or Medical Consenter and must provide the ISP in other Prevalent Languages, if requested. The MCO must update the ISP for all Members no less than at least annually. The MCO must ensure the ISP is updated upon identifying a Change in Condition, a placement change, or upon the request of a Member, Medical Consenter, or DFPS Staff.

The Service Coordinator must update each Member's ISP:

1. At least annually for Level 2 Members and twice annually for Level 1 Members;
2. Following a significant Change in Condition or a placement change that impacts service needs;
3. Upon request from the Member, Medical Consenter, or DFPS Staff;
4. At the recommendation of the Member's PCP; and
5. Following the Member's receipt of any new screening or assessment.

The MCO must upload the ISP to the Member's Health Passport record within seven Days of creation or an update.

The MCO must ensure the ISP includes the following:

1. The Member's medical and social history;
2. Member and Medical Consenter goals and preferences;
3. The Member's natural strengths and special capabilities;
4. The Member's informal supports, such as the Medical Consenter and other persons in their community;
5. A summary of the Member's current medical and social needs and concerns, including:
    a. Recommended services identified through screenings and assessments;
    a. BH needs;
    b. Physical, occupational, speech, or other specialized therapy service needs;
    c. DME and medical supplies needs;
    d. Needed nursing services, including home health skilled nursing and PDN; and
    e. Prescription drugs, including psychotropic medication needs.
6. A list of Covered Services required and their frequency;
7. A description of who will provide the Covered Services;
8. A list of non-Covered Services, community supports, and other resources that the Member already receives or that would be beneficial to the Member;
9. With respect to maintaining and maximizing the health and well-being of the Member, a description of roles and responsibilities for the Member, Medical Consenter, and others who support the Member, key Providers, the MCO, and the Member's school, if applicable;
10. A plan for coordinating and integrating care between providers of covered and non-covered services;
11. Psychotropic Medication Utilization Reviews (PMUR), if applicable, to include the outcome of each review and any actions taken to address identified concerns with the Member’s medication regimen;

12. If applicable, Non-capitated Services provided to the Member through waivers such as YES, TxHmL, DBMD, HCS, or CLASS, and the providers of those services;
13. For Members in the ECI program, the IFSP as required by **Section 2.6.44.4 of this Exhibit H, SOW**;
14. Any additional plans of care, such as for MDCP, PCS, CFC, DM, or TYP;
15. Any additional information describing strategies to meet a Member's needs and goals; and
16. Documentation supporting PPECC services.

The MCO must ensure that the Member's ISP includes Member's access to treatment by a multidisciplinary team when the Member's PCP determines the treatment is Medically Necessary or to avoid separate and fragmented evaluations and Service Plans. The multidisciplinary team must include both physician and non-physician providers that the PCP determines are necessary for the comprehensive treatment of the Member. The MCO must ensure the multidisciplinary team does the following:

1. Participates in Hospital Discharge planning;
2. Participates in pre-admission Hospital planning for non-emergency hospitalizations;
3. Develops nursing, specialty care, and support service recommendations to be incorporated into the ISP;
4. Provides information to the Member or Medical Consenter concerning nursing and specialty care recommendations; and
5. Uses the Person-Centered planning process required by CMS to develop the ISP and to ensure the ISP is Person-Centered. See 42 C.F.R. § 441.301(c)(1)-(2).

The MCO must provide a printed or electronic copy of the completed ISP, including the ISP-narrative form and service tracking tool, to each Member and Medical Consenter within seven Days of any update and no less than annually, in the format requested by the Medical Consenter or Member. Upon request, the MCO must provide a copy of the ISP to the Member's Providers, DFPS Staff, and other individuals specified by the Member or Medical Consenter, no later than seven Days of request.

The MCO must ensure the named Service Coordinator is responsible for examining the ISP for all Level 1 and Level 2 Members prior to every face-to-face visit and scheduled telephonic visit to ensure it is updated and adequately reflects the Member's status, goals, preferences, and needs. For all Level 3 Members, the MCO is responsible for developing a strategy to ensure the ISP is closely reviewed and monitored with the Member and Medical Consenter by either a named Service Coordinator or another qualified representative of the MCO no less than annually.

The MCO must complete the ISP in an electronic format compliant with HHSC requirements. The MCO must provide HHSC with information from the ISP upon request, in the format prescribed by HHSC. The MCO must retain all previous finalized versions of the ISP in the Member's Health Passport record, according to the retention of records requirements set forth in **Exhibit F, Health Passport Overview and Requirements**.

HHSC may use information collected in the ISP to measure the quality of Service Coordination and overall care.

### 2.6.49 DISEASE MANAGEMENT

The MCO must provide DM programs consistent with State and federal statutes and regulations that focus on the whole person. The MCO's DM programs must identify Members at highest risk of utilization of medical services, tailor interventions to better meet Members' needs, encourage Provider input in ISP development, and apply clinical EBP protocols for individualized care.

The MCO must ensure that any refusal to utilize DM for a Member must be authorized by DFPS Staff.

The MCO must ensure that the MCO DM program(s) include the following components:

1. Member self-management as age appropriate, in which a Member becomes an informed and active participant in the management of physical and mental health conditions and co-morbidities;
2. Caregiver and Medical Consenter care management education;
3. Provider education;
4. Technological supports;
5. EBPs and TIC;
6. Standardized protocols and participation criteria;
7. Physician-directed or physician-supervised care;
8. A continuum of interventions to address individualized need;
9. Mechanisms to modify or change interventions that are not proven effective; and
10. Mechanisms to monitor the clinical and financial impact of the DM program over time.

The MCO must maintain a system to track and monitor all DM participants for clinical, utilization, and cost measures.

The MCO must provide designated staff to implement and maintain DM programs and to assist participating Members and Medical Consenters in accessing DM services.

The MCO must educate Members, Caregivers, Medical Consenters, DFPS staff, and Providers about the MCO's DM programs and activities. Additional requirements related to the MCO's DM programs and activities are found in **Chapter 9 of Exhibit B, UMCM**.

For all new Members not previously enrolled in the MCO and who require DM services, the MCO must evaluate and ensure Continuity of Care with any previous DM services in accordance with the requirements in **Chapter 9 of Exhibit B, UMCM**.

#### 2.6.49.1 DISEASE MANAGEMENT FOR MEMBERS WITH COMPLEX CARE NEEDS AND HIGH COSTS

The MCO must have a specialized program for targeting, outreach, education, and intervention for MCN who have excessive utilization patterns that indicate typical DM approaches are not effective. The MCO must, at a minimum, have the following infrastructure in place to address MCNs' needs:

1. Methodology for identification of MCNs on an ongoing basis, based on cost, utilization of the ER, utilization of inpatient or pharmacy services, physical and BH comorbidities, or other specified basis;
2. Resources dedicated to ongoing targeting and identification of MCNs;
3. Staff resources for effective outreach and education of Providers and MCNs;
4. Specialized intervention strategies for MCNs. The interventions must include an option for in-person interactions with the Member that occur outside of a standard clinical setting. This in-person intervention may be performed by medical care Providers or other non-medical Providers that are employed by the MCO or are Subcontracted with the MCO;
5. Evaluation process to determine effectiveness of the MCN program. As part of the annual evaluation of effectiveness, the MCO must include a description or example of an intervention it found effective, e.g., a Member case study with a description of the interventions and improvements or a specific project with demonstrated effectiveness; and
6. APMs for Providers of services to MCNs: The MCO is strongly encouraged to implement APMs for Providers who provide interventions for this population. Funds expended on APMs for this population will be counted toward APM targets delineated in **Section 2.6.21.5 of this Exhibit H, SOW**.

Upon request, the MCO must demonstrate to HHSC its methodologies for identification and intervention strategies for this population, to include the MCO's dedicated resources to support this effort. On an ad hoc basis, the MCO must provide HHSC its plan for management of MCNs including the criteria listed above using **Chapter 9 of Exhibit B, UMCM.** HHSC will evaluate the plan and provide feedback to the MCO. Upon HHSC's approval of the plan, the MCO will be retrospectively evaluated on its execution of the written plan, as described in **Section 2.6.49.3 of this Exhibit H, SOW**. The MCO may reuse elements of the same plan as long as the submission reflects the current state of its special population program and is updated as necessary on evaluation methodologies and key findings.

### 2.6.49.2 DISEASE MANAGEMENT AND PARTICIPATING PROVIDERS

At a minimum, the MCO must:

1. Implement a system for Providers to request specific DM interventions;
2. Give Providers and Service Coordinators information, including information about differences between recommended prevention and treatment and actual care received by Members enrolled in a DM program, and information concerning such Members' adherence to an ISP; and
3. For Members enrolled in a DM program, provide reports on changes in a Member's health status to their PCP and Service Coordinator.

### 2.6.49.3 HHSC EVALUATION OF DISEASE MANAGEMENT PROGRAM

HHSC or the EQRO will evaluate the performance of the MCO's DM program at a frequency determined by HHSC. The MCO must provide all information HHSC deems necessary for such evaluation.

## 2.6.50 BEHAVIORAL HEALTH SERVICES

The MCO must provide or arrange for the delivery of all Medically Necessary community-based, rehabilitative, and inpatient Hospital BH Services as described in the Contract, as well as Medically Necessary BH Emergency Services, including emergency screening services and short-term crisis stabilization. The MCO must outreach to and recruit Providers who serve the foster care population, including individual BH Providers providing services in Residential Treatment Centers (RTCs).

All BH Services must be provided in conformance with the access standards included in **Section 2.6.33 of this Exhibit H, SOW.** BH Services are described in more detail in **Section 2.6.32 of this Exhibit H, SOW, and Exhibit E, TMPPM**.

The MCO must cover up to three, five-Day Medically Necessary extensions in a Psychiatric facility after treatment is completed if DFPS Staff is in the process of finalizing the Member's placement, as described in **Exhibit E, TMPPM**. HHSC has determined that extended stay days are Medically Necessary for Members without placement. The MCO is bound by that determination and may not deny payment.

The MCO's PA processes for BH Services must recognize the intensive or ongoing need for these services often present among the Members and the PA processes should not be unnecessarily burdensome to Providers or Members. Therefore, the MCO must not require a PA for all outpatient medication management services, and a PA must not be required for the first 10 outpatient BH sessions, to include the initial evaluation.

The MCO must comply with DFPS rules and licensing standards regarding the provision of Covered Services, including certain BH Services, to the population. Medicaid BH Services are described in further detail in **Exhibit E, TMPPM.**

The MCO may provide BH Services not only in offices and clinics, but also in schools, homes, and other locations as appropriate. A continuum of services, as indicated by the BH needs of Members, must be available. The MCO must include Providers in its Network who utilize EBPs and promote Provider use of EBPs.

When assessing Members for BH Services, the MCO and its BH Service Providers must include a primary and secondary (if present) diagnosis using the most recent DSM. HHSC may require the use of other assessment instruments or outcome measures in addition to the current DSM. The MCO must require that Providers document DSM and assessment or outcome information in the Member's medical record and in **Section 2.8 of Exhibit F, Health Passport Overview and Requirements,** as applicable.

Because mental health conditions and SUD commonly co-occur in Members, the MCO must screen all Members for both conditions. The MCO must document diagnostic

information and outcome measurement information in the Member's Health Passport and must contractually require BH Providers to:

1. Assess Members using the Texas CANS 2.0 according to the requirements in **Section 2.6.46.3 of this Exhibit H, SOW**, or refer to a Provider who is trained and certified to perform this assessment;
2. Document timely the Texas CANS 2.0 score results in the eCANS system;
3. Evaluate each Member's progress using a standardized outcome measurement instrument, to be provided by the MCO, quarterly at placement change, or as significant changes are made to the ISP, and document the scores in Health Passport;
4. Participate as a member of the PCP Team by coordinating with the PCP and Service Coordinator as appropriate; and
5. Testify in court as needed for child protection litigation.

The MCO must contractually require BH Providers to provide the following information for the Health Passport:

1. Primary and secondary (if present) diagnosis;
2. Screening and assessment information;
3. Brief initial and monthly (or more frequently if a Member's medical condition indicates) narrative summary of clinical visits/progress for inclusion in the Health Passport;
4. Scores on each outcome rating form(s);
5. Referrals to other Providers or community resources;
6. Evaluations of each Member's progress at intake, monthly, and as significant changes are made in the ISP; and
7. Any other relevant healthcare information.

The MCO must contractually require that PCPs use the THSteps BH forms, at a minimum, for the detection and treatment of, or referral for, any known or suspected BH problems and disorders. The PCP must submit completed THSteps screening and evaluation results to the MCO to include in the Health Passport.

### 2.6.50.1 Behavioral Health Provider Network Additional Requirements

Due to the significant BH needs of the Members, appropriate access to BH Services is considered a critical component of effective healthcare for this population. The MCO must contract with BH Providers specializing in treatment of issues that are common to Members such as abuse, neglect, sexual offender behavior, and exposure to complex and multiple traumas, in order to meet the BH needs of the Members.

To best address the special needs of the Members and provide effective treatment, the MCO must ensure that BH Services Providers are culturally competent based on national CLAS standards and sensitive to Member issues.

The MCO must ensure equal access to services by all racial and ethnic populations and improve service delivery to underserved populations. To the extent possible, the diversity of the Network should reflect the cultural groups of the Members.

The Network, which must meet the applicable requirements in **Section 2.6.35,** must also include Providers who use EBPs and promising practices such as TF-CBT, PCIT, CPP, and TBRI for disorders common to Members to address risk factors and stressors that influence future abuse and neglect.BH treatment may require family counseling, when family reunification is planned.

The BH Services Network must include Providers who are trained in and knowledgeable about screening, assessment, and treatment for:

1. Co-occurring BH and SUD;
2. Physical and sexual abuse and in providing sex offender treatment, such as registered sex offender treatment Providers;
3. Lesbian, Gay, Bi-sexual, Transgender (LGBT)-related issues;
4. Screening and treating eating disorders;
5. Children and young adults with a history of trauma;
6. Intellectual and Developmental Disability (IDD) or children dually diagnosed with IDD and BH issues;
7. Young children;
8. Children with autism; and
9. Fetal Alcohol Syndrome (FAS) or related disorders.

#### 2.6.50.2 MEMBER EDUCATION AND SELF-REFERRAL FOR BEHAVIORAL HEALTH SERVICES

The MCO must permit Members and Medical Consenters to self-refer to any Network BH Services Provider without a referral from the Member's PCP. The MCO's policies and procedures, including its Provider manual and Member handbook, must include written policies and procedures for allowing such self-referral to BH Services. If the Member has not been assessed as needing BH Services, the MCO must require an assessment to authorize treatment after the provision of 10 outpatient BH sessions. The MCO must permit Members, Medical Consenters, and DFPS Staff to participate in the selection of appropriate BH Providers and must provide the Member, Medical Consenter, and DFPS Staff with information on Providers with relevant experience within the distance standards for BH Providers as detailed in **Chapter 5.28.1 of Exhibit B, UMCM**.

#### 2.6.50.3 BEHAVIORAL HEALTH CRISIS SERVICES HOTLINE

This section discusses BH Crisis Services Hotline functions pertaining to Member Hotlines. BH Provider Hotline requirements are referenced in **Section 2.6.9 of this Exhibit H, SOW**. The MCO's BH Crisis Services Hotline must also meet the requirements of **Section 2.6.16 of Exhibit H, SOW**.

The MCO must operate a toll-free BH Crisis Services Hotline staffed by trained personnel 24 hours a Day, 7 Days a week, answered by a live voice. BH Crisis Services Hotline staff must include or have access to qualified BH Services professionals to assess crisis or Emergency BH Conditions. The MCO's BH Crisis Services Hotline must not be answered by an answering machine. BH Crisis Services Hotline staff must coordinate emergency and

crisis BH Services, which may be arranged through mobile crisis teams. The MCO may use mobile crisis teams to provide on-site emergency response services.

The MCO may choose to incorporate the functionality and requirements of the BH Crisis Services Hotline into its Member Services call center by having options and procedures in place for warm transfers of BH crisis services-related calls, including emergency calls, to appropriate BH Crisis Services Hotline staff. However, the MCO must submit hotline performance reports separately as required by **Chapter 5.24 of Exhibit B, UMCM**.

Clinicians staffing the BH Crisis Services Hotline must be available to accept emergency and crisis calls. Routine calls received from Providers, Members, DFPS Staff, Caregivers and Medical Consenters on an emergency hotline after normal business hours will be returned the next Business Day.

The MCO must provide clear and obvious information on its Member-facing website regarding the availability of the 24/7 BH crisis services support through its hotline. The information should specify that a licensed mental health professional is available to support a Member and the Caregiver during a BH crisis.

The MCO must monitor its performance against the BH Crisis Service Hotline standards and submit performance reports summarizing call center performance as indicated in **Section 2.6.27 of this Exhibit H, SOW, and Chapter 5.24 of Exhibit B, UMCM**.

#### 2.6.50.4 COORDINATION BETWEEN THE BEHAVIORAL HEALTH PROVIDER AND THE PRIMARY CARE PROVIDER

The MCO must ensure that the behavioral and physical health clinical Member information is shared efficiently and effectively between the PCP and BH Providers. If the MCO uses a BHO as a Material Subcontractor, the MCO must ensure that the MCO and BHO have shared, integrated data systems to facilitate Service Coordination and the timely sharing of Member information with PCPs and BH specialists.

The MCO must require, through Provider Contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected BH problems and disorders. The MCO must provide training to Network PCPs on:

1. Using the results and recommendations of the Texas CANS 2.0 to guide treatment decisions;
2. The MCO's referral process for BH Services and clinical coordination requirements for such services; and
3. Coordination and quality of care such as BH screening techniques for PCPs and new models of BH interventions.

The MCO must include in its trainings, Provider Materials and handbooks guidelines, policies and procedures related to physical and BH coordination of treatment and services. MCO training for PCPs and BH Providers must include the use of valid screening and assessment instruments as well as the use of the forms and documents related to the Member's THSteps checkup. The MCO must provide training to Network PCPs on identifying and referring Members three years of age and older suspected of having a

developmental delay or developmental Disability, SED, mental illness, or SUD. The MCO must provide training to Network PCPs on identifying and referring Members for assessments and for neuropsychological assessments to determine if Members have suffered trauma to the brain.

The MCO will develop and disseminate policies regarding clinical coordination and the sharing of Member information between BH Providers and PCPs, as clinically indicated. The MCO must require that BH Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment. The MCO must require that PCPs and BH Providers engage in an appropriate level of communication and consultation necessary to properly assess, evaluate, refer, or treat a Member with both a physical health and BH condition. The MCO must develop in concert with PCPs, child psychiatrists and other relevant BH Providers, a simple communication format for sharing information between BH Providers and PCPs and other subspecialty Providers and require the use of such form for sharing necessary information among the PCP Team.

The MCO must educate all members of the PCP Team to understand the role of the Service Coordinator in the coordination and sharing of health information and status. BH Providers may only provide physical Covered Services if they are licensed in Texas to do so.

The MCO must require that BH Providers and PCPs send each other initial and quarterly (or more frequently if clinically indicated, directed by a PCP Team, or court-ordered) summary reports of a Member's physical and BH status, as agreed to by the PCP Team members. The reports must include information required for judicial review of medical care under Tex. Fam. Code § 266.007. The MCO must include this requirement in Provider Contracts, handbooks and manuals.

