Health and Human Services Commission

STAR Health Contract Terms
## DOCUMENT HISTORY LOG

<table>
<thead>
<tr>
<th>STATUS¹</th>
<th>DOCUMENT REVISION²</th>
<th>EFFECTIVE DATE</th>
<th>DESCRIPTION³</th>
</tr>
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<tbody>
<tr>
<td>Baseline</td>
<td>2.0</td>
<td>July 1, 2015</td>
<td>Initial version of Attachment A, &quot;STAR Health Managed Care Contract Terms and Conditions&quot; that includes all modifications negotiated by the Parties.</td>
</tr>
</tbody>
</table>
| Revision | 2.1                | September 1, 2015 | Definition for Abuse, Neglect, or Exploitation is added.  
Definition for Consolidated FSR Report or Consolidated Basis is modified to exclude the Dual Demonstration Project.  
Definition for Court Order is modified to clarify the MCOs requirements.  
Definition for Covered Services is modified to clarify that court ordered services are not necessarily Covered Services.  
Definition for Dual Demonstration is added.  
Definition for Targeted Case Management is changed to Mental Health Targeted Case Management and clarified.  
Definition for Severe and Persistent Mental Illness (SPMI) is better defined.  
Definition for Severe Emotional Disturbance (SED) is better defined.  
Section 3.03 is modified to clarify the language.  
Section 3.07 is modified to require prior approval from HHSC.  
Section 3.08 is modified to clarify the language.  
Section 4.03 is modified to clarify the language.  
Section 4.12 “E-Verify System” is added.  
Section 5.03 is amended to clarify existing requirements and clean-up language relating to span of coverage. In addition, Section 5.03 is modified to add Enrollment Changes with Custom DME Prior Authorizations.  
Section 7.02 is modified to clarify the language.  
Section 10.08 is modified to carve-out the new Duals Demonstration Program from the "Consolidated Basis," with respect to FSR reporting, the Experience Rebate, and the Admin Cap. |
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<tr>
<td></td>
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<td>Section 10.08.1 is modified to conform to the other contracts and to carve-out the new Duals Demonstration Program from the &quot;Consolidated Basis,&quot; with respect to FSR reporting, the Experience Rebate, and the Admin Cap. Section 11.01 is modified to clarify part (h).</td>
</tr>
<tr>
<td></td>
<td>Revision 2.2</td>
<td>March 1, 2016</td>