The MCO must use evidence-based integrated healthcare practices. These practices include, for example, the use of an appropriate outcome measurement instrument to monitor the effectiveness of medication and psychotherapy, and access to psychiatric consultation for the PCP and Service Coordinator. The MCO must contractually require all Providers to comply with the most recent version of the *Psychotropic Medication Utilization Parameters for Children and Youth in Texas Public Behavioral Health* found at the HHSC website. The MCO must ensure that PCPs have valid screening and assessment instruments to identify and refer children to Providers specializing in evaluations to determine whether a Member has a developmental Disability or is at risk for or has a SED or mental illness. The MCO must also ensure that Members who may need access to ICF/IIDs and home and community-based 1915(c) waiver services receive the appropriate evaluation and psychometric testing required for admission to these facilities or approval of waiver services.

The MCO must provide information on EBPs for BH problems commonly seen in primary care, e.g. depression and anxiety disorders. The MCO must encourage PCPs to contact MCO Service Coordinators to discuss the Member's needs, referral and treatment options, and request names of specialty BH Providers to address the Member's special needs.

For rural areas, the MCO must assist PCPs and other Providers with access by facilitating specialty consults through the use of Telemedicine technology. Provider training must include information on how to access Telemedicine or Telehealth resources.

### 2.6.50.5 Follow-Up after Hospitalization for Behavioral Health Services

The MCO must require, through Provider Contract provisions, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up or continuing treatment prior to Discharge. The outpatient treatment must occur within seven Days from the date of Discharge.

The MCO must ensure that BH Service Providers contact Members who have missed appointments within 24 hours of the missed appointment to reschedule appointments.

### 2.6.50.6 Local Mental Health Authority or Local Behavioral Health Authority

The MCO must coordinate with the LMHA or LBHA, other appropriate Providers, and the State psychiatric facility regarding admission and Discharge planning, treatment objectives, and projected length of stay for Members committed by a court of law to a State psychiatric facility.

In addition, the MCO must notify an LMHA or LBHA upon notification, but in no event later than three Business Days, that a Member is admitted to a Hospital for inpatient psychiatric services if the LMHA or LBHA has provided Covered Services to the Member in the 12 months preceding the admission. If the Member has received Covered Services at more than one LMHA or LBHA in the 12 months preceding the admission, the MCO must notify only the LMHA or LBHA who last delivered Covered Services to the Member.

### 2.6.50.7 Mental Health Rehabilitative Services and Mental Health Targeted Case Management Services

The MCO must ensure that Mental Health Rehabilitative Services and Mental Health TCM are available to eligible Members based on the appropriate standardized assessment, the ANSA or CANS. The MCO must maintain a qualified Network of entities, including LMHAs, LBHAs, multi-specialty groups, and clinic/group practices that employ Providers of these services.

The MCO must ensure Mental Health Rehabilitative Services include training and services that help the Member maintain independence in the home and community, including the following:

1. Medication training and support – curriculum-based training and guidance that serves as an initial orientation for the Member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community;

2. Psychosocial rehabilitative services – social, educational, vocational, behavioral, or cognitive interventions to improve the Member's potential for social relationships, occupational or educational achievement, and living skills development;
3. Skills training and development – skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers;
4. Crisis intervention – intensive, community-based, one-to-one service provided to Members who require services to control acute symptoms that place the Member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting; and
5. Day program for acute needs – short-term, intensive, site-based treatment in a group modality to a Member who requires multidisciplinary treatment to Stabilize acute psychiatric symptoms, prevent admission to a more restrictive setting, or reduce the amount of time spent in the more restrictive setting.

The MCO must provide Mental Health Rehabilitative Services and Mental Health TCM in accordance with **Chapter 15 of Exhibit B, UMCM**, including ensuring Providers meet all training requirements and the use of the HHSC Resiliency and Recovery Utilization Management Guidelines (RRUMG) at https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual. The MCO must also ensure that a Provider reviews a Member's plan of care for Mental Health Rehabilitative Services in accordance with the RRUMG to determine whether a change in the Member's condition or needs warrants a reassessment or change in service. If the Member's condition warrants a change in service, the Provider must submit a new plan of care to the MCO for authorization.

Additionally, the MCO must ensure that Providers of Mental Health Rehabilitative Services and Mental Health TCM use, and are trained and certified to use, the ANSA and CANS tools for assessing a Member's needs.

Service Coordinators must ensure Providers of Mental Health TCM integrate the behavioral and physical health needs of Members. The MCO must ensure that if a Member loses Medicaid eligibility, Service Coordinators refer the Member to community resources.

#### 2.6.50.8 MENTAL HEALTH PARITY

The MCO must comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 110-343, div. C, tit. V, subtit. B (Sec. 511 et seq.), 122 Stat. 3881 (2008), and all related regulations, including 42 C.F.R. pt. 438, subpt. K, and 45 C.F.R. §§ 146.136, 147.136, and 147.160. The MCO must work with HHSC to comply with the MHPAEA and must provide HHSC with:

1. A non-quantitative treatment limitation assessment tool;
2. Surveys or Corrective Action Plans related to compliance with MHPAEA;
3. Statements of attestation stating compliance with MHPAEA; and
4. Any other information as requested by HHSC.

The information must be provided within the timeframe included in HHSC's request.

### 2.6.50.9 Substance Use Disorder

The MCO must comply with 28 Tex. Admin. Code pt.1, ch. 3, subch. HH regarding UM and SUD treatment. SUD includes substance use and dependence as defined by the current DSM.

#### 2.6.50.9.1 Substance Use Care Coordination

The MCO must ensure Service Coordinators work with Providers and facilities to coordinate care for Members with a SUD and to ensure Members with a SUD have access to the full continuum of SUD treatment Covered Services, including assessment, detoxification, residential treatment, outpatient services, and medication therapy, as Medically Necessary and appropriate.

The MCO must also coordinate services with the appropriate State agencies, including HHSC, DFPS, and their designees, for Members requiring services that are not Covered Services or Non-capitated Services but that are available under the Federal Substance Abuse and Prevention and Treatment block grant when provided by an HHSC-funded provider or covered by DFPS under direct contract with a treatment provider.

The MCO must work with State agencies, including HHSC and DFPS, and providers to ensure payment for Covered Services is available to OON providers who also provide related services when Covered Services are not available through Providers.

#### 2.6.50.9.2 Requirements for Medication Assisted Treatment

The MCO must comply with Tex. Hum. Res. Code § 32.03115 when reimbursing Providers for medication assisted treatment for opioid or SUD.

#### 2.6.50.9.3 Member Education and Self-Referral for Substance Use Disorder Treatment Services

The MCO must maintain a Member education process, including call centers, manuals, policies, and other Member Materials, to inform Members of the availability of and access to SUD treatment services, including information on self-referral.

### 2.6.51 Continuity of Care

The MCO must ensure Continuity of Care such that the care of newly enrolled Members and Members who disenroll from the Program is not disrupted or interrupted.

### 2.6.51.1 PRIOR AUTHORIZATIONS

Upon notification from HHSC, a Member, Medical Consenter, or Provider of the existence of a PA, the MCO must ensure Members receiving Covered Services through a PA from another Medicaid or CHIP MCO or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

1. 90 Days after the Effective Date of Coverage;
2. Until the end of the current authorization period; or
3. Until the MCO has evaluated and assessed the Member and issued or denied a new authorization.

For instances in which a newly enrolled Member was receiving a service that did not require a PA but does require one by the MCO, the MCO must ensure Members receive services for the same amount, duration, and scope for the shortest period of one of the following:

1. 90 Days after the transition to a new MCO, for Acute Care; or
2. Until the MCO has evaluated and assessed the Member and issued or denied a new authorization.

### 2.6.51.2 OUT-OF-NETWORK PROVIDERS

The requirements in this section regarding access to and payment of OON providers apply only to OON providers who are enrolled in the Medicaid program. The MCO must pay a Member's existing OON providers for Covered Services until the Member's records, clinical information, and care can be transferred to a Provider, or until the Member is no longer enrolled in STAR Health, whichever is shorter. The MCO must apply the same payment standards and rates as described in 1 Tex. Admin. Code pt. 15, ch. 353, subch. A, § 353.4 and subch. J, § 353.913 to OON services provided pursuant to this section.

The MCO must allow pregnant Members past the 24th week of pregnancy to remain under the care of the Member's current OB/GYN provider through the Member's postpartum checkup, even if the provider is OON. If a Member wants to change the OON OB/GYN provider to one who is in the Network, the Member must be allowed to do so if the Provider to whom the Member wishes to transfer agrees to accept the Member in the last trimester of pregnancy.

The MCO's obligation to reimburse the Member's existing OON provider for services provided to a pregnant Member past the 24th week of pregnancy extends through delivery or miscarriage of the child, immediate postpartum care, and the follow-up checkup within the first 6 weeks of delivery or miscarriage.

With the exception of pregnant Members who are past the 24th week of pregnancy, this section does not extend the obligation of the MCO to reimburse the Member's existing OON providers for ongoing care provided:

1. More than 90 Days after a Member enrolls in the MCO, for Acute Care; or

2. For more than nine months, in the case of a Member who, at the time of enrollment in the MCO, has been diagnosed with and is receiving treatment for a terminal illness and remains enrolled in the MCO.

The MCO must reimburse OON ECI providers no less than the Medicaid FFS amounts for ECI services delivered to Members.

The MCO must provide or pay OON providers who provide Covered Services to Members who move out of the State through the end of the period for which capitation has been paid for the Member. If a Member transitions from a placement in the State of Texas to a placement in another state, it is the MCO's responsibility to make any necessary single case agreements and contractual relationships to ensure the health and safety of the Member until an enrollment change takes effect.

If Covered Services are not available within the MCO's Network, the MCO must provide Members with timely and adequate access to OON providers of Covered Services for as long as those services are necessary and are not available within the Network, in accordance with 42 C.F.R. § 438.206(b)(4). The MCO is not obligated to provide a Member with access to OON providers of Covered Services if such services become available and are within acceptable appointment availability timeframes described in the contract from a Provider.

The MCO must ensure that each Member, DFPS Staff, Caregiver, or Medical Consenter has access to a second opinion regarding any Medically Necessary Covered Service. A Member, DFPS Staff, Caregiver, or Medical Consenter must be allowed access to a second opinion from a Provider or OON provider if a Provider is not available, at no cost to the Member, in accordance with 42 C.F.R. §§ 438.206(b)(3) and 457.1230.

The MCOs must allow a Member with coverage under a non-Medicaid health insurance organization who is receiving Level 1 Service Coordination in STAR Health to remain under the care of a Medicaid enrolled specialty provider from whom the Member is receiving care through the non-Medicaid health insurance organization on the date of enrollment into MCO, even if that specialty provider is OON with the MCO. The list of specialty provider types to be considered for this purpose are the individual providers listed in **Chapter 3 of Exhibit B, UMCM**.

1. The MCO must comply with OON provider reimbursement rules as adopted by HHSC at 1 Tex. Admin. Code. pt. 15, ch. 353, subch. A, § 353.4 until one of the following events occurs: An alternate reimbursement agreement is reached with the Member's specialty provider;
2. The Member is no longer enrolled in a non-Medicaid health insurance organization;
3. The Member or the Member's LAR agrees to select an alternate specialty provider; or
4. The Member is no longer enrolled in the MCO.

Under the provisions of this section, MCOs shall not include Members seeing an OON provider as part of its Out-of-Network Utilization Reporting requirements under **Chapter 5.24 of Exhibit B, UMCM**.

### 2.6.51.3 Responsibilities in the Event of a Federal Emergency Management Agency or Governor-Declared Disaster or other Emergencies

In the event of a Federal Emergency Management Agency (FEMA) or State of Texas Governor-declared disaster or other emergencies, including but not limited to man-made or natural, the MCO must ensure the care of Members in compliance with the MCO's Continuity of Member Care Emergency Response (COMCER) plan, particularly the care of Members whose health or BH condition has been treated by specialty care providers or whose health could be placed in jeopardy if Covered Services are disrupted or interrupted. Requirements for the COMCER plan and other disaster-related requirements are described in **Chapter 16 of Exhibit B, UMCM**.

Additionally, the MCO must have a COMCER plan based on a risk assessment using an "all hazards" approach to respond as a business to a local disaster. As part of the plan, the MCO must describe the method to ensure that Members with a permanent address in FEMA or Governor-declared disaster areas or areas in which internal, man-made, or natural disasters have occurred, are able to access OON providers if they are unable to access Covered Services from Providers.

The MCO must also describe the method it will use to ensure that PAs are extended and transferred without burden to new Providers if directed by HHSC, and the method by which the MCO will identify the location of Members who have been displaced. The MCO must describe how it will work with DFPS to address any relocation activities with residential providers and SSCCs to ensure a coordinated response to any disaster. Annually, the MCO must conduct exercises carrying out the plan's provisions, evaluate its performance, and make necessary updates.

The MCO must coordinate with local emergency management departments or agencies prior to an event to understand local emergency management plans and processes, identify plans to escalate needs through local emergency management departments or agencies, and identify mechanisms for assistance at the local level.

Additionally, the MCO must maintain a continuity of operations business plan which includes a collection of resources, actions, procedures, and information that is developed, tested, and held in readiness for use to continue operations in the event of a major disruption of operations due to a FEMA or State of Texas Governor-declared disaster or other emergencies that are internal to the MCO and its facilities within the scope of this Contract, man-made, or natural. The Business Continuity Plan must address emergency financial needs, essential functions for Member Services, critical personnel, and the return to normal operations as quickly as possible.

During a FEMA or State of Texas Governor-declared disaster or other emergency including, but not limited to, internal to the MCO and its facilities within the scope of this Contract, man-made or natural, the MCO is required to report to HHSC, daily or at an interval determined by HHSC, when requested, on the status of Members and issues regarding Member access to Covered Services.

The MCO/PBM claims system must have the capability to waive edits or allow override of edits by at least ZIP code and county for specific date ranges.

The MCO or its PBM may not use circumstances described in Tex. Health & Safety Code § 483.047(b-1) as a justification for rejecting a claim, provided the pharmacy or pharmacist meets the requirements of Tex. Health & Safety Code § 483.047(b-1).

### 2.6.52 VISION SERVICES AND VISION NETWORK

The MCO or any Subcontractor must authorize, arrange, coordinate, and provide all Covered Services for vision as described in **Exhibit E, TMPPM**. The MCO must recruit and maintain an adequate vision Network in accordance with **Section 2.6.35 of this Exhibit H, SOW**, including optometrists.

The MCO must enroll, train, support, and maintain a statewide Network of vision Providers who understand and are responsive to the special health and vision care needs of the Members.

Vision providers providing emergency vision services outside the State of Texas are required to be located in the United States and licensed in the state that the Member received the Emergency Services.

### 2.6.53 PHARMACY SERVICES

The MCO must provide pharmacy-dispensed and compounded prescriptions as a Covered Service. The MCO must ensure that such coverage meets the standards provided for by 42 U.S.C. § 1396r-8 and 42 C.F.R. § 438.3(s).

The MCO must submit pharmacy clinical guidelines and PA policies to HHSC for review and approval prior to making any changes. In determining whether to approve these materials, HHSC will review factors such as the clinical efficacy and Members' needs.

The MCO must allow pharmacies to fill prescriptions for covered drugs ordered by any licensed and Medicaid-enrolled provider regardless of Network participation and must encourage Network pharmacies to also become Medicaid-enrolled DME providers. The MCO must ensure through its pharmacy contracts that a pharmacy only fills prescriptions for covered drugs that have been prescribed by a prescribing provider who is licensed to prescribe.

The MCO is responsible for negotiating reasonable pharmacy Provider reimbursement rates, including individual MCO Maximum Allowable Cost (MAC) rates as described in **Section 2.6.53.11 of this Exhibit H, SOW.** The MCO must ensure that, as an aggregate, rates comply with 42 C.F.R. Part 50, Subpart E, regarding upper payment limits.

The MCO must comply with all applicable provisions of 42 C.F.R. pt. 438, subpt. K, which implements MHPAEA of 2008 for pharmacy services. The MCO must ensure compliance with Tex. Ins. Code ch. 1369, subch. J.

HHSC will provide the MCO with pharmacy data on the MCO's Members on a weekly basis through the VDP or, should these services be outsourced, through the PBM.

### 2.6.53.1 FORMULARY AND PREFERRED DRUG LIST

The MCO must demonstrate compliance for all covered outpatient drugs on the Medicaid formulary including those provided under a non-risk based payment mode or otherwise carved-out of managed care. The MCO must demonstrate compliance with any FFS edits or other prescription drug limitations applicable to the MCO or related to the HHSC's PDL and any other State-mandated PA or clinical edit.

The MCO must provide access to covered outpatient drugs and biological products, certain LHHS, and vitamins and minerals through formularies and the PDL developed by HHSC. HHSC will maintain separate Medicaid and CHIP formularies, and a Medicaid PDL.

The MCO must educate Providers about how to access HHSC's formularies and the Medicaid PDL on HHSC's website. The MCO must allow Providers access to the formularies and Medicaid PDL through a free, point-of-care, web-based application accessible on smart phones, tablets, or similar technology. The application must also identify preferred and non-preferred drugs, Clinical PAs, and any preferred drugs that can be substituted for non-preferred drugs. The MCO must update this information at least weekly.

The MCO must feature HHSC's formularies on the MCO's website. The MCO must also inform Members that the formulary is available in paper form without charge and provide it upon request within five Business Days.

In accordance with Tex. Ins. Code ch. 1369, subch. J, the MCO must establish a process by which the MCO, the Member, the prescribing physician or health care provider, and a pharmacist may jointly approve a medication synchronization plan. A medication synchronization plan may be used only for prescribed drugs that treat chronic illnesses and that complies with Tex. Ins. Code § 1369.453. The eligibility of a Member's prescriptions for medication synchronization must be determined on a case-by-case basis, considering Member-specific needs as determined by the Member's physician or healthcare provider.

The MCO must submit its proposed medication synchronization plan to HHSC for approval before the MCO may undertake any implementation activities. All MCO implementation activities must adhere to the approved medication synchronization plan.

The MCO may not pro-rate the dispensing fee associated with a prescription that is eligible for medication synchronization. The MCO must pro-rate any associated co-payment, although this section may not be read to authorize an MCO to charge a co-payment.

### 2.6.53.2 PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS AND 72-HOUR EMERGENCY SUPPLIES

HHSC's Medicaid PDL PA, Clinical PA, and other drug policies for the VDP are available on HHSC's VDP website.

HHSC will identify both required and optional Clinical PAs on the VDP website, www.txvendordrug.com. The MCO must ensure Clinical PAs are processed correctly. If the information about a Member's medical condition meets the PA criteria, the claim or

PA request may be approved automatically without action from the prescribing Provider or dispensing pharmacy. If a Member's medical condition does not meet the PA criteria, the claim or PA request may be denied and require the prescribing Provider to request a PA. The MCO is responsible for managing PA denials through its appeal process.

The MCO must submit any proposed clinical criteria not listed on the VDP website to HHSC for review and approval following the process outlined in **Chapter 3 of Exhibit B, UMCM**. The MCO may choose to implement additional Clinical PAs once the criteria are approved by the Drug Utilization Review (DUR) board or by HHSC.

The MCO must adhere to VDP's PDLs for Medicaid drugs. The MCO must Adjudicate preferred drugs as payable without PDL PA, unless subject to Clinical PAs. If a requested drug is subject to more than one drug PA, e.g., the drug is both non-preferred and subject to one or more Clinical PAs, the MCO must process all edits concurrently and independently so that each drug PA, Clinical PA, or PDL PA is checked for approval.

HHSC's website, https://www.txvendordrug.com/, also includes exception criteria for each drug class included on HHSC's Medicaid PDL. These exception criteria describe the circumstances under which a non-preferred drug may be dispensed without a PDL PA. If HHSC modifies the policies described above on the VDP website, HHSC will notify the MCO.

The MCO must submit new Clinical PA proposals to HHSC for DUR board review and approval.  The MCO may also submit any proposed revisions to existing Clinical PAs to HHSC for DUR board review and approval. The MCO must submit all Clinical PA proposals in compliance with the required information outlined in **Chapter 3 of Exhibit B, UMCM**. HHSC will conduct preliminary review of these edit proposals and respond to the MCO before the next DUR board meeting. If the MCO has Clinical PAs that are identical to VDP's Clinical PAs, the MCO can reference VDP's Texas Medicaid formulary on Epocrates. The MCO may choose to implement additional Clinical PAs once the criteria are approved by the DUR board or by HHSC.

If the MCO cannot provide a response to the PA request within 24 hours after receipt or the prescriber is not available to make a PA request because it is after the prescriber's office hours and the dispensing pharmacist determines it is an emergency situation, the MCO must allow the pharmacy to dispense a 72-hour supply of the drug. In this context, emergency situation includes a situation in which, based on the dispensing pharmacist's judgement, a Member may experience a detrimental change in his or her health status within 72 hours from when the pharmacy receives the prescription due to the inability to obtain the drug. The pharmacy Provider may fill consecutive 72-hour supplies if the prescriber's office remains unavailable. The MCO must reimburse the pharmacy Provider for dispensing the temporary supply of medication.

The MCO must provide access to a toll-free call center for prescribers to call to request a PDL PA for non-preferred drugs or drugs that are subject to Clinical PAs. If the prescriber's office calls the MCO's PA call center, the MCO must provide a PA approval or denial immediately. For all other PA requests, the MCO must notify the prescriber's office of a PA denial or approval no later than 24 hours after receipt of the request. If the MCO cannot

make a timely PA determination, the MCO must allow the Member to receive at least a 72-hour supply of the medication pending resolution of the PA request.

The MCO must have an automated process that may be used to assess a Member's medical and drug claim history to determine whether the Member's medical condition satisfies the applicable criteria for dispensing a drug without an additional PA request. See Tex. Gov't Code § 531.073(h). This process must automatically evaluate whether a submitted pharmacy claim meets PA criteria for both PDL and Clinical PAs. See **Chapter 2 of Exhibit B, UMCM,** for the definition of an Automated PA Request.

The MCO's PA system must accept PA requests from prescribers that are sent electronically, by phone, fax, or mail. The MCO may not charge pharmacies for PA transaction, Software, or related costs for processing PA requests.

If the MCO or its PBM operates a separate call center for PA requests, the PA call center must meet the Provider Hotline performance standards set forth in **Section 2.6.9 of this Exhibit H, SOW**. The MCO must train all PA, Provider Hotline, and pharmacy call center staff on the requirements for dispensing 72-hour emergency supplies of medication.

The MCO must not require a PA for any drug exempted from PA requirements by federal law.

For drug products purchased by a pharmacy through the Health Resources and Services Administration (HRSA) 340B discount drug program, the MCO may only impose Clinical PA requirements. These drugs must be exempted from all PDL PA requirements.

A Provider may appeal PA denials on a Member's behalf, in accordance with **Section 2.6.31 of this Exhibit H, SOW**.

If a Member changes to another MCO, the MCO must provide the new MCO information about the Member's PA and medication history at no cost and upon request. The MCO, in consultation with HHSC, will develop a standard process and timeline for implementing a standard format for sharing Member medication and PA history. HHSC expects the former MCO to respond with the requested information within 48-hours of the new MCO's request.

#### 2.6.53.3 COVERAGE EXCLUSIONS

In accordance with 42 U.S.C. § 1396r-8, the MCO must exclude coverage for any drug marketed by a drug company or labeler that does not participate in the federal drug rebate program. The MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product. A list of participating drug companies can be found on the CMS website under contact information.

The MCO may restrict some compounded medications available through the pharmacy benefit. The MCO's coverage of compounded medications must follow the same requirements as outlined in this section and must be listed on the Texas Medicaid

formulary. The MCO may not reimburse pharmacies for compounding powders since these are not included on the Texas Medicaid formulary.

### 2.6.53.4 COMPOUNDED MEDICATIONS

The MCO must allow approval for the following:

1. Compounded medications prepared for Members with allergies to the commercially prepared medications.
2. Compounded oral medications used for Members 12 years and younger or for Members with difficulty swallowing.
3. Compounded medications if the FDA-approved product is not available or in short supply, but not because the drug has been withdrawn or removed from the market for safety reasons.
4. Compounded medication, if the specific Member has a medical need for a different dosage, form, or strength than is commercially available.

The MCO may reject claims for compounded medications for which the MCO, based on the MCO's determination, finds no evidence that the compounded medication is safe and effective. The MCO may reject a claim for a compounded medication if the MCO determines the drug is included in one or more of the classes as defined in 1 Tex. Admin. Code pt. 15, ch. 354, subch. F, div. 7, § 354.1923(c). The MCO may reject a claim for a compounded medication if the active ingredients and the use of the compound prescriptions do not have a medically accepted use supported by the compendia or peer review literature. The MCO may select from and use the following compendia: Thomson Micromedex, American Hospital Formulary Service, clinical pharmacology, physician supported guidelines, or current primary literature when available. The MCO must have a process in place to allow a prescriber or pharmacy to dispute a rejected claim for a compounded medication.

The MCO may pend a claim for compounded medications $200.00 or more for further review to determine if the product is safe and effective.

For auditing purposes, an MCO may request prescription compounding logs from a pharmacy to verify National Drug Codes (NDCs), quantities, and calculations.

### 2.6.53.5 PHARMACY REBATE PROGRAM

Under the provisions 42 U.S.C. § 1396r-8, drug companies that wish to have their products covered through the Texas Medicaid program must sign an agreement with the federal government to provide the pharmacy claims information that is necessary to return federal rebates to the State.

Under Tex. Gov't Code § 533.005(a)(23)(D)(i), the MCO may not negotiate rebates with drug companies for pharmaceutical products. HHSC or its designee will negotiate rebate agreements. If the MCO or its PBM has an existing rebate agreement with a manufacturer, all Medicaid outpatient drug claims, including clinician-administered drugs, must be exempt from such rebate agreements. The MCO must include rebateable NDCs on all

Encounters for outpatient drugs and biological products, including clinician-administered drugs. Encounters containing clinician-administered drugs must include, in addition to a CMS-rebate-eligible NDC, the correctly matched Healthcare Common Procedural Coding System (HCPCS) code and billing units per the applicable date of service according to HHSC NDC-to-HCPCS Crosswalk.

The MCO must implement a process to support HHSC's Medicaid rebate dispute resolution processes in a timely manner. The MCO must:

1. Allow HHSC or its designee to contact pharmacy Providers to verify information submitted on claims, and upon HHSC's request, assist with this process; and
2. Establish a single point of contact with the MCO where HHSC can send information or request clarification.

HHSC will notify the MCO of claims submitted with incorrect information. The MCO must correct this information on the next scheduled pharmacy Encounter Data transmission and respond in writing to the original request with the outcome of the correction.

For purposes of this section, the term rebates is intended to include all Revenues, proceeds, reimbursements, funds, discounts, monies and payments generated from or in any way related to pharmaceutical products, whether or not such Revenues, proceeds, reimbursements, funds, discounts, monies and/or payments are described as 'rebates' by and between any such pharmaceutical manufacturers, their Affiliates, agents, assigns, or other parties and PBM or PBM's agents.

### 2.6.53.6 DRUG UTILIZATION REVIEW PROGRAM

The MCO must have a DUR program process in place to conduct prospective and retrospective Utilization Review of prescriptions. The MCO's DUR program must comply with 42 U.S.C. § 1396r-8, 42 C.F.R. pt. 456, subpt. K. The MCO must submit an annual report to VDP that provides a detailed description of its DUR program activities, as provided for under 42 C.F.R. § 438.3(s).

The MCO must implement a prospective review in the pharmacy claims processing systems at Point of Sale (POS). The prospective review at the POS must include screening to identify potential drug therapy problems such as drug-disease contraindication, therapeutic duplication, adverse drug-drug interaction, incorrect drug dosage, incorrect duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.

The MCO's retrospective review must monitor prescribers and contracted pharmacies for outlier activities as outlined in 42 U.S.C. § 1396r-8 and 42 C.F.R. § 456.709. MCO's retrospective reviews must also determine whether services were delivered as prescribed and consistent with the MCO's payment policies and procedures. The MCO must provide the requested data as described in **Chapter 2 of Exhibit B, UMCM**.

### 2.6.53.7 PHARMACY BENEFITS MANAGER

The MCO must use a PBM to process prescription claims.

The MCO must identify the proposed PBM and the ownership of the proposed PBM. If the PBM is owned wholly or in part by the MCO or by the MCO's parent company, a retail pharmacy provider, chain drug store, or pharmaceutical manufacturer, the MCO will submit a written description of the assurances and procedures that must be put in place under the proposed PBM Subcontract, such as an independent audit, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The MCO must provide a plan documenting how it will monitor these Subcontractors. These assurances and procedures must be submitted for HHSC's review during Readiness Review, see **Section 2.5.2.1 of this Exhibit H, SOW**, prior to initiating any PBM Subcontract after the Operational Start Date.

The MCO must provide a plan documenting how it will monitor any PBM providing services as a part of this Contract and allow HHSC 30 Days to comment on the plan before MCO executes the PBM contract.

The MCO must ensure its PBM Subcontractor follows all pharmacy-related Contract, **Exhibit B, UMCM**, state, and federal law requirements related to the provision of pharmacy services.

Further, the MCO's reimbursement methodology for the PBM Subcontractor must be developed as a pass-through pricing model based on the actual amount paid by the PBM Subcontractor to a pharmacy Provider for dispensing and ingredient costs. All monies related to services provided by the PBM for the MCO are passed through to the MCO, including but not limited to, dispensing fees and ingredient costs paid to pharmacies, and all Revenue received, including but not limited to pricing discounts eligible to be paid to the PBM, rebates, inflationary payments, and supplemental rebates. All payment streams, including any financial benefits such as rebates, as defined in **Section 2.6.53.5 of this Exhibit H, SOW**, discounts, credits, claw backs, fees, grants, chargebacks, reimbursements, or other payments that the PBM receives related to services provided for the MCO must be fully disclosed to the MCO, and provided to HHSC upon request. However, this prohibition on the industry practice commonly known as spread pricing is not intended to prohibit the MCO from paying the PBM reasonable administrative and transactional costs for services, as described in **Chapter 6 of Exhibit B, UMCM**. The payment model for the PBM's administrative and transactional fees will be made available to HHSC. If concerns are identified regarding the administrative fee, HHSC reserves the right to request any changes be made to the payment model.

#### 2.6.53.7.1 PHARMACY BENEFITS MANAGER AGREEMENT

The MCO must include the following provisions in any agreement between the MCO and its PBM:

1. The term of the PBM Subcontract will not exceed two years.
2. The PBM will not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of or component or mechanism related to the claim adjudication process, including the development or management of a claim processing or adjudication network, or participation in a claim processing or adjudication network.

3. At least annually, the PBM will hire an independent third party to complete a SOC 1 audit over the PBM's services and activities. This report will be provided to the MCO, and information from this audit will be made available to HHSC upon request.
4. In addition to the SOC 1 audits, the PBM and the MCO will cooperate with and grant full access to any independent audit entity retained by HHSC to perform periodic compliance audits of the PBM. These compliance audits would measure the PBM's compliance with any contractual obligations as well as with federal and State requirements. The PBM will agree to correct any noncompliance issues discovered during these audits.
5. The PBM will not steer or require any providers or Members to use a specific pharmacy or mail order pharmacy service in which the PBM or MCO has an ownership interest or that has an ownership interest in the PBM, if for the primary purpose of reducing competition or financially benefitting the PBM's associated businesses. Arrangements between MCO and PBMs to promote value-based reimbursement and payment or enhancing health outcomes are permitted.
6. Whether the MCO or its designee has ownership or control interest with the PBM or not, the MCO and HHSC have the right to audit and review contracts or agreements between the PBM and their pharmacies at least annually to ensure correct pricing has been applied. This includes, but is not limited to, prescription drug claim data, billing records, and other records to ensure the PBM's compliance with the terms and conditions of their agreement.
7. PBM will not sell any pharmacy data related to services provided for the MCO.
8. A clause that allows the MCO to terminate the agreement for cause, including conduct that is likely to mislead, deceive, or defraud the public, as well as unfair or deceptive business practices.
9. PBM will assign to HHSC all of PBM's State and federal antitrust claims and causes of action that relate to all goods, services, or Deliverables provided for or related to this Contract.

### 2.6.53.8 FINANCIAL DISCLOSURES FOR PHARMACY SERVICES

The MCO must disclose all contracts and financial terms and arrangements for remuneration of any kind that apply between the MCO or the MCO's PBM and any provider of outpatient drugs, any prescription drug manufacturer or distributor or labeler, including formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, rebates and any other fees. **Article 8 of Exhibit A, STAR Health Uniform Terms and Conditions**, provides HHSC with the right to audit such information at any time. HHSC agrees to maintain the confidentiality of information disclosed by the MCO pursuant to this section, to the extent that such information is confidential under State or federal law.

### 2.6.53.9 Limitations Regarding Registered Sex Offenders

The MCO must comply with the requirements of Tex. Gov't Code § 531.089 prohibiting the provision of sexual performance enhancing medication to persons required to register as sex offenders under Tex. Crim. Proc. Code ch. 62.

### 2.6.53.10 Specialty Drugs

The MCO must adhere to the HHSC specialty drug list for specialty drugs provided through selective specialty pharmacy contracts. The MCO's policies and procedures must comply with 1 Tex. Admin. Code pt. 15, ch. 353, subch. J § 353.905 and ch.354, subch. F, div. 3, § 354.1853 and include processes for notifying Network pharmacy Providers.

### 2.6.53.11 Maximum Allowable Cost Requirements

The MCO must develop MAC prices and lists that comply with State and federal laws, including Tex. Gov't Code § 533.005(a)(23)(K). To place an outpatient drug on a MAC list, the MCO must ensure that:

1. The drug is listed as A or B rated in the most recent version of the United States Food and Drug Administration's approved drug products with therapeutic equivalence evaluations, also referred to as the *Orange Book*, has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and
2. The drug is generally available for purchase by pharmacies in Texas from national or regional wholesalers and is not obsolete.

In formulating the MAC price for a market basket of drugs, e.g. a group of therapeutically related drugs that will be assigned the same price, the MCO and PBM must use only the prices of the drugs listed as therapeutically equivalent in the most recent version of the *Orange Book*. Drugs listed as therapeutically equivalent are A-rated drugs. Therefore, the MCO and PBM can only use A-rated drugs to set MAC prices. The MCO must not use the B-rated drugs in MAC pricing calculation. The MCO and PBM can include B-rated drugs in the same market basket, but those B-rated drugs must be assigned the same price as the A-rated drugs.

The MCO must not set a MAC on a drug that is both preferred on HHSC's PDL and a brand name drug.

The MCO must provide a pharmacy Provider the sources used to determine the MAC pricing at contract execution, renewal, and upon request.

The MCO must review and update MAC prices at least once every seven Days to reflect any modifications of MAC pricing and establish a process for eliminating products from the MAC list or modifying MAC prices in a timely manner to remain consistent with pricing changes and product availability in the SA.

The MCO must provide a quarterly report regarding MAC price review and updates in the manner and format specified in **Chapter 5.13.4 of Exhibit B, UMCM**.

The MCO must have a process for allowing Network pharmacies to challenge a MAC price, including Network pharmacies that are contracted with a Pharmacy Services Administrative Organization (PSAO). The MCO must submit the process for HHSC's review and approval prior to implementation and modification. The MCO must respond to and resolve a challenge by the 15th Day after it is received by the MCO. If the challenge is successful, the MCO must adjust the drug price, effective on the date the challenge is resolved, and apply the new price to all similarly situated Network pharmacies, as appropriate and determined by the MCO. If the challenge is denied, the MCO must provide the pharmacy the reasons for the denial. The MCO must provide a quarterly report regarding MAC price challenges in the manner and format specified in the **Chapter 5.13.4 of Exhibit B, UMCM**.

The MCO or PBM, as applicable, must provide a process for each of its pharmacy Providers to readily access the MAC list specific to that pharmacy Provider directly from the MCO or PBM, even if the pharmacy is contracted with a PSAO. At a minimum, the MCO and PBM must allow a pharmacy Provider to download a searchable file of the MAC list specific to that pharmacy Provider from the MCO or PBM website. Alternatively, the MCO or PBM may allow a pharmacy Provider to view and search the MAC list specific to that pharmacy Provider on the website. The list provided on the website must be searchable by drug name. The MCO must provide HHSC with access to MAC lists upon request as outlined in **Article 8 of Exhibit A, STAR Health Uniform Terms and Conditions,** no later than 10 Days after the MCO receives the request. The MCO must submit the process for HHSC's review and approval prior to implementation and modification. As described in Tex. Gov't Code § 533.005(a-2), a MAC price list that is specific to a pharmacy Provider is confidential for all other purposes.

The MCO must inform HHSC by email no later than 21 Days after implementing a MAC price list for drugs dispensed at retail pharmacies.

#### 2.6.53.12 MAIL ORDER AND DELIVERY

The MCO may include mail-order pharmacies in its pharmacy Network; but must not require Members to use a mail-order pharmacy Provider.

The MCO must not charge a Member who opts to use a mail-order pharmacy Provider any fees for using this service, including postage or handling for standard or expedited deliveries. The MCO must implement a process to ensure that Members receive free outpatient pharmaceutical deliveries from community retail pharmacies in the SA or through other methods approved of by HHSC. The MCO must not substitute mail-order delivery for delivery from a qualified community retail pharmacy Provider unless requested by the Member. The MCO's process must be submitted to HHSC for review using HHSC's provided template and include all qualified community retail pharmacies identified by HHSC. The MCO must obtain HHSC approval before implementing the process.

### 2.6.53.13 HEALTH RESOURCES AND SERVICES ADMINISTRATION 340B DISCOUNT DRUG PROGRAM

The MCO must use a shared-savings approach for reimbursing Providers that participate in the federal HRSA's 340B discount drug program.

The MCO, through its Provider contract, must require a 340B-covered entity seeking to use 340B stock to contract with the MCO as a 340B pharmacy and accept the payment terms of the MCO’s shared-savings model. If the 340B covered entity does not accept the terms, then the MCO may contract with the covered entity as a retail pharmacy. If the covered entity contracts with the MCO as a retail pharmacy, the MCO must prohibit the entity from using 340B-purchased drugs.

The MCO must not require a Provider to submit its Actual Acquisition Cost (AAC) on outpatient drugs and biological products purchased through the HRSA’s 340B program, consistent with **Chapter 2 of Exhibit B, UMCM**. In addition, the MCO must not impose PA requirements based on non-preferred status, sometimes referred to as PDL PAs, for these drugs and products.

### 2.6.53.14 PHARMACY CLAIMS AND FILE PROCESSING

The MCO must process claims in accordance with Tex. Ins. Code § 843.339 and **Chapter 2 of Exhibit B, UMCM**. This law requires the MCO to pay Clean Claims that are submitted electronically no later than 18 Days after adjudication, and no later than 21 Days after adjudication if the claim is not submitted electronically. In addition, the MCO must comply with **Section 2.6.51 of this Exhibit H, SOW,** regarding payment of OON pharmacy claims.

HHSC will provide the MCO or its designee with pharmacy interface files, including formulary, HHSC’s PDL, TPL, master provider, drug exception files, and other relevant files required to administer the Program. Due to the POS nature of outpatient pharmacy benefits, the MCO must ensure all applicable MIS, including pharmacy claims adjudication systems, are updated to include the data provided in the pharmacy interface files. The MCO must update within two Business Days of the files becoming available through HHSC’s file transfer process, unless clarification is needed, or data file exceptions are identified. If clarification is needed, the MCO must notify HHSC within the same two Business Days. Additionally, the MCO must be able to perform off-cycle formulary and PDL updates at HHSC’s request.

The MCO must ensure that all Enrollment Files in the JIP are loaded into the pharmacy claims adjudication system within two Days of receipt.

### 2.6.53.15 PHARMACY AUDITS

The MCO and its PBM are prohibited from using extrapolation in pharmacy audits.

### 2.6.53.16 E-PRESCRIBING

The MCO must provide the appropriate data to the national e-prescribing network, which must support: eligibility confirmation; HHSC's PDL benefit confirmation; identification of preferred drugs that can be used in place of non-preferred drugs, also referred to as alternative drugs; medication history; and prescription routing.

### 2.6.53.17 CANCELLATION OF PRODUCT ORDERS

If a Provider offers delivery services for covered products, such as DME, home health supplies, or outpatient drugs or biological products, the Provider Contract must require the Provider to reduce, cancel, or stop delivery at the written or oral request of the Member, or Medical Consenter. The Provider Contract must require the Provider to maintain records documenting the request.

### 2.6.53.18 AUTOMATED REFILLS

For automated refill orders for covered products, the Provider Contract must require the Provider to confirm with the Member that a refill, or new prescription received directly from the physician, should be delivered. Further, the MCO must ensure that the Provider completes a drug regimen review on all prescriptions filled as a result of the auto-refill program in accordance with 22 Tex. Admin. Code pt. 15, ch. 291, subch. B, § 291.34. The MCO must ensure that the Member or Medical Consenter has the option to withdraw from an automated refill delivery program at any time.

### 2.6.54 DENTAL SERVICES AND DENTAL NETWORK

The MCO must authorize, arrange, coordinate and provide all dental Covered Services as described in this section and **Exhibit E, TMPPM**. Dental services include, preventive, diagnostic, and therapeutic services. Dental services must comply with the THSteps dental policy and procedures and American Academy of Pediatric Dentistry (AAPD) recommendations, as described in **Exhibit E, TMPPM**. See **Section 2.6.58.2 of this Exhibit H, SOW,** for requirements for THSteps dental checkups.

The MCO must begin providing dental services to a Member beginning on the Effective Date of Coverage regardless of pre-existing conditions, prior diagnosis, receipt of any prior dental services, or for any other reason, subject to HHSC-prescribed benefit limitations.

The MCO must reimburse Providers for medical or Hospital charges, such as anesthesia, that are necessary for Members to access standard therapeutic dental Covered Services. The MCO must provide access to facilities and physician services that are necessary to support the dental Provider who is providing dental services to a Member under general anesthesia or Intravenous (IV) sedation.

The MCO must provide for coverage of dental-related Emergency Services, including dislocated jaw, traumatic damage to teeth and supporting structures, removal of cysts,

treatment of oral abscess of tooth or gum origin, treatment and devices for correction of craniofacial anomalies, and drugs required for these Emergency Services.

The MCO must inform Network facilities, anesthesiologists, and PCPs about required PA procedures and how Providers are to be reimbursed for facility services and preoperative evaluations completed by the PCP or anesthesiologist.

For dental-related Emergency Services, the MCO must reimburse Network and OON providers in accordance with federal and State laws, rules, and regulations. Dentists providing dental-related Emergency Services outside the State of Texas are required to be located in the United States and licensed in the state that the Member received the Emergency Services.

In the development of medical necessity determinations, the MCO must adopt practice guidelines that:

1. Are based on valid and reliable clinical evidence or a consensus of oral health care professionals in the particular field;
2. Consider the needs of the MCO's Members;
3. Do not conflict in part or in whole with State or federal policy;
4. Are adopted in consultation with contracting oral health care professionals;
5. Are reviewed and updated periodically as appropriate or as requested by HHSC; and
6. Are shared with Providers in the MCO Network as a means of transparency.

The MCO must enroll, train, support, and maintain an adequate statewide Network of dental Providers, including dentists for First Dental Home for Members age 6 months through 35 months, MSHCN, and Providers who understand and are responsive to the STAR Health Program's special health and dental care needs as referenced in **Sections 2.6.54.1 and 2.6.54.2 of this Exhibit H, SOW**.

The MCO must ensure that all Members have access to a choice of Providers in accordance with **Section 2.6.33.2.3 of this Exhibit H, SOW**. If the MCO is unable to meet this standard, the MCO must request an exception from HHSC, as required by **Section 2.6.33.3 of this Exhibit H, SOW.**

The MCO must comply with the applicable access requirements established by TDI under 28 Tex. Admin. Code pt.1, ch. 3, subch. KK, § 3.9208 and ch. 11, subch. Q, § 11.1607 for all MCO operating in Texas, except as otherwise required by the Contract. Where conflicts exist between TDI access requirements and the Contract, the shortest mileage and timeframe requirements apply.

#### 2.6.54.1 First Dental Home

The MCO must implement First Dental Home, a package of dental services aimed at improving the oral health of children 6 months through 35 months of age, which enhances the dental Providers' ability to assist Members, Medical Consenters, and Caregivers in obtaining optimum oral healthcare through First Dental Home visits. The MCO must ensure the First Dental Home visit can be initiated as early as six months of age and must include the following:

1. Comprehensive oral examination;
2. Oral hygiene instruction with the Caregiver or Medical Consenter;
3. Dental prophylaxis, if appropriate;
4. Topical fluoride varnish application when teeth are present;
5. Caries risk assessment; and
6. Dental anticipatory guidance.

Members from 6 months through 35 months of age may be seen for dental checkups by a certified First Dental Home Provider as frequently as every 3 to 6 months for up to 10 First Dental Home visits.

The MCO is required to verify that Providers who submit claims for First Dental Home services have the appropriate certification from HHSC THSteps. To become a First Dental Home Provider, the dentist must complete the required online course through the THSteps online Provider education website and submit a certification request form to THSteps. The course may be found at the THSteps online Provider education site at https://www.txhealthsteps.com/. Click on courses at the top of the page, then select oral health from the topic dropdown menu.

### 2.6.54.2 MAIN DENTAL HOME

The MCO must develop a Network of Main Dentists consisting of general dentists, pediatric dentists, FQHCs, and RHCs, that will provide a Main Dental Home that includes the provision of diagnostic and preventive services in accordance with AAPD recommendations found at www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf, and referrals to specialty care as needed.

The MCO must ensure the establishment of a Member's Main Dental Home begins no later than at six months of age and supports an ongoing relationship with the Member and Medical Consenter that includes all aspects of oral healthcare delivered in a comprehensive, continuously accessible, coordinated, and Person-Centered way.

The MCO must require Main Dentists follow the THSteps dental periodicity requirements and assess Members' needs for referrals and make such referrals. The MCO must require that referrals to specialists are processed within 72 hours after receiving the referral from the Provider. The MCO must require Main Dentists to coordinate a Member's care with specialty care providers after each referral. The MCO must address specialty care in its Provider education activities and review Provider referral patterns.

The MCO must assist the Member or Medical Consenter in selecting a Main Dentist within 30 Days of enrollment with the MCO. If the Member or Medical Consenter has not selected a Main Dentist within 30 Days of enrollment, the MCO must assign the Member to a Main Dentist using an automated algorithm approved by HHSC that considers:

1. The Member's established history with a Main Dentist, as demonstrated by Encounter history with the Provider in the preceding year, if available;
2. The geographic proximity of the Member or Medical Consenter's home address to the Main Dentist;

3. Whether the Provider serves as the Main Dentist to other children in the Member's household who are enrolled in Medicaid;
4. Limitations on default assignment, such as restrictions on age and capacity by the Main Dentist; and
5. Other criteria as approved by HHSC.

The MCO must furnish each Main Dentist with a current list of enrolled Members assigned to that Provider no later than five Business Days after the MCO receives the Enrollment File from the EB each month. The MCO may offer and provide such enrollment information in alternative formats when such format is acceptable to the Main Dentist.

### 2.6.55 HEALTH HOME SERVICES

The MCO must provide Health Home services. The MCO must include a designated Provider to serve as the Health Home. The designated Provider may be a provider operating with a team of healthcare professionals or a Health Team selected by the Member or Medical Consenter. The MCO's Health Home services must be part of a Person-Centered, holistic approach to address the needs of Members with multiple chronic conditions or a single serious and persistent mental or health condition.

The MCO's Health Home services must include:

1. Member self-management education;
2. Provider education;
3. EBPs and trauma informed standards of care;
4. Standardized protocols and participation criteria;
5. Provider-directed or Provider-supervised care;
6. A mechanism to incentivize Providers for provision of timely and quality care;
7. Implementation of interventions that address Continuity of Care;
8. Mechanisms to modify or change interventions that are not proven effective;
9. Mechanisms to monitor the impact of the Health Home services over time, including both the clinical and the financial impact;
10. Comprehensive care management;
11. Service Coordination and health promotion;
12. Comprehensive traditional care, including appropriate follow-up, from inpatient to other settings;
13. Member and family support, including authorized representatives;
14. Referral to community and social support services, if relevant; and
15. Technological support.

The Health Home services requirements do not apply to Dual Eligible Members.

#### 2.6.55.1 HEALTH HOME SERVICES AND PARTICIPATING PROVIDERS

HHSC encourages the MCO to develop Provider-incentive programs for designated Providers who meet the requirements for Patient-Centered Medical Homes found in Tex. Gov't Code § 533.0029.

The MCO must:

1. Maintain a system to track and monitor all Health Home services participants for clinical, utilization, and cost measures;
2. Implement a system for Providers to request specific Health Home interventions;
3. Inform Providers about differences between recommended prevention and treatment and actual care received by Members enrolled in a Health Home services program and Members' adherence to their ISP;
4. Incentivize Health Home Providers to develop their expertise in child welfare and their experience in TIC; and
5. Provide reports on changes in a Member's health status to his or her PCP for Members enrolled in a Health Home services program.

The MCO must develop a series of enhanced clinics that have expertise in child welfare, TIC, and disorders and conditions prevalent in the STAR Health population and are capable of providing peer-to-peer consultation and support to less experienced Providers, according to its HHSC-approved implementation plan.

### 2.6.56 MEDICAID WRAP-AROUND SERVICES

The MCO may be required to supplement Medicare coverage for Dual Eligible Members by providing services, supplies, and outpatient drugs and biologicals that are available under the Texas Medicaid program. There are three categories of Medicaid Wrap-Around Services:

1. Medicaid only services (i.e., services that do not have a corresponding Medicare service);
2. Medicare services that become a Medicaid expense due to a benefit limitation on the Medicare side being met; and
3. Medicare services that become a Medicaid expense due to coinsurance (true Cross-over claims).

The MCO must provide Medicaid Wrap-Around Services for outpatient drugs, biological products, certain LHHS, and vitamins and minerals as identified on the HHSC drug exception file to Dual Eligible Members under a non-risk, cost settlement basis, as described in **Section 2.8.16 of this Exhibit H, SOW**. Refer to **Chapter 2 of Exhibit B, UMCM,** for additional information regarding the claims processing requirements for these Medicaid Wrap-Around Services.

The MCO will supplement the Medicare coverage for Members by providing LTSS as Medicaid Wrap-Around Services, including:

1. CFC services for qualified Members, as specified in **Section 2.6.40 of this Exhibit H, SOW;**
2. MDCP services for qualified Members, as specified in **Section 2.6.57 of this Exhibit H, SOW**;
3. PCS;
4. PPECC; and
5. PDN.

The MCO may not require a Provider to obtain a denial or explanation of benefits from Medicare prior to covering these services.

### 2.6.57 Additional Requirements Regarding the Medically Dependent Children Program

The purpose of MDCP is to prevent unnecessary placement of an individual in a long-term care facility and to support de-institutionalization of individuals by providing them with LTSS in the community. The programmatic goals for MDCP are to:

1. Enable children and young adults who are medically dependent to remain safely in a home-like setting;
2. Offer cost-effective alternatives to placement in nursing facilities and Hospitals; and
3. Support Caregivers and Medical Consenters in providing a stable placement in a home-like setting for children and young adults who are medically dependent.

#### 2.6.57.1 Program Eligibility and Assessment

MDCP enrollment is limited to the number of individuals and the amount of state funding approved by the Texas Legislature except as otherwise provided in 1 Tex. Admin. Code pt.15, ch.353, subch. M, § 353.1155. Individuals will be considered for program entry through an interest list process or following an institutional stay.

To be eligible for MDCP services, an individual must meet Disability and medical necessity criteria, as well as other program requirements determined by HHSC or its designee. A determination of medical necessity must be based on information collected as part of the SAI and MDCP module and authorized through HHSC or its designee.

If a Member is considered by HHSC for MDCP entry, the MCO must schedule and complete the SAI, including the MDCP Module, within 30 Days of notification from HHSC. Once the SAI and MDCP module are complete, the MCO must submit and confirm the receipt of the results of the assessment to HHSC or its designee within 72 hours. The MCO must submit the ISP no later than 60 Days following the initial notice from HHSC.

The MCO must ensure medical necessity is reviewed for each Member receiving MDCP services on an annual basis. Annual assessments for MDCP eligibility must occur at the same time as annual reassessment with the SAI. For reassessments, the MCO may not submit an SAI earlier than 90 Days prior to the expiration of the Member's ISP. The MCO must work to prevent a lapse in MDCP eligibility by performing the Member’s annual reassessment for MDCP eligibility and submitting the medical necessity determination to HHSC in time to prevent coverage gaps. The reassessment must be submitted to HHSC or its designee no later than 30 Days prior to the expiration of the Member’s ISP to ensure that HHSC or its designee has sufficient time to process the Member’s medical necessity determination so that the Member does not experience a lapse in MDCP eligibility. The MCO must submit the ISP Tracking Tool no later than 30 Days prior to the end date of the current ISP on file.

If a placement change occurs that is related to a Change in Condition, the MCO must complete a re-assessment using the required elements of the SAI. If a placement change occurs that is not related to a Change in Condition, the MCO must review the budget plan for MDCP services with the Member, Caregiver and Medical Consenter within 14 Days of receipt of placement change information on the DNF. The MCO must complete all re-assessments related to a Change in Condition within 30 Days or notification from the Member of Medical Consenter or receipt of placement change information on the DNF.

The MCO must complete an electronic ISP for each Member receiving MDCP services. The ISP is established for a one-year period. After the initial ISP is established, the ISP must be completed on an annual basis and the end date or expiration date does not change. The MCO must ensure the required elements of the ISP, as directed by HHSC, are completed and submitted to HHSC or its designee's portal within 14 Days of completion and submission of the SAI. The MCO must initiate all applicable MDCP services on the effective date of the ISP.

The MCO must coordinate with the Member and Medical Consenter to update the Member's ISP with the MDCP service plan.

#### 2.6.57.2 SERVICE COORDINATION REQUIREMENTS FOR MEDICALLY DEPENDENT CHILDREN PROGRAM MEMBERS

The MCO must ensure the SAI for the MDCP eligibility is administered by a RN, APRN, or physician assistant. These modules may not be administered by any contracted entity providing direct services to the Member.

Any MCO staff or MCO-contracted staff administering the SAI must take the SAI training module required by HHSC before administering the SAI. All MCO staff or MCO-contracted staff administering the MDCP portion of the SAI also must be certified through the State-approved Resource Utilization Group (RUG) training found at the Texas State University website under "Continuing Education" currently located at https://www.txstate.edu/continuinged/CE-Online/RUG-Training.html

The SAI MDCP module will establish an annual cost limit for each Member receiving MDCP services, which will be based on the anticipated cost if the Member received services in a nursing facility. The MCO must develop an MDCP plan of care that does not exceed the Member's cost limit and include the MDCP plan of care in the Member's ISP. If the MCO does not properly establish this plan of care and the Member's cost exceeds the individual limit, the MCO must continue to provide MDCP services to the Member at the MCO's expense. The MCO may not terminate MDCP enrollment if a Member exceeds the cost limit. The MCO must also adopta process to track each Member's MDCP-related expenditures on a monthly basis and provide an update on the progress to the Member and Medical Consenter no less than once per month.

The MCO must ensure that the Service Coordinator for an MDCP Member follows up with the Member and Medical Consenter no later than four weeks following the start date of the ISP, either in-person or by telephone, to ensure that necessary services are in place and maintain documentation of the contact and result in the Member's file. The MCO must

ensure that the Service Coordinator for an MDCP Member continue to make monthly in-person or by telephone contact with the Member and Medical Consenter to ensure the Member's needs are met.

Service authorizations for MDCP must include the amount, frequency, and duration of each service to be provided and the schedule for when services will be rendered. The MCO must ensure the MDCP Member does not experience gaps in authorizations and that authorizations are consistent with information in the Member's ISP.

For all MDCP Members, the MCO must consult with the Member and Medical Consenter to determine if the Member needs Minor Home Modifications and Adaptive Aids as part of the annual assessment process, or if the Member experiences a Change in Condition or requests assistance. The MCO must ensure the MDCP Member's ISP includes the components of a Person-Centered ISP described in 42 C.F.R. § 441.301(c)(1) and (2).

On the date of the assessment or reassessment, the MCO must ensure that the Service Coordinator in the STAR Health Program reviews the information gathered in the SAI with the Medical Consenter. The Service Coordinator must attempt to obtain the signature of the Medical Consenter to verify that the Medical Consenter has reviewed the information gathered in the SAI. If the Medical Consenter disagrees with the information gathered in the SAI and refuses to sign, the Service Coordinator must document the refusal; the Service Coordinator must escalate the refusal to the DFPS well-being specialist. The review of the results by the Medical Consenter must not delay the determination of the services to be provided to the Member or the ability to authorize or initiate services. The MCO must provide a copy of the SAI within seven Business Days of the request. The MCO must monitor HHSC or its designee's portal and, upon notification of a preliminary denial of medical necessity, must contact the Medical Consenter to offer an opportunity to hold a peer-to-peer review with the treating physician of the Member or Medical Consenter's choice and the MCO Medical Director. The MCO must ensure that the peer-to-peer review does not affect Member rights to appeal an initial assessment or reassessment through the MCO Internal Appeal process or the State Fair Hearing Process. In addition, the MCO must monitor HHSC or its designee's portal through the final medical necessity determination and must follow the guidelines stated in **Chapter 16 of Exhibit B, UMCM**.

#### 2.6.57.3 MEDICALLY DEPENDENT CHILDREN PROGRAM PROVIDER REQUIREMENTS

The MCO must provide MDCP Covered Services to eligible Members. The MCO must contract with Providers with the following qualifications, consistent with requirements in the MDCP HCBS Waiver:

**Respite**: Attendants providing Respite Care must be at least 18 years of age. The attendant must have a high school diploma or GED credentials and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the Required Services as needed by the Member. RNs and LVNs must have current licenses under Tex. Occ. Code ch. 301. Child day care facilities must be licensed by HHSC.

The MCO must ensure MSHCN receives the care recommended by a healthcare professional or qualified professional affiliated with the local school district or ECI program.

Specific licensure requirements apply based on the place of service for Respite care.

For in-home Respite delivered by a HCSSA licensed by HHSC under 26 Tex. Admin. Code pt. 1, ch. 558, skilled care must be performed by a RN or LVN or delegated by a RN. Non-licensed individuals providing delegated skilled tasks must be supervised by a RN. Any delegated skilled care must meet the requirements of the Texas Nursing Practice Act, Tex. Occ. Code ch. 301. The HCSSA must employ a Respite attendant who meets the following requirements:

1. Is at least 18 years of age;
2. Has a high school diploma, GED credentials, or documentation of a proficiency evaluation of experience and competence to perform job tasks;
3. Is trained in Cardiopulmonary Resuscitation (CPR) and first-aid;
4. Can pass criminal history and sex offender registry checks;
5. Is not on the Employee Misconduct Registry or Nurse Aide Registry list;
6. Is familiar with the Member's specific tasks;
7. Is not on the State and federal lists of excluded individuals and entities; and
8. Is not the Member's spouse, Caregiver, or Medical Consenter.

For out-of-home Respite delivered by a host family licensed as a foster home by DFPS or verified as a foster home by a child-placing agency that is licensed by DFPS (26 Tex. Admin. Code pt. 1, chs. 745, 749, and 750), the provider of the Respite service component must be at least 18 years of age and have a high school diploma or GED credentials. The host family must not provide services in its residence to more than four persons unrelated to the Member at one time. The host family may not be the foster family that is receiving payment from DFPS for the residential care of the Member. The host family must ensure that the individual participates in age-appropriate community activities; and the host family home environment is healthy and safe for the Member. The host family must provide services in a residence that the host family owns or leases. The residence must be a typical residence in the neighborhood and must meet the needs of the individual.

For out-of-home Respite delivered by a child day care facility licensed by HHSC under 26 Tex. Admin. Code pt. 1, ch. 745, the provider of the Respite service component must be at least 18 years of age. The provider must have a high school diploma or certificate of high school equivalency GED credentials and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the Required Services as needed by the individual. RNs and LVNs must have current licenses under Tex. Occ. Code ch. 301.

For out-of-home Respite delivered by special care facilities licensed by HHSC under 26 Tex. Admin. Code pt. 1, ch. 510, the provider of the Respite service component must be at least 18 years of age. The provider must have a high school diploma or certificate of high school equivalency GED credentials and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the Required

Services as needed by the individual. RNs and LVNs must have current licenses under Tex. Occ. Code ch. 301.

For out-of-home Respite delivered by a Hospital licensed by HHSC under 25 Tex. Admin. Code pt.1, ch. 133 and participating in Medicare, the provider of the Respite service component must be at least 18 years of age. The provider must have a high school diploma or certificate of high school equivalency GED credentials and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the Required Services as needed by the individual. RNs and LVNs must have current licenses under Tex. Occ. Code ch. 301.

For out-of-home Respite delivered by a nursing facility licensed by HHSC under 26 Tex. Admin. Code pt. 1, ch. 554, the nursing facility Respite provider must employ staff who meet items 1-7 in the Respite attendant requirements list above.

For out-of-home Respite delivered by a camp licensed by DSHS under 25 Tex. Admin. Code pt. 1, ch. 265, subch. B, the provider of the Respite service component must be at least 18 years of age. The camp's provider must have a high school diploma or certificate of high school equivalency GED credentials and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the Required Services as needed by the individual. RNs and LVNs must have current licenses under Tex. Occ. Code ch. 301. These camps must be accredited by the American Camping Association.

**Supported Employment and Employment Assistance:** HCSSAs providing Supported Employment or Employment Assistance are licensed by HHSC. The provider of Supported Employment services must meet all the criteria in one of the following three options:

**Option 1:**

1. A bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
2. Six months of documented experience providing services to people with Disabilities in a professional or personal setting.

**Option 2:**

1. An associate degree in rehabilitation, business, marketing, or a related human services field; and
2. One year of documented experience providing services to people with Disabilities in a professional or personal setting.

**Option 3:**

1. A high school diploma or GED; and
2. Two years of documented experience providing services to people with Disabilities in a professional or personal setting.

**Financial Management Services:** Private entities furnish Financial Management Services. These entities, called FMSAs, are procured through an open enrollment process and are required to hold a Medicaid provider agreement with the State.

An FMSA must comply with the requirements for delivery of Financial Management Services, including attending an HHSC mandatory three-day training session. For more information, please see https://apps.hhs.texas.gov/providers/training/FMSA.cfm

The FMSA must not be the Member's spouse, Caregiver, Medical Consenter, legal guardian, or the spouse of the Member's legal guardian.

**Adaptive Aids**: The provider of Adaptive Aids must be a DME supplier or be a manufacturer of items not supplied through DME suppliers.

**Flexible Family Support Services:** HCSSAs providing flexible family support services are licensed by HHSC. Skilled care must be performed by a RN or LVN or delegated by a RN. Non-licensed individuals providing delegated skilled tasks must be supervised by a RN. Any delegated skilled care must meet the requirements of the Texas Nursing Practice Act, Tex. Occ. Code ch. 301. The HCSSA must employ a Respite attendant who meet items 1-8 in the Respite attendant requirements list above.

**Minor Home Modifications:** A Minor Home Modification provider must comply with city building codes and American with Disabilities Act standards. A Minor Home Modification program Provider must have:

1. Five years of experience as a building contractor;
2. Three references from previous contractor clients; and
3. Current general comprehensive liability coverage for errors and omissions.

**Transition Assistance Services:** The transition assistance Services provider must comply with the requirements for delivery of transition assistance Services, which include requirements regarding allowable purchases, costs limits, and timeframes for delivery. Transition assistance Services Providers must demonstrate knowledge of, and history in, successfully serving individuals who require HCBS.

The MCO must offer the CDS option for Respite, Supported Employment, Employment Assistance, flexible family support services, Adaptive Aids, and Minor Home Modifications.

#### 2.6.57.4 Continuity of Care Requirements for Medically Dependent Children Program Members

The MCO must ensure that the healthcare of MDCP Members is not disrupted, compromised, or interrupted. The MCO must take special care to provide Continuity of Care for enrolled Members who are medically fragile and those whose physical health or BH could be placed in jeopardy if Covered Services are disrupted, compromised, or interrupted.

The MCO must continue to provide all Covered Services included in an MDCP Member's existing Service Plan and may not reduce or replace services until the Member has been re-assessed using the required elements of the SAI, the Member's initial ISP has been submitted, and the ISP is updated to include the MDCP service plan. If an MDCP Member is disenrolled from STAR Health and enrolls in the STAR Kids program, the MCO must provide the STAR Kids MCO with the results from the most recent SAI assessment.

Upon notification from a Member or Provider of the existence of a PA, the MCO must ensure Members receiving services through a PA receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

1. 180 Days after the transition to a new MCO,
2. Until the end of the current PA, or
3. Until the MCO has appropriately evaluated and administered the SAI and issued or denied a new authorization.

The MCO must allow Members to continue seeing their existing MDCP service providers, including OON providers, for a period of 180 Days after the transition to a new MCO.

### 2.6.58 TEXAS HEALTH STEPS

The following sections outline requirements for THSteps. The MCO must provide all THSteps services except the Non-capitated services referenced in **Section 2.6.60.7 of this Exhibit H, SOW.**

### 2.6.58.1 TEXAS HEALTH STEPS MEDICAL CHECKUPS

The MCO must develop effective methods to ensure that all new Members birth through age 20 receive a THSteps medical checkup within 30 Days of enrollment, and all subsequent THSteps medical checkups according to the recommendations established by the THSteps periodicity schedule for children as described in **Exhibit E, TMPPM**.

The MCO must arrange for timely THSteps medical checkups for all eligible Members, as noted below, except when the Member, Caregiver, or Medical Consenter knowingly and voluntarily declines or refuses THSteps services after receiving sufficient information to make an informed decision. The MCO must notify the DFPS caseworker of all refusals to obtain a THSteps checkup.

For purposes of timely THSteps medical checkups, the terms new Member and existing Member are defined in **Chapter 12 of Exhibit B, UMCM**.

For new Members birth through age 20, a THSteps medical checkup should be offered as soon as practicable, but in no case later than within 30 Days of enrollment.

A THSteps medical checkup for an existing Member birth through 35 months of age is timely if received no later than 60 Days after the periodic due date based on the Member's birth date.

A THSteps medical checkup for an existing Member age three years and older is due annually beginning on the Member's birthday and is considered timely if it occurs no later than 364 Days after the Member's birthday.

For the purposes of this section only, **Section 2.6.58 of this Exhibit H, SOW**, enrollment means the effective date provided in the DNF or Enrollment Files, which reflects the date that the Member entered DFPS care.

For the purposes of this section only, **Section 2.6.58 of this Exhibit H, SOW,** effective methods, include but are not limited to, educating Medical Consenters about the THSteps requirements and attempts to schedule the THSteps appointment for the Medical Consenter. The MCO must report these effective methods through the Medicaid Managed Care THSteps Medical Checkups reports described in **Chapters 12 of Exhibit B, UMCM**. As required by Texas Government Code § 533.0054(b), if the MCO does not report these effective methods, the MCO is subject to contractual remedies.

In addition, in compliance with Tex. Fam. Code § 264.1075(b), the MCO must arrange for an assessment of each Member in conservatorship to determine if the Member has an intellectual or developmental Disability. The MCO may use the THSteps checkup and other relevant screenings or assessments performed by the PCP or BH Provider to comply with this provision of the Texas Family Code.

If the initial THSteps medical checkup required within 30 Days of enrollment exceeds the number of allowable checkups for the Member's age range, the MCO must reimburse the additional checkup as an exception to periodicity in accordance with **Exhibit E, TMPPM**.

### 2.6.58.2 TEXAS HEALTH STEPS DENTAL CHECKUPS

The MCO must ensure Members receive a THSteps dental checkup within 60 Days of enrollment for Members six months of age and older. MCO must ensure Members under 6 months of age at the time of enrollment must receive their THSteps dental checkup within 30 Days of becoming six months of age.

The MCO must arrange for timely THSteps dental checkups for all eligible Members, except when the Member, Member's Caregiver, or Medical Consenter knowingly and voluntarily declines or refuses THSteps services after receiving sufficient information to make an informed decision. The MCO must notify the DFPS caseworker of all refusals to obtain a THSteps checkup for the Member.

### 2.6.58.3 ORAL EVALUATION AND FLUORIDE VARNISH

The MCO must educate Providers on the availability of the Oral Evaluation and Fluoride Varnish (OEFV) Covered Service that can be rendered and billed by OEFV-certified THSteps Providers when performed on the same day as the THSteps medical checkup. The MCO must educate Providers about the importance of OEFV documentation for inclusion in the Member's medical record and the necessity of documentation to support a qualification for reimbursement for appropriate provision of OEFV to eligible Members. MCO must ensure that the Provider education includes information about how to assist a Member with referral to a dentist to establish a Dental Home.

### 2.6.58.4 LAB

The MCO must educate Providers about THSteps requirements for submitting laboratory tests to DSHS. The MCO must ensure that all laboratory specimens collected as a required component of a THSteps checkup, including newborn screens, are submitted to DSHS or

to a laboratory approved by DSHS under Tex. Health & Safety Code § 33.016 for analysis unless otherwise provided by **Exhibit E, TMPPM**.

The MCO must require Providers to include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow-up THSteps medical checkup.

#### 2.6.58.5 EDUCATION AND OUTREACH

The MCO must ensure Members, Caregivers, and Medical Consenters are provided information and educational materials about THSteps services, including:

1. How and when Members should obtain the preventive THSteps medical checkups, along with diagnostic and treatment services, and dental services;
2. How Members, Caregivers, and Medical Consenters can access transportation services through NEMT; and
3. How the Member can request advocacy and assistance from the MCO.

The MCO must use required language describing THSteps services, including medical, dental, and case management services as provided in **Chapter 2 of Exhibit B, UMCM**. Any additions to or deviations from the required language must be reviewed and approved by HHSC prior to publication and distribution to Members.

The MCO will contact Members, Caregivers, and Medical Consenters in the manner designated by HHSC to remind them that they are responsible for obtaining the THSteps exam within 30 Days of the Member entering DFPS conservatorship, as required by DFPS form 2085-B Designation of Medical Consenter which is available at https://www.dfps.state.tx.us/site_map/forms.asp. The MCO must educate the Members, Caregivers, and Medical Consenters that they must schedule the THSteps appointments as soon as possible to ensure the exam is completed within 30 Days of entering DFPS conservatorship. The MCO will also inform the Members, Caregivers, and Medical Consenters of outreach opportunities and resources.

The MCO must provide outreach to Members, Caregivers, and Medical Consenters to ensure Members are effectively informed about available THSteps services and to ensure Members have access to prompt services. Each month, the MCO must retrieve from the HHSC EB bulletin board system a list of Members who are due and overdue for THSteps services. Using these lists and its own internally generated list, the MCO must contact such Members, Caregivers and Medical Consenters to encourage scheduling the service as soon as possible. The MCO outreach staff must ensure that Members, Caregivers and Medical Consenters are aware of and can access NEMT. The MCO outreach staff must coordinate with the THSteps Outreach and Informing Unit, DFPS, HHSC, and any other agency at the discretion of HHSC, for the purpose of coordinating THSteps outreach, informing, and services.

The MCO must make an effort to coordinate and cooperate with existing community and school-based health and education programs that offer services to school-aged children in a location that is both familiar and convenient to the Members.

The MCO must coordinate with Head Start programs to assist Members enrolling or enrolled in Head Start with scheduling THSteps checkups. This coordination must include informing Head Start programs on how to request scheduling assistance from the MCO when a Member needs a THSteps checkup.

### 2.6.58.6 TRAINING

The MCO must provide appropriate training to all Providers and Provider staff regarding THSteps services. Training must include:

1. THSteps services including preventive, diagnostic, and treatment services, as outlined in **Exhibit E, TMPPM**;
2. The periodicity schedule for THSteps medical and dental checkup services as outlined in **Exhibit E, TMPPM**;
3. The required components of THSteps medical and dental checkups, the importance of documenting all required components of the checkup in the medical record and Health Passport, and the necessity of documentation to support a complete checkup qualifying for reimbursement;
4. CCP services available under the THSteps program to Members birth through age 20;
5. Importance of updating contact information to ensure accurate Provider directories and the Medicaid online Provider lookup;
6. The process to submit missed appointment referrals either to THSteps Outreach and Informing Unit or the MCO and the assistance provided by the MCO for these referrals;
7. The existence of and information about the online THSteps materials catalog, including how to request an account, and how to order materials free of charge; and
8. Education and training to treat each THSteps checkup as an opportunity for a comprehensive assessment of the Member.

The MCO must implement a process by which it will systematically outreach to contracted PCPs for participation in the THSteps program. The MCO must implement a process to ensure contracted PCPs understand how to properly bill for the THSteps checkup and how to perform a complete checkup and document each checkup component. The MCO must also require non-PCP THSteps Providers to notify the Members' PCP of the results of the THSteps checkups and refer Members to the PCP for follow-up services recommended as a result of the THSteps screening.

### 2.6.58.7 DOCUMENTATION

The MCO must educate the Providers about the importance of documenting each component or element of a THSteps checkup for the checkup to be considered complete and to support a qualification for reimbursement for appropriate provision of the THSteps checkup to eligible Members. Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element.

#### 2.6.58.8 DATA VALIDATION

The MCO must require all Providers delivering THSteps services to submit claims for services paid on the NSF 837 claim form or CMS 1500 claim form and use the HIPAA compliant code set required by HHSC.

Encounter Data will be validated by chart review of a random sample of all THSteps-eligible Members against monthly Encounter Data reported by the MCO. HHSC or its designee will conduct chart reviews to validate that all screens are performed when due and as reported, and that reported data is accurate and timely. Substantial deviation between reported and charted Encounter Data could result in the MCO or Providers being investigated for potential FWA infractions without notice to the MCO or the Provider.

### 2.6.59 IMMUNIZATIONS

The MCO must educate Providers on the immunization standard requirements set forth in Tex. Health & Safety Code ch. 161; the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule; the AAP Periodicity Schedule for CHIP Members; and the ACIP Immunization Schedule for Medicaid Members. The MCO must educate Providers that Medicaid Members birth through age 20 must be immunized during the THSteps checkup according to the ACIP routine immunization schedule. The MCO must also educate Providers that the screening Provider or its appropriate designee is responsible for administration of the immunization and must not refer children to Local Health Departments or other entities to receive immunizations.

The MCO must educate Providers about the importance of including documentation for immunizations in the Member's medical record, and the necessity of the Provider's documentation to support a qualification for reimbursement for appropriate provision of immunizations to eligible Members.

The MCO must educate Providers about and require Providers to comply with the requirements of Tex. Health & Safety Code ch. 161, relating to the Texas Immunization Registry (ImmTrac2), to include Medical Consenter consent on the vaccine information statement.

The MCO must notify Providers that they may enroll, as applicable, as Texas Vaccines for Children Providers. See DSHS web page: Texas Vaccines for Children. In addition, the MCO must work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac2 registry.

### 2.6.60 PROVISIONS RELATED TO COVERED SERVICES FOR MEMBERS

The following sections provide additional requirements associated with Covered Services for Members.

### 2.6.60.1 EMERGENCY SERVICES

The MCO must contractually require Providers to comply with medical consent and informed consent requirements in Tex. Fam. Code § 266.004 that require the Member's Medical Consenter to consent to the provision of medical care and specify when the consent is considered valid. A provider does not need the medical consent of the Member's Medical Consenter to provide Emergency Services for a Member that has an Emergency Medical Condition. The MCO must contractually require the Provider to notify the Medical Consenter about the provision of Emergency Services no later than the second Business Day after providing Emergency Services, as required by Tex. Fam. Code § 266.009.

The MCO's policies and procedures, provision of Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services and Post-stabilization Care Services must comply with all applicable State and federal laws, rules, and regulations, including 42 C.F.R. § 438.114 and 1 Tex. Admin. Code pt. 15, ch. 353, whether the provider is in the MCO's Network or OON. MCO policies and procedures must be consistent with the prudent layperson definition of an Emergency Medical Condition and the claims adjudication processes required under the Contract and 42 C.F.R. § 438.114.

The MCO must pay for the professional, facility, and ancillary Covered Services that are Medically Necessary to perform the medical screening, examination, and stabilization of a Member presenting with an Emergency Medical Condition, an Emergency BH Condition, and Post-stabilization Care Services to the Hospital ER, 24 hours a Day, 7 Days a week, rendered by either the MCO's Network or OON providers.

The MCO must not require a PA or a PA number as a condition for payment for an Emergency Medical Condition, an Emergency BH Condition, or labor. and delivery. The MCO must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. In accordance with 42 C.F.R. § 438.114, the MCO must not refuse to cover Emergency Services based on the ER provider, Hospital, or fiscal agent not notifying the Member's PCP or the MCO of the Member's screening and treatment within 10 Days of presentation for Emergency Services.

The MCO must not hold the Member who has an Emergency Medical Condition or an Emergency BH Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the Member. The MCO must accept the attending emergency physician's or the treating Provider's determination of when the Member is sufficiently stabilized for Transfer or Discharge.

The MCO must ensure that a medical screening examination needed to diagnose an Emergency Medical Condition is provided in a Hospital-based ER that meets the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 C.F.R. §§ 438.114(b) and (c), 489.20, and 489.24. The MCO must pay for the emergency medical screening examination, as required by 42 U.S.C. § 1395dd. The MCO must reimburse for both the physician services and the Hospital's Emergency Services, including the ER and its ancillary services.

When the medical screening examination determines an Emergency Medical Condition or an Emergency BH Condition exists, the MCO must pay for Emergency Services performed to Stabilize the Member (Post-stabilization Care Services). The MCO must reimburse for both the physician and Hospital's emergency stabilization services, including the ER and its ancillary services.

The MCO must cover and pay for Post-stabilization Care Services in the amount, duration, and scope necessary to comply with 42 C.F.R. §§ 438.114(b) and (e) and 42 C.F.R. § 422.113(c)(2). The MCO is financially responsible for Post-stabilization Care Services provided by Network or OON providers that are not pre-approved by a Provider or other MCO representative, but administered to maintain, improve, or resolve the Member's Stabilized condition if:

1. The MCO does not respond to a request for PA within one hour of receipt of the request;
2. The MCO cannot be contacted; or
3. The MCO representative and the treating physician cannot reach an agreement concerning the Member's care and a Provider is not available for consultation.

In this situation, the MCO must give the treating physician the opportunity to consult with a Provider and the treating physician may continue with care of the Member until a Provider is reached. In accordance with the requirements in 42 C.F.R. § 422.113 (c)(3), the MCO's financial responsibility ends as follows:

1. The Provider with privileges at the treating Hospital assumes responsibility for the Member's care;
2. The Provider assumes responsibility for the Member's care through Transfer;
3. The MCO representative and the treating physician reach an agreement concerning the Member's care; or
4. The Member is Discharged.

The requirements in this section regarding access to and payment of OON providers apply only to OON providers who are enrolled as Texas Medicaid providers.

### 2.6.60.2 Family Planning – Specific Requirements

The MCO must require, through Provider Contract provisions, that Members requesting contraceptive services or family planning services are also provided counseling and education about family planning and family planning services available to Members.

The MCO must develop outreach programs to increase community support for family planning and encourage Members to use available family planning services.

The MCO must ensure Members and Medical Consenters have the right to choose any Medicaid participating family planning provider, whether the provider chosen by the Member and Medical Consenter is in the Network or OON. The MCO must provide Members and Medical Consenters access to information about available Providers of family planning services and the Member and Medical Consenter's right to choose any Medicaid family planning Provider. The MCO must provide access to confidential family planning services.

The MCO must provide, at minimum, the full scope of Covered Services available under Texas Medicaid for family planning services. The MCO must reimburse family planning agencies the Medicaid FFS amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies not covered by the VDP, and must reimburse OON family planning providers in accordance with 1 Tex. Admin. Code pt. 15, ch. 353, subch. A, § 353.4. The MCO must not require PA for family planning services whether rendered by a Network or OON provider.

The MCO must provide medically approved methods of contraception to Members, provided that the methods of contraception are Covered Services. Contraceptive methods must be accompanied by verbal and written instructions on their correct use. The MCO must establish mechanisms to ensure all medically approved methods of contraception are made available to the Member, either directly or by referral to a Subcontractor.

The MCO must develop, implement, monitor, and maintain standards, policies and procedures for providing information regarding family planning to Providers, Members, Caregivers, and Medical Consenters, specifically regarding State and federal laws governing Member confidentiality, including minors. Providers and family planning agencies must not require parental consent for minors to receive family planning services. The MCO must require, through contractual provisions, that Subcontractors have mechanisms in place to ensure Member (including minors) confidentiality for family planning services.

#### 2.6.60.3 PERINATAL SERVICES

The MCO's perinatal Covered Services must ensure appropriate care is provided to Members and infant Members from the preconception period through the infant's first year of life. The MCO's perinatal healthcare system must comply with the requirements of the Tex. Health & Safety Code ch. 32 and administrative rules codified at 25 Tex. Admin. Code pt. 1, ch. 37, subch. M.

The MCO must have a perinatal healthcare system in place that, at a minimum, provides the following:

1. Pregnancy planning and perinatal health promotion and education for reproductive-age women and adolescents;
2. Perinatal risk assessment of non-pregnant women, pregnant, and postpartum women, and infants up to one year of age;
3. Access to appropriate levels of care based on risk assessment, including Emergency Services;
4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
5. Availability and accessibility of OB/GYN Providers, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems;
6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems; and

7. Education and care coordination for Members who are at high risk for preterm labor, including education on the availability of medication regimens to prevent preterm birth, such as hydroxyprogesterone caproate.

The MCO must also educate Providers on the PA processes for these benefits and Covered Services.

On a monthly basis, HHSC will supply the MCO with a file containing birth record data. The MCO must use this file every month to identify reproductive-age Members with a previous preterm birth. The MCO must provide outreach, education, Service Coordination, and Member referrals to Providers, to assess the need for the use of hydroxyprogesterone caproate, sometimes referred to as 17P, to identified Members as described in this section to prevent additional preterm births. The MCO must report on use of the data file as specified in **Chapter 5.16 of Exhibit B, UMCM**.

In accordance with the appointment access standard in **Section 2.6.33.1 of this Exhibit H, SOW**, the MCO must have a process to expedite an obstetrical exam for a pregnant Member. Specifically, a pregnant Member must have an obstetrical exam no later than five Days after the Member is diagnosed as pregnant or five Days after the Member's Effective Date of Coverage, whichever is later.

The MCO must have procedures in place to contact and assist a DFPS Staff, Medical Consenter, pregnant Member, or a Member who has recently given birth in selecting a PCP for her baby either before the birth or soon after the baby is born.

The MCO must provide Covered Services relating to the labor and delivery for its pregnant and delivering Members, including inpatient care and professional services for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated caesarian delivery. The MCO must provide all Medically Necessary neonatal care to the newborn Member and may not place limits on the duration of such care.

The MCO must notify Providers involved in the care of newborns, pregnant, or delivering women, including OON providers and Hospitals, of the MCO’s PA requirements. The MCO must not require a PA as a condition for payment for Covered Services provided to a pregnant or delivering Member for a medical condition that requires Emergency Services, regardless of when the Emergency Medical Condition arises.

The MCO must adjudicate provider claims for services provided to a newborn Member in accordance with HHSC’s claims processing requirements using the proxy ID number or State-issued Medicaid ID number. The MCO cannot deny claims based on a provider’s non-use of HHSC-issued Medicaid ID number for a newborn Member. The MCO must accept provider claims for newborn services based on mother’s name or Medicaid ID number, with accommodations for multiple births, as specified by the MCO. The MCO can specify whether the mother’s name, Medicaid ID number, or both must be used when the newborn’s Medicaid ID number is not yet available, and the MCO must specify how multiple births are distinguished.

### 2.6.60.4 SEXUALLY TRANSMITTED INFECTIONS AND HUMAN IMMUNODEFICIENCY VIRUS

The MCO must provide Sexually Transmitted Infection (STI) and Human Immunodeficiency Virus (HIV) Covered Services that include STI and HIV prevention, screening, counseling, diagnosis, and treatment. The MCO must ensure that Members have prompt access to appropriate services for STIs and HIV. The MCO must allow Members access to STI services and HIV diagnosis services without PA or referral by a PCP.

The MCO must comply with Tex. Fam. Code § 32.003, relating to consent to treatment by a child. The MCO must provide all Covered Services required to form the basis for a diagnosis by the Provider as well as the STI and HIV treatment plan. The MCO must make education available to Providers, Members, Caregivers, and Medical Consenters on the prevention, detection, and effective treatment of STIs and HIV.

The MCO must inform and require its Providers who provide STI and HIV services to comply with all State laws relating to communicable disease reporting requirements. The MCO must require Providers to report all confirmed cases of STIs and HIV to the local or regional health authority according to 25 Tex. Admin. Code pt. 1, ch. 97, subch. F, §§ 97.131–.134, using the required forms and procedures. The MCO must require Providers to coordinate with the DSHS regional health authority to ensure Members with confirmed cases of syphilis, chancroid, gonorrhea, chlamydia, neonatal herpes, and HIV receive risk reduction and partner elicitation and notification counseling.

The MCO must have established procedures to make Member records available to public health agencies with authority to conduct disease investigation, receive confidential Member information, and provide follow-up activities.

The MCO must require Providers to have procedures in place to protect the confidentiality of Members who receive STI and HIV services. These procedures must include, but are not limited to, the manner in which medical records are to be safeguarded, how employees are to protect medical information, and under what conditions information can be shared. The MCO must implement policies and procedures to monitor Provider compliance with confidentiality requirements. The MCO must have policies and procedures in place regarding obtaining informed consent from, and counseling for, Members who are provided STI and HIV services.

### 2.6.60.5 TUBERCULOSIS

The MCO must provide Members, Caregivers, Medical Consenters, and Providers with education on the prevention, detection, and effective treatment of Tuberculosis (TB). The MCO must establish mechanisms to ensure all procedures required to screen at-risk Members, and to form the basis for a diagnosis and proper prophylaxis and management of TB are available to all Members, except services referenced in **Section 2.6.60.7 of this Exhibit H, SOW,** as Medicaid Non-capitated Services.

The MCO must develop policies and procedures to ensure Members who may be or are at risk for exposure to TB are screened for TB. For purposes of this section, an at-risk Member means a person who is susceptible to TB because of the association with certain risk factors, behaviors, drug resistance, or environmental conditions.

The MCO must consult with the local TB control program to ensure that all services and treatments provided comply with the guidelines recommended by the American Thoracic Society, the CDC, and DSHS policies and standards.

The MCO must implement policies and procedures requiring Providers to report all confirmed or suspected cases of TB to the local TB control program within one Business Day of identification, using the most recent DSHS forms and procedures for reporting TB. Upon request, the MCO must provide access to Member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases.

The MCO must coordinate with the local TB control program to ensure that all Members with suspected or confirmed TB have a contact investigation and receive Directly Observed Therapy (DOT).

The MCO must require, through Provider Contracts, that Providers report to DSHS or the local TB control program any Member who is non-compliant, who is drug resistant, or who is or may be posing a public health threat due to TB.

The MCO must cooperate with the local TB control program in enforcing the control measures and quarantine procedures contained in Tex. Health & Safety Code ch. 81.

The MCO must have a mechanism for coordinating a post-discharge plan for follow-up DOT with the local TB program. The MCO must coordinate with the DSHS South Texas Hospital and Texas Center for Infectious Disease, for voluntary and court-ordered admission, Discharge plans, treatment objectives, and projected length of stay for Members with multi-drug resistant TB.

#### 2.6.60.6 OBJECTION TO PROVIDING CERTAIN SERVICES

In accordance with 42 C.F.R. § 438.102, the MCO may file an objection to providing, reimbursing for, or providing coverage of a counseling or referral service for a Covered Service based on moral or religious grounds.

To meet the requirements of this section, the MCO must notify HHSC of grounds for and provide detail concerning its moral or religious objection and the specific Covered Services under the objection, no less than 180 Days prior to the proposed effective date of the policy change.

The MCO must work with HHSC to develop a work plan to complete the necessary tasks and determine an appropriate date for implementation of the requested changes to the requirements related to Covered Services. The work plan must include timeframes for

completing the necessary Contract and waiver amendments, adjustments to Capitation Rates, identification of the MCO and enrollment materials needing revision, and notifications to Members.

HHSC may make downward adjustments to Capitation Rates for the MCO if it objects to providing certain Covered Services based on moral or religious grounds. The MCO must notify their Members of any policy change 30 Days before the policy effective date and must inform Members when these services are not covered and how to obtain information on receiving these services from HHSC.

### 2.6.60.7 NON-CAPITATED SERVICES

The following Texas Medicaid programs, services, or benefits have been excluded from MCO Covered Services. Medicaid Members are eligible to receive these Non-capitated Services on another basis, such as a FFS basis, and FFCC Members may be eligible for some of these services. The MCO should refer to relevant chapters in **Exhibit B, UMCM,** for more information:

1. THSteps Environmental Lead Investigation (ELI)
2. ECI case management;
3. ECI Specialized Skills Training;
4. Case Management for Children and Pregnant Women;
5. Texas School Health and Related Services (SHARS);
6. HHSC Blind Children's Vocational Discovery and Development program;
7. TB services provided by DSHS-approved providers including DOT and contact investigation;
8. HHSC's NEMT;
9. HHSC hospice services;
10. DFPS Nurse-Family Partnership (NFP)
11. Mental Health TCM and Mental Health Rehabilitative Services for Dual Eligible Members;
12. SUD treatment in a chemical treatment facility for Dual Eligible Members.

The MCO must educate Members, Caregivers, Medical Consenters, and DFPS Staff regarding the availability of Non-capitated Services and provide appropriate referrals for Members to obtain or access these services. The MCO is responsible for educating Providers that claims for all Non-capitated Services must be submitted to HHSC or its designee for reimbursement.

### 2.6.60.8 PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS AND SERVICES

The MCO must ensure that PPECC services are prescribed by a physician. PPECC services are considered an alternative to PDN; but must not supplant a Member's right to receive PDN pursuant to Tex. Health & Safety Code § 248A.151(b). The MCO must ensure that service hours in a PPECC are a one-to-one replacement of PDN services hours, unless

additional hours are Medically Necessary, in accordance with Tex. Health & Safety Code § 248A.158. A Member may receive both PDN and PPECC services when Medically Necessary. These services may be billed on the same day; but cannot be received at or billed for the same time in that day. The MCO must not pay for PPECC services provided overnight. PPECC services are limited to no more than 12 hours a Day. The MCO must not consider the cost of service as a factor in determining the most appropriate setting for an eligible Member to receive skilled nursing services. Members receiving PPECC services will be classified as MSHCN as described in **Section 2.6.45** this **of Exhibit H, SOW**.

The MCO must ensure that Network PPECCs adhere to licensing requirements contained in Tex. Health & Safety Code ch. 248A and 26 Tex. Admin. Code pt. 1, ch. 550. The MCO and Network PPECCs must also adhere to Medicaid rules contained in 1 Tex. Admin. Code pt. 15, ch. 363, subch. B.

The MCO must ensure that admission to a PPECC is voluntary and based on the preference of the Member or Medical Consenter pursuant to Tex. Health & Safety Code § 248A.151(a)(4).

The MCO must ensure continuity of PPECC services in accordance with the authorization timeframes established in **Section 2.6.51 of this Exhibit H, SOW**. The MCO must also coordinate care and authorizations between PPECCs and a Member's other Providers, including home health agencies, to ensure the Member's PPECC plan of care does not include an overlap or duplication of Covered Services, including PDN, home health skilled nursing, home health aide services, and therapies. Therapy services, including occupational, speech, physical, and respiratory therapies rendered in a PPECC may be provided by:

1. Therapists employed by or contracted with the PPECC; or
2. Credentialed Network therapists not employed by or contracted with the PPECC.

#### 2.6.60.8.1 Prior Authorization for Prescribed Pediatric Extended Care Center Services

The MCO must ensure that PPECC services, excluding PPECC transportation, are prior authorized. All PA requests must contain documentation of medical necessity, including a physician order and PPECC plan of care. The MCO may choose to use PA forms used in FFS Medicaid, such as the plan of care and nursing addendum, which includes a 24-hour daily care flow sheet, or similar plan-developed forms as supplements to the standardized TDI PA form.

The MCO must ensure that an initial authorization for PPECC services lasts for a maximum period of 90 Days, at which point a PPECC Provider must seek a new authorization of services up to a maximum of 180 Days. Additionally, if there is a change in the Member's status before expiration of the authorization period, the PPECC Provider must modify the plan of care and seek a new authorization or a change in authorization.

### 2.6.60.9 MEMBER RIGHTS AND RESPONSIBILITIES

In accordance with 42 C.F.R. § 438.100, the MCO must maintain written policies and procedures for informing Members, DFPS Staff, and Medical Consenters of their rights and responsibilities, and must notify all Members of their right to request a copy of these rights and responsibilities, and the right to a State Fair Hearing separate from the appeals process for all Members. The MCO must ensure the Member handbook includes notification of Member rights and responsibilities, as set forth in **Exhibit B, UMCM**.

### 2.6.60.10 COORDINATION WITH PUBLIC HEALTH ENTITIES

The MCO must identify MCO staff who will be available to assist Public Health Entity Providers and PCPs in efficiently referring Members to the Public Health Entity Providers, specialists, and health-related service providers, either within or outside of the MCO's Network.

The MCO must also inform Members in writing that confidential healthcare information will be provided to the PCP and educate Members on how to better utilize their PCPs, Public Health Entity Providers, ERs, specialists, and health-related service Providers.

#### 2.6.60.10.1 REIMBURSED ARRANGEMENTS WITH PUBLIC HEALTH ENTITIES

The MCO must make a good faith effort to enter into a Subcontract for Covered Services with Public Health Entities. Possible Covered Services that could be provided by Public Health Entities include the following services:

1. STIs services;
2. Confidential HIV testing;
3. Immunizations;
4. TB care;
5. Family planning services;
6. THSteps medical checkups, and
7. Prenatal services.

If the MCO is unable to enter into a Subcontract with Public Health Entities, the MCO must document efforts to contract with Public Health Entities and make such documentation available to HHSC upon request.

The MCO's Subcontracts with Public Health Entities must specify the scope of responsibilities of each party, the methodology and agreements regarding billing and reimbursements, reporting responsibilities, Member and Provider educational responsibilities, and the methodology and agreements regarding sharing of confidential medical record information between the Public Health Entity and the MCO or PCP.

The MCO must:

1. Identify care managers available to assist Public Health Entities and PCPs in efficiently referring Members and Medical Consenters to the public health providers, specialists, and health-related service providers either within or outside the MCO's Network; and
2. Inform Members and Medical Consenters that confidential healthcare information will be provided to the PCP and educate Members and Medical Consenters on how to better utilize their PCPs, public health providers, emergency departments, specialists, and health-related service providers.

#### 2.6.60.10.2 NON-REIMBURSED ARRANGEMENTS WITH LOCAL PUBLIC HEALTH ENTITIES

The MCO must coordinate with Public Health Entities in each region regarding the provision of essential Covered Services. The MCO must:

1. Report to Public Health Entities regarding communicable diseases or diseases that are preventable by immunization as defined by State law;
2. Notify the local Public Health Entity of communicable disease outbreaks, as defined by State law, involving Members;
3. Educate Members and Providers regarding WIC services available to Members;
4. Ensure through Provider Contracts that Providers coordinate with local Public Health Entities that have a child lead program, or with the DSHS Texas Childhood Lead Poisoning Prevention program when the local Public Health Entity does not have a child lead program, when following up on suspected or confirmed cases of childhood lead exposure; and
5. Make a good faith effort to establish and maintain an effective working relationship with all State and local Public Health Entities in each region to identify issues and promote initiatives addressing public health concerns.

### 2.6.60.11 COORDINATION WITH OTHER STATE HEALTH AND HUMAN SERVICES PROGRAMS

The MCO must coordinate with other State HHSC programs regarding the provision of essential Covered Services. The MCO must:

1. Require Providers to use the DSHS laboratories for specimens obtained as part of a THSteps medical checkup, as indicated in **Section 2.6.58.4 of this Exhibit H, SOW**;
2. Notify Providers of the availability of vaccines through the Texas Vaccines for Children program;
3. Work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac2;
4. Educate Providers and Members about the Case Management for Children and Pregnant Women services available;
5. Coordinate services with Case Management for Children and Pregnant Women;
6. Participate, to the extent practicable, in the community-based coalitions with the Medicaid-funded case management programs;

7. Cooperate with activities required of State and local public health authorities necessary to conduct the annual population and community-based needs assessment;
8. Require Providers to: (1) report all blood lead results to the Texas Childhood Lead Poisoning Prevention program; (2) follow-up on suspected or confirmed cases of childhood lead exposure with the Childhood Lead Poisoning Prevention program; and (3) follow the CDC guidelines for testing children for lead and follow-up actions for children with elevated lead levels, in accordance with Tex. Health & Safety Code ch. 88 and 25 Tex. Admin. Code pt. 1, ch. 37, subch. Q;
9. Coordinate with THSteps Outreach and Informing Unit;
10. Coordinate care protocols for working with dental Subcontractors, as well as protocols for reciprocal referral and communication of data and clinical information regarding the Member's Medically Necessary dental services;
11. Develop a coordination plan to share with local entities regarding Members identified as requiring special needs or assistance during a disaster;
12. Educate Providers and Members about primary and family planning services available through the Healthy Texas Women Program and Family Planning Program;
13. Require Providers to report confirmed diagnosis of STIs including HIV, in accordance with Tex. Health & Safety Code ch. 81 and 25 Tex. Admin. Code pt. 1, ch. 97, subch. F;
14. Require Providers to screen all newborns for certain genetic disorders or medical conditions, in accordance with Tex. Health & Safety Code § 33.011 and 25 Tex. Admin. Code pt.1, ch. 37, subch. D;
15. Require Providers to report suspected child abuse or neglect no later than the 48th hour after the hour the professional first suspects that a child may be abused or neglected, in accordance with the Tex. Fam. Code § 261.101;
16. Require Providers to comply with newborn hearing screening requirements, in accordance with Tex. Health & Safety Code ch. 47 and 25 Tex. Admin. Code pt. 1, ch. 37, subch. S; and
17. Require Providers to refer any child with a qualifying medical diagnosis or suspected developmental delay to an ECI program, in accordance with 34 C.F.R. pt. 303, Tex. Hum. Res. Code ch. 73, and 26 Tex. Admin. Code pt.1, ch. 350.

### 2.6.60.12 Advance Directives

The MCO must maintain written policies and procedures for informing all Members 18 years of age and older, in writing. about their rights to refuse, withhold, or withdraw medical treatment and mental health treatment through advance directives in accordance with 42 U.S.C. §§ 1396a(a)(57) and 1396b(m)(1)(A).

The MCO's Member handbooks must inform the Member how to exercise an advance directive. The MCO's policies and procedures must include written notification to Members 18 years of age and older and comply with provisions of 42 C.F.R. § 422.128 and 42 C.F.R. pt. 489, subpt. I, regarding advance directives for all Hospitals, critical

access Hospitals, skilled nursing facilities, home health agencies, Providers of home health care, Providers of PCS and hospice, as well as the following State laws and rules:

1. A Member's right to self-determination in making healthcare decisions;
2. The Advance Directives Act, Tex. Health & Safety Code ch. 166, which includes:
   a. A Member's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold, or withdraw life-sustaining treatment in the event of a terminal or irreversible condition;
   b. A Member's right to make written and non-written out-of-hospital Do-Not-Resuscitate (DNR) orders; and
   c. A Member's right to execute a medical power of attorney to appoint an agent to make healthcare decisions on the Member's behalf if the Member becomes incompetent.
3. The Declaration for Mental Health Treatment, Tex. Civ. Prac. & Rem. Code ch. 137, which includes a Member's right to execute a declaration for mental health treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

The MCO must maintain written policies for Providers to follow regarding receiving and documenting consent from a DFPS caseworker or Medical Consenter prior to implementing a Member's advance directive. Those policies must include a clear and precise statement of limitation if the MCO or a Provider cannot or will not implement a Member's advance directive.

The MCO must not require a Member to execute or issue an advance directive as a condition of receiving Covered Services. The MCO must not discriminate against a Member based on whether or not the Member has executed or issued an advance directive.

The MCO's policies and procedures must require the MCO and its Subcontractors to comply with the requirements of State and federal law and DFPS relating to advance directives.

The MCO must provide education and training to employees and Members, Caregivers and Medical Consenters on issues concerning advance directives.

All materials provided to Members regarding advance directives must be written at a sixth grade reading comprehension level, except where a provision is required by State or federal law and the provision cannot be reduced or modified to a sixth grade reading level because it is a reference to the law or is required to be included "as written" in the State or federal law.

The MCO must notify Members, Medical Consenters, DFPS Staff, and Caregivers of any changes in State or federal laws relating to advance directives within 90 Days from the effective date of the change, unless the law or regulation contains a specific time requirement for notification.

### 2.6.60.13 ABUSE, NEGLECT, OR EXPLOITATION (ANE)

The MCO must protect against ANE.

#### 2.6.60.13.1 MEMBER EDUCATION ON ABUSE, NEGLECT, OR EXPLOITATION

At the time of assessment, but no later than when the Member is approved for LTSS, the MCO must ensure the Member and Medical Consenter are informed orally and in the Member handbook of the processes for reporting allegations of ANE. The MCO must provide the toll-free numbers for HHS Regulatory Services Division and DFPS in the event that the member needs to report ANE.

#### 2.6.60.13.2 ABUSE, NEGLECT, OR EXPLOITATION EMAIL NOTIFICATIONS

The MCO must provide HHSC with an email address at which the MCO will receive and respond to Adult Protective Services (APS) ANE notifications. The MCO must respond to emails received through this email address and provide the information requested by APS within 24 hours of delivery of the notification, 7 Days a week.

#### 2.6.60.13.3 MANAGED CARE ORGANIZATION TRAINING ON ABUSE, NEGLECT, OR EXPLOITATION, AND UNEXPLAINED DEATH

The MCO must provide ANE and Unexplained Death training to all MCO staff who have direct contact with a Member. Direct contact includes in-person and telephone contact. The MCO must use the approved training materials provided by HHSC as set forth in **Chapter 16 of Exhibit B, UMCM,** regarding policy guidance.

The MCO must ensure that all newly hired staff who have direct contact with a Member are trained no later than 30 Days from the date of hire. The MCO must also ensure all employees that receive the required training sign, upon completion of the training, an acknowledgement of their understanding of their duty to report.

The MCO must retain records of the ANE training, including copies of all training materials and the employee’s signed acknowledgment, during the employment of the staff member and for 10 years thereafter.

For Service Coordinators working with Members receiving community-based LTSS, this training must be provided before contact with Members, no later than 30 Days from the date of hire and annually thereafter.

## 2.7 TURNOVER PHASE SCOPE

This section presents the SOW for the Turnover Phase of the Contract. The MCO is required to perform all required activities prior to, upon, and following termination, expiration, merger, assignment, or acquisition of the Contract in accordance with the

HHSC-approved Turnover Plan. HHSC reserves the right to update the Turnover requirements and related reporting requirements at any time during the Contract.

The MCO, in the instance of termination, expiration, merger, assignment, or acquisition of the Contract, is responsible for all Turnover Phase costs, including HHSC's costs for modifying its business rules, systems identifiers, communications materials, web page, and all other costs as a result of the termination, expiration, merger, or acquisition. If the MCO terminates the Contract, the MCO will be responsible for HHSC's reprocurement costs.

### 2.7.1 TURNOVER PLAN

Twelve months after the start of the Contract Term, the MCO must provide a Turnover Plan covering the turnover of the records and information maintained to either HHSC or a subsequent Contractor. Thereafter, the MCO must update the Turnover Plan annually and submit to HHSC for approval.

Twelve months prior to the end of the Contract Term, or earlier with enough lead time to complete turnover, the MCO must update its Turnover Plan and submit it to HHSC for approval.

If HHSC terminates the Contract prior to the expiration of the Contract Term, HHSC requires the MCO to propose the Turnover Plan immediately. In such cases, HHSC's notice of termination will include the date the Turnover Plan is due.

If the MCO terminates the Contract, MCO will provide a Turnover Plan with the notice of termination compliant with this section.

Until the Turnover Plan is complete to HHSC satisfaction, MCO will not be relieved of responsibilities and obligations under the Contract except as expressly set forth in the approved Turnover Plan.

The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must, at a minimum, describe the MCO's policies and procedures that will assure:

1. The least disruption in the delivery of Covered Services to Members who are enrolled with the MCO during the transition to a subsequent Contractor;
2. The least disruption in authorization and payment to Providers contracted with the MCO during transition to a subsequent Contractor;
3. Cooperation with HHSC and the subsequent Contractor in notifying Members and Providers of the transition, as requested and in the form required or approved by HHSC; and
4. Cooperation with HHSC and the subsequent Contractor in transferring information to the subsequent Contractor, as requested and in the form required or approved by HHSC.

The Turnover Plan must be approved by HHSC and, at a minimum, include:

1. The MCO's approach and schedule for the transfer of data and information, as described above;
2. The Quality Assurance process the MCO must use to monitor turnover activities;
3. The MCO's approach to training HHSC or a subsequent Contractor's staff in the operation of its business processes; and
4. The MCO's staffing plan to ensure sufficient staffing resources to execute the Turnover Plan throughout the turnover period and for six months after turnover.
5. Information about Custom Software, MCO Proprietary Software, Third-Party Software (collectively "STAR Health Software") used by the MCO in the performance of duties under the Contract, including the manner in which the STAR Health Software is used and terms of any STAR Health Software license agreements, so that HHSC can determine if the STAR Health Software is needed to transition operations.

The MCO must provide additional information or modify the Turnover Plan as requested by HHSC.

### 2.7.2 TRANSFER OF DATA AND INFORMATION

For the purposes of this section, "Data and Information" means all operations, technical, and user manuals used in conjunction with the STAR Health Software, Services, and Deliverables, in whole or in part, that HHSC determines are necessary to view and extract application data in a proper format. The MCO must provide the Data and Information in the formats in which it exists at the expiration or termination of the Contract. To the extent the Data and Information requires proprietary or MCO-owned viewers, translators, or other manipulation programs, MCO must likewise provide such viewers, translators, or other manipulation programs. HHSC reserves the right to request Data and Information in additional or differing formats.

The MCO must transfer to HHSC or a subsequent Contractor, identified by HHSC, all Data and Information necessary to transition operations, including but not limited to:

1. Source code;
2. Data dictionaries
3. Data and reference tables;
4. Data entry interfaces;
5. License agreements for Third-Party Software;
6. License rights for MCO Proprietary Software;
7. Ownership rights for Custom Software;
8. Documentation relating to STAR Health Software and interfaces;
9. Functional business process flows;
10. Operational information, including correspondence, documentation of ongoing or outstanding issues;
11. Operations support documentation;

12. Operational information regarding Subcontractors;
13. Any data, information, and services necessary and sufficient to enable HHSC to map all managed care program data from the MCO's systems to the replacement systems of HHSC or a subsequent Contractor; and
14. STAR Health Program Hardware.

The MCO must provide all of the data, information and services:

1. According to the schedule approved by HHSC in the Turnover Plan; and
2. At no additional cost to HHSC.

The MCO must ensure all relevant Data and Information is received and accepted by HHSC or the subsequent Contractor. If HHSC determines that Data and Information are not accurate or complete, HHSC may hire an independent contractor to assist HHSC in obtaining and transferring all the required Data and Information. The MCO must bear all of the costs of providing these services.

### 2.7.3 POST TURNOVER SERVICES

Within 30 Days following turnover of operations, the MCO must provide HHSC with a turnover results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by HHSC. HHSC may withhold up to 20 percent (20%) of the final month's Capitation Payment until the turnover activities are complete and the turnover results report is approved by HHSC.

## 2.8 TERMS OF PAYMENT

### 2.8.1 CALCULATION OF MONTHLY CAPITATION PAYMENT

This is a Risk-based Contract. The MCO will provide Healthcare Services for Members on a fully insured basis. HHSC will calculate the fixed monthly Capitation Payments by multiplying the number of Members enrolled on the first day of the month by the Capitation Rate. HHSC will not pay a Capitation Payment for new Members during the first month of coverage unless the Member's Effective Date of Coverage occurs on the first day of the month. In consideration of the Monthly Capitation Payment(s), the MCO agrees to provide the Services and Deliverables described in this Contract.

MCO will be required to provide timely financial and statistical information necessary in the Capitation Rate determination process. Encounter Data provided by MCO must conform to all HHSC requirements. Encounter Data containing non-compliant information, including inaccurate client or Member identification numbers, inaccurate Provider identification numbers, or diagnosis or procedures codes insufficient to adequately describe the diagnosis or medical procedure performed, will not be considered in the MCO's experience for rate-setting purposes.

Information or data, including complete and accurate Encounter Data, as requested by HHSC for rate-setting purposes, must be provided to HHSC:

1. Within 30 Days of receipt of the letter from HHSC requesting the information or data; and
2. No later than March 31 annually.

The fixed monthly Capitation Rate consists of the following components:

1. An amount for Healthcare Services performed during the month;
2. An amount for administering the Program; and
3. An amount for the MCO's Risk margin.

HHSC will employ or retain qualified actuaries to perform data analysis and calculate the Capitation Rates for each Rate Period.

MCO understands and expressly assumes the risks associated with the performance of the duties and responsibilities under this Contract, including the failure, termination, or suspension of funding to HHSC, delays or denials of required approvals, and cost overruns not reasonably attributable to HHSC.

### 2.8.2 TIME AND MANNER OF PAYMENT

During the Contract Term and beginning after the Operational Start Date, HHSC will pay the monthly Capitation Payments by the 10th Business Day of each month.

The MCO must accept Capitation Payments by direct deposit into the MCO's account.

HHSC may adjust the monthly Capitation Payment to the MCO: in the case of an Overpayment to the MCO; for Experience Rebate amounts due and unpaid; and if monetary damages (including any associated interest) are assessed in accordance with **Article 10 of Exhibit A, STAR Health Uniform Terms and Conditions**.

HHSC's payment of monthly Capitation Payments is subject to availability of federal and State appropriations. If appropriations are not available to pay the full monthly Capitation Payment, HHSC may:

1. Equitably adjust Capitation Payments and reduce scope of service requirements as appropriate in accordance with **Article 7 of Exhibit A, STAR Health Uniform Terms and Conditions**; or
2. Terminate the Contract in accordance with **Article 10 of Exhibit A, STAR Health Uniform Terms and Conditions**.

### 2.8.3 CERTIFICATION OF CAPITATION RATES

As federally required, HHSC will employ or retain a qualified actuary to certify the actuarial soundness of the Capitation Rates contained in this Contract. HHSC will also employ or retain a qualified actuary to certify all revisions or modifications to the Capitation Rates.

### 2.8.4 MODIFICATION OF CAPITATION RATES

The Parties understand and agree that the Capitation Rates are subject to modification in accordance with **Article 7 of Exhibit A, STAR Health Uniform Terms and Conditions,** if changes in State or federal laws, rules, regulations, or policies affect the rates or the actuarial soundness of the rates. HHSC will provide the MCO with notice of a modification to the Capitation Rates 60 Days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the MCO does not accept the rate change, either Party may terminate the Contract in accordance with **Article 10 of Exhibit A, STAR Health Uniform Terms and Conditions**.

### 2.8.5 CAPITATION RATE STRUCTURE

HHSC will establish base Capitation Rates for the Rate Periods following Rate Period 1 by analyzing historical Encounter Data and financial data. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

VAS will not be included in the rate-setting process.

Case-by-case Services will not be included in the rate setting process.

### 2.8.6 MCO INPUT DURING RATE SETTING PROCESS

MCO must provide certified Encounter Data and financial data as described in **Chapters 5 and 6 of Exhibit B, UMCM** or as otherwise requested by HHSC. The required information may include: claims lag information, capitation expenses, and stop loss reinsurance expenses. The MCO must provide written explanation to an HHSC request for clarification or provide additional financial information to HHSC upon request. HHSC will notify the MCO of the deadline for submitting a response, which will include a reasonable amount of time for response.

HHSC will allow the MCO to review and comment on data used by HHSC to determine base Capitation Rates. HHSC will notify the MCO of the deadline for submitting comments, which will include a reasonable amount of time for response. HHSC will not consider in its rate analysis comments received after the deadline.

During the rate-setting process, HHSC will conduct a minimum of two meetings with the MCO. HHSC may conduct the meetings in person, via teleconference, or by another appropriate method determined by HHSC. Prior to the first meeting, HHSC will provide the MCO with proposed Capitation Rates. During the first meeting, HHSC will describe the process used to generate the proposed Capitation Rates, discuss major changes in the rate-setting process, and receive input from the MCO. HHSC will notify the MCO of the deadline for submitting comments, which will include a reasonable amount of time to review and comment on the proposed Capitation Rates and rate-setting process. After reviewing any comments and making any necessary changes due to those comments, HHSC will conduct a second meeting to discuss the final Capitation Rates and any changes.

### 2.8.7 ADJUSTMENTS TO CAPITATION PAYMENTS

HHSC may adjust a payment made to the MCO for a Member if:

1. A Member's eligibility status or program type is changed, corrected as a result of error, or is retroactively adjusted;
2. The Member is enrolled into the MCO in error;
3. The Member moves outside the United States;
4. The Member dies before the first day of the month for which the payment was made; or
5. Payment has been denied by CMS in accordance with the requirements in 42 C.F.R. § 438.730.

The MCO may appeal the adjustment of Capitation Payments in the above circumstances using the HHSC dispute resolution process in **Section 10.13 of Exhibit A, STAR Health Uniform Terms and Conditions**.

### 2.8.8 EXPERIENCE REBATE

#### 2.8.8.1 MCO'S DUTY TO PAY

At the end of each FSR Reporting Period, the MCO must pay an Experience Rebate if the MCO's Net Income Before Taxes is greater than the percentage set forth below of the total Revenue for the period. The Experience Rebate is calculated in accordance with the tiered rebate method in **Section 2.8.8.2 of this Exhibit H, SOW**. The Net Income Before Taxes and the total Revenues are as measured by the FSR and as reviewed and confirmed by HHSC. Various factors in this Contract may impact the final amount used in the calculation of the percentage, including the loss carry forward, the Administrative Expense Cap ("Admin Cap"), or the reinsurance cap.

The percentages are calculated on a Consolidated Basis and include the consolidated Net Income Before Taxes for all of the MCO's and its Affiliates' Texas HHSC programs and SAs, with the exception of the Dual Demonstration.

#### 2.8.8.2 GRADUATED EXPERIENCE REBATE SHARING METHOD

The graduated Experience Rebate sharing method is:

| Pre-tax Income as a Percentage of Revenues | MCO Share | HHSC Share |
|---|---|---|
| ≤ 3% | 100% | 0% |
| > 3% and ≤ 5% | 80% | 20% |
| > 5% and ≤ 7% | 60% | 40% |

| > 7% and ≤ 9% | 40% | 60% |
|---|---|---|
| > 9% and ≤ 12% | 20% | 80% |
| > 12% | 0% | 100% |

HHSC and the MCO will share the consolidated Net Income Before Taxes for its HHSC programs as follows, unless HHSC provides the MCO an Experience Rebate in accordance with **Section 2.6.21.6 of this Exhibit H, SOW,** and **Chapter 6 of Exhibit B, UMCM**:

1. The MCO will retain all the Net Income Before Taxes that is equal to or less than three percent (≤ 3%) of the total Revenues received by the MCO;
2. HHSC and the MCO will share that portion of the Net Income Before Taxes that is over three percent (> 3%) and less than or equal to five percent (≤ 5%) of the total Revenues received, with 80 percent (80%) to the MCO and 20 percent (20%) to HHSC;
3. HHSC and the MCO will share that portion of the Net Income Before Taxes that is over five percent (> 5%) and less than or equal to seven percent (≤ 7%) of the total Revenues received, with 60 percent (60%) to the MCO and 40 percent (40%) to HHSC;
4. HHSC and the MCO will share that portion of the Net Income Before Taxes that is over seven percent (> 7%) and less than or equal to nine percent (≤ 9%) of the total Revenues received, with 40 percent (40%) to the MCO and 60 percent (60%) to HHSC;
5. HHSC and the MCO will share that portion of the Net Income Before Taxes that is over nine percent (> 9%) and less than or equal to 12 percent (≤ 12%) of the total Revenues received, with 20 percent (20%) to the MCO and 80 percent (80%) to HHSC; and
6. HHSC will be paid the entire portion of the Net Income Before Taxes that exceeds 12 percent (> 12%) of the total Revenues.

#### 2.8.8.3 NET INCOME BEFORE TAXES

The MCO must compute the Net Income Before Taxes in accordance with applicable federal regulations and **Chapters 5 and 6 of Exhibit B, UMCM,** and other similar instructions for other HHSC programs. The Net Income Before Taxes will be confirmed by HHSC or its agent for the FSR Reporting Period relating to all Revenues and Allowable Expenses incurred under the Contract. HHSC reserves the right to modify **Chapters 5 and 6 of Exhibit B, UMCM,** in accordance with **Section 7.05 of Exhibit A, STAR Health Uniform Terms and Conditions**.

For purposes of calculating Net Income Before Taxes, certain items are omitted from the calculation as they are not Allowable Expenses; these include:

1. The payment of an Experience Rebate;

2. Any interest expense associated with late or underpayment of the Experience Rebate;
3. Financial incentives; and
4. Financial disincentives, including without limitation, the liquidated damages described in **Exhibit C, Deliverables Liquidated Damages Matrix**. See **Chapter 6 of Exhibit B, UMCM**.

Financial incentives are true net bonuses and must not be reduced by the potential increased Experience Rebate payments. Financial disincentives are true net disincentives, and must not be offset in whole or part by potential decreases in Experience Rebate payments.

For FSR reporting purposes, financial incentives incurred must not be reported as an increase in Revenues or as an offset to costs, and any financial incentive award will not increase reported income. Financial disincentives incurred must not be included as reported expenses, and must not reduce reported income. The reporting or recording of any of these incurred items will be done on a memo basis, which is below the income line, and will be listed as separate items.

#### 2.8.8.4 CARRY FORWARD OF PRIOR FSR REPORTING PERIOD

Losses incurred on a Consolidated Basis for a given FSR Reporting Period may be carried forward to the next FSR Reporting Period, and applied as an offset against consolidated pre-tax net income for determination of any Experience Rebate due. These prior losses may be carried forward for the next two contiguous FSR Reporting Periods.

In the case of a loss in a given FSR Reporting Period being carried forward and applied against profits in either or both of the next two FSR Reporting Periods, the loss must first be applied against the first subsequent FSR Reporting Period such that the profit in the first subsequent FSR Reporting Period is reduced to a zero Pre-tax Income; any additional loss then remaining unapplied may be carried forward to any profit in the next subsequent FSR Reporting Period. In such a case, the revised income in the third FSR Reporting Period would be equal to the cumulative income of the three contiguous FSR Reporting Periods. In no case could the loss be carried forward to the fourth FSR Reporting Period or beyond.

Carrying forward of losses may be impacted by the Admin Cap. See **Section 2.8.8.7 of this Exhibit H, SOW**.

Losses incurred in the last or next-to-last FSR Reporting Period of a prior contiguous contract with HHSC may be carried forward up to two FSR Reporting Periods, into the first or potentially second FSR Reporting Period of this Contract, if such losses meet all other requirements of both the prior and current contracts.

##### 2.8.8.4.1 BASIS FOR CONSOLIDATION

In order for a loss to be eligible as a potential loss carry-forward to offset future income, the MCO must have a negative Net Income Before Taxes for an FSR Reporting Period on a Consolidated Basis.

#### 2.8.8.5 SETTLEMENTS FOR PAYMENT

There may be one or more MCO payment(s) of the Experience Rebate on income generated for a given FSR Reporting Period under the STAR Health Program. The first scheduled payment (the Primary Settlement) will equal 100 percent (100%) of the owed Experience Rebate as derived from the FSR, and will be paid on the same day the 90-Day FSR Report is submitted to HHSC.

The Primary Settlement, as utilized in this section, refers strictly to what should be paid with the 90-Day FSR, and does not refer to the first instance in which an MCO may tender a payment. For example, an MCO may submit a 90-Day FSR indicating no Experience Rebate is due, but then submit a 334-Day FSR with a higher income and a corresponding Experience Rebate payment. In this case, this initial payment would be subsequent to the Primary Settlement.

The next scheduled payment will be an adjustment to the Primary Settlement, if required, and will be paid on the same day that the 334-Day FSR Report is submitted to HHSC if the adjustment is a payment from the MCO to HHSC. **Section 2.8.8.6 of this Exhibit H, SOW,** describes the interest expenses associated with any payment after the Primary Settlement.

An MCO may make non-scheduled payments at any time to reduce the accumulation of interest under **Section 2.8.8.6 of this Exhibit H, SOW**. For any nonscheduled payments prior to the 334-Day FSR, the MCO is not required to submit a revised FSR; but is required to submit an Experience Rebate calculation form and an adjusted summary page of the FSR. The FSR summary page is labeled "Summary Income Statements (Dollars), All Coverage Groups Combined (FSR, Part I)."

HHSC or its agent may audit or review the FSRs. If HHSC determines that corrections to the FSRs are required, based on an HHSC audit/review or other documentation acceptable to HHSC, then HHSC will make final adjustments. Any payment resulting from an audit or final adjustment will be due from the MCO within 30 Days of the earlier of:

1. The date of the management representation letter resulting from the audit; or
2. The date of any invoice issued by HHSC.

Payment within this 30-Day timeframe will not relieve the MCO of any interest payment obligation that may exist under **Section 2.8.8.6 of this Exhibit H, SOW.**

In the event that any Experience Rebates or corresponding interest payments owed to HHSC are not paid by the required due dates, then HHSC may offset these amounts from any future Capitation Payments or collect these sums directly from the MCO. HHSC may adjust the Experience Rebate if HHSC determines the MCO has paid amounts for goods or services that are not reasonable, necessary, allocable, or allowable in accordance with **Chapters 6 and 5 of Exhibit B, UMCM**, and the FAR, or other applicable federal or State regulations. HHSC has final authority in auditing and determining the amount of the Experience Rebate.

#### 2.8.8.6 Interest on Experience Rebate

Interest on any Experience Rebate owed to HHSC will be charged beginning 35 Days after the due date of the Primary Settlement, as described in **Section 2.8.8.5 of this Exhibit H, SOW**. Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at 35 Days after the due date for the 90-Day FSR Report. For example, any Experience Rebate payment(s) made in conjunction with the 334-Day FSR, or as a result of audit findings, will accrue interest back to 35 Days after the due-date for submission of the 90-Day FSR.

The MCO has the option of preparing an additional FSR based on 120 Days of claims run-out (a “120-Day FSR”). If a 120-Day FSR, and an Experience Rebate payment based on it, are received by HHSC before the interest commencement date above, then such a payment would be counted as part of the Primary Settlement.

If an audit or adjustment determines a downward revision of income after an interest payment has previously been required for the same SFY, then HHSC will recalculate the interest and, if necessary, issue a full or partial refund or credit to the MCO.

Any interest obligations that are incurred that are not timely paid will be subject to daily compounding and accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

All interest assessed will continue to accrue until such point as a payment is received by HHSC, at which point interest on the amount received will stop accruing. If a balance remains at that point that is subject to interest, then the balance will continue to accrue interest. If interim payments are made, then any interest that may be due will only be charged on amounts for the time period during which they remained unpaid. By way of example only, if $100,000 is subject to interest commencing on a given day, and a payment is received for $75,000 27 Days after the start of interest, then the $75,000 will be subject to 27 Days of interest, and the $25,000 balance, along with any unpaid interest, will continue to accrue interest until paid. The accrual of interest as defined in this section will continue during any period of dispute. If a dispute is resolved in the MCO’s favor, then interest will only be assessed on the revised unpaid amount.

If the MCO incurs an interest obligation under this section for an Experience Rebate payment, HHSC will assess that interest at 12 percent (12%) per annum, compounded daily. If the interest rate stipulated in this section is found by a court of competent jurisdiction to be outside the legal and enforceable range, then the rate in this section will be adjusted to the maximum allowable rate the court of competent jurisdiction finds legal and enforceable.

Any interest expense incurred under this section is not an Allowable Expense for reporting purposes on the FSR.

In the event that the MCO achieves a net profit in Rate Period 1 or any subsequent rate period, the Parties agree to enter into negotiations to develop reasonable financial incentives for the MCO’s Providers for the following Rate Period.

#### 2.8.8.7 ADMINISTRATIVE EXPENSE CAP

##### 2.8.8.7.1 GENERAL REQUIREMENT

The calculation methodology of Experience Rebates described in **Section 2.8.8.6 of this Exhibit H, SOW, will** be adjusted by an Admin Cap. While administrative expenses may be limited by the Admin Cap to determine Experience Rebates, all valid Allowable Expenses will continue to be reported on the FSRs. Thus, the Admin Cap does not impact FSR reporting but may impact any associated Experience Rebate calculation.

The calculation of any Experience Rebate due under the Contract will be subject to limitations on total deductible administrative expenses. The limitations will be calculated as set forth below.

##### 2.8.8.7.2 CALCULATION METHODOLOGY

HHSC will determine the administrative expense component of the applicable Capitation Rate structure for the MCO prior to each applicable Rate Period. At the conclusion of an FSR Reporting Period, HHSC will apply that predetermined administrative expense component against the MCO's actually incurred number of Member Months and aggregate premiums received (i.e, monthly Capitation Payments plus any Delivery Supplemental Payments, which excludes any investment income or interest earned), to determine the specific Admin Cap, in aggregate dollars, for a given MCO for that FSR Reporting Period.

If Capitation Rates are changed during the FSR Reporting Period, this same methodology of multiplying the predetermined HHSC rates for a given month against the ultimate actual number of Member Months or Revenues that occurred during that month will be utilized, such that each month's actual results will be applied against the rates that were in effect for that month.

##### 2.8.8.7.3 DATA SOURCES

In determining the amount of Experience Rebate payment to include in the Primary Settlement, or in conjunction with any subsequent payment or settlement, the MCO will need to make the appropriate calculation, in order to assess the impact, if any, of the Admin Cap:

1. The total premiums paid by HHSC and received by the MCO, and corresponding Member Months, will be taken from the relevant FSR (or audit report) for the FSR Reporting Period;
2. There are three components of the administrative expense portion of the Capitation Rate structure;
    a. The percentage rate to apply against the total premiums paid (the "percentage of premium" within the administrative expenses);
    b. The dollar rate per Member Month (the "fixed amount" within the administrative expenses); and

c. The portion incorporated into the pharmacy (prescription expense) rate that pertains to prescription administrative expenses.

These will be taken from the supporting details associated with the official notification of final Capitation Rates, as supplied by HHSC. This notification is sent to the MCO during the annual rate setting process via e-mail, labeled as "the final rate exhibits for your health plan." The e-mail has one or more spreadsheet files attached, which are particular to the given MCO. The spreadsheet(s) show the fixed amount and percentage of premium components for the administrative component of the Capitation Rate.

The components of the administrative expense portion of the Capitation Rate can also be found on HHSC's Medicaid website at https://rad.hhs.texas.gov/managed-care-services. Under each program, there is a separate rate-setting document for each Rate Period that describes the development of the Capitation Rates. Within each document, there is a section entitled "Administrative Fees," where it refers to "the amount allocated for administrative expenses."

In cases where the administrative expense portion of the Capitation Rate refers to "the greater of (a) [one set of factors], and (b) [another set of factors]," then the Admin Cap will be calculated each way, and the larger of the two results will be the Admin Cap utilized for the determination of any Experience Rebates due.

#### 2.8.8.7.4 EXAMPLE OF CALCULATION

By way of example only, HHSC will calculate the Admin Cap as follows:

1. Multiply the predetermined administrative expense rate structure "fixed amount," or dollar rate per Member Month (for example, $8.00), by the actual number of Member Months for the Program during the FSR Reporting Period (for example, 70,000):
    a. $8.00 x 70,000 = $560,000.
2. Multiply the predetermined percent of premiums in the administrative expense rate structure (for example, 5.25 percent), by the actual aggregate premiums earned by the MCO during the FSR Reporting Period (for example, $6 million).
    a. 5.25% x $6,000,000 = $345,000.
3. Multiply the predetermined pharmacy administrative expense rate (for example, $1.80), by the actual number of Member Months for the Program during the FSR Reporting Period (for example, 70,000):
    a. $1.80 x 70,000 = $126,000.
4. Add the totals of items 1, 2, and 3, plus applicable premium taxes and maintenance taxes (for example, $112,000), to determine the Admin Cap
    a. ($560,000 + $345,000 + $126,000) + $112,000 = $1,143,000.

In this example, $1,143,000 would be the MCO's Admin Cap for a single program, for the FSR Reporting Period.

#### 2.8.8.7.5 Consolidation and Offsets

The Admin Cap will be first calculated individually by program, and then totaled and applied on a Consolidated Basis. There will be one aggregate amount of dollars determined as the Admin Cap for each MCO, which will cover all of an MCO's and its Affiliates' programs and SAs, excluding the Dual Demonstration. (The Dual Demonstration will have its own separate Admin Cap calculated.) This consolidated Admin Cap will be applied to the administrative expenses of the MCO on a Consolidated Basis. The net impact of the Admin Cap will be applied to the Experience Rebate calculation. Calculation details are provided in the applicable FSR Templates and FSR Instructions in **Exhibit B, UMCM**.

#### 2.8.8.7.6 Impact of Loss Carry Forward

For Experience Rebate calculation purposes, the calculation of any loss carry-forward, as described in **Section 2.8.8.4 of this Exhibit H, SOW**, will be based on the allowable pre-tax loss as determined under the Admin Cap.

#### 2.8.8.7.7 Unforeseen Events

If HHSC, in its sole discretion, determines that unforeseen events have created significant hardships for the MCO, HHSC may revise or temporarily suspend the Admin Cap as necessary.

### 2.8.9 Payment by Members

The MCO and its Providers are prohibited from billing or collecting any amount from a Member for Healthcare Services covered by this Contract. The MCO must inform Members of costs for non-covered services, and must require its Providers to:

1. Inform Members of costs for non-covered services prior to rendering the services; and
2. Obtain a signed private pay form from Members prior to rendering the services.

### 2.8.9.1 Reinsurance Cap

Reinsurance is reported on HHSC's FSR report format as:

1. Gross reinsurance premiums paid, and
2. Reinsurance recoveries received.

The premiums paid are treated as a part of medical expenses, and the recoveries received are treated as an offset to those medical expenses (also known as a contra-cost). The net of the gross premiums paid minus the recoveries received is called the net reinsurance cost. The net reinsurance cost, as measured in aggregate dollars over the FSR Reporting Period, divided by the number of member-months for that same period, is referred to as the net reinsurance cost per-member-per-month (PMPM).

The MCO will be limited to a maximum amount of net reinsurance cost PMPM for purposes of calculating the pre-tax net income that is subject to the Experience Rebate. This limitation does not impact an MCO's ability to purchase or arrange for reinsurance. It only impacts what is factored into the Experience Rebate calculation. The maximum amount of allowed net reinsurance cost PMPM (Reinsurance Cap) varies by MCO program and is equal to 110 percent (110%) of the net reinsurance cost PMPM contained in the Capitation Rates for the Program during the FSR Reporting Period.

Regardless of the maximum amounts as represented by the Reinsurance Cap, all reinsurance reported on the FSR is subject to audit, and must comply with **Chapter 6 of Exhibit B, UMCM**.

### 2.8.10 RESTRICTION ON ASSIGNMENT OF FEES

During the term of the Contract, MCO may not, directly or indirectly, assign to any third party any beneficial or legal interest of the MCO in or to any payments to be made by HHSC under this Contract. This restriction does not apply to fees paid to Subcontractors.

### 2.8.11 LIABILITY FOR TAXES

HHSC is not responsible in any way for the payment of any federal, State, or local taxes related to or incurred in connection with the MCO's performance of this Contract. MCO must pay and discharge any taxes, including any penalties and interest. In addition, HHSC is exempt from federal excise taxes and will not pay any personal property taxes or income taxes levied on MCO or any taxes levied on employee wages.

### 2.8.12 LIABILITY FOR EMPLOYMENT RELATED CHARGES AND BENEFITS

MCO will perform work under this Contract as an independent contractor and not as agent or representative of HHSC. MCO is solely and exclusively liable for payment of all employment-related charges incurred in connection with the performance of this Contract, including salaries, benefits, employment taxes, workers compensation benefits, unemployment insurance and benefits, and other insurance or fringe benefits for staff.

### 2.8.13 NO ADDITIONAL CONSIDERATION

MCO is not entitled to nor will receive from HHSC any additional consideration, compensation, salary, wages, charges, fees, costs, or any other type of remuneration for Services and Deliverables provided under the Contract, except by properly authorized and executed Contract amendments.

No other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other State agency, nor will the failure of HHSC or any other party to pay for these incidental or ancillary services entitle the MCO to withhold Services and Deliverables due under the Contract.

MCO is not entitled by virtue of the Contract to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind.

### 2.8.14 FEDERAL DISALLOWANCE

If the federal government recoups money from the State for unallowable expenses or costs, the State has the right to recoup payments made to the MCO in turn for these same expenses or costs. HHSC is allowed to recoup payments from the MCO even if the expenses or costs had not been previously disallowed by the State and were incurred by the MCO. Any of the same future expenses or costs would then be unallowable by the State. If the State retroactively recoups money from the MCO due to a federal disallowance, the State will recoup the entire amount paid to the MCO for the federally disallowed expenses or costs, not just the federal portion.

### 2.8.15 PASS-THROUGH PAYMENTS FOR PROVIDER RATE INCREASES

The Capitation Rates do not include the costs of federally-mandated Provider rate increases, per PPACA as amended by Section 1202 of the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010). HHSC will make supplemental payments to the MCO for these rate increases, and the MCO will pass through the full amount of the supplemental payments to qualified Providers no later than 30 Days after receipt of HHSC's supplemental payment report, contingent upon the receipt of HHSC's payment allocation.

### 2.8.16 NON-RISK PAYMENTS FOR CERTAIN DRUGS

The Capitation Rates do not include the costs of certain clinician-administered and pharmacy drugs as identified in **Chapter 2 of Exhibit B, UMCM**. For providing these drugs to Members, HHSC will make non-risk payments to the MCO based on Encounter Data received by HHSC or its designee during an encounter reporting period.

For drugs dispensed by a pharmacy, non-risk payment will cover pharmacy Encounter Data received from the date the drugs are added to the Medicaid formulary through the end of that State fiscal quarter. Thereafter, non-risk payments will cover quarterly encounter reporting periods. HHSC will make non-risk payments within a reasonable amount of time after the encounter reporting period, but no later than 95 Days after HHSC or its designee has processed the Encounter Data. Non-risk payments will be limited to the actual amounts the MCO paid to pharmacy Providers for these drugs as represented in "Net Amount Due" field (Field 281) on the NCPDP Encounter transaction up to the FFS reimbursement amount. To be eligible for reimbursement, pharmacy encounters must contain a Financial Arrangement Code "14" in the "Line of Business" field (Field 270) on the NCPDP Encounter transaction.

For clinician-administered drugs, the first non-risk payment will cover medical Encounter Data received from the date specified in **Chapter 2 of Exhibit B, UMCM,** through the end of that State Fiscal Quarter. Thereafter, non-risk payments will cover State fiscal quarterly

encounter reporting periods. HHSC will make non-risk payments within a reasonable amount of time after the encounter reporting period, but no later than 95 Days after HHSC's or its designee has processed the medical Encounter Data. Non-risk payments will be limited to the actual amounts paid to medical Providers for the ingredient cost of these drugs up to the FFS reimbursement amount.

### 2.8.17 Supplemental Payments for Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products

The Capitation Rates do not include the costs of Medicaid Wrap-Around Services for outpatient drugs and biological products for STAR Health Members. HHSC will make supplemental payments to the MCO for these Medicaid Wrap-Around Services, based on Encounter Data received by HHSC or its designee during an Encounter reporting period. Supplemental payments will cover six-month Encounter reporting periods. HHSC will make supplemental payments within a reasonable amount of time after the Encounter reporting period, generally no later than 95 Days after HHSC or its designee has processed the Encounter Data. Supplemental payments will be limited to the actual amounts paid to pharmacy Providers for these Medicaid Wrap-Around Services, as represented in "Net Amount Due" field (Field 281) on the NCPDP Encounter transaction. To be eligible for reimbursement, Encounters must contain a Financial Arrangement Code "14" in the "Line of Business" field (Field 270) on the NCPDP Encounter transaction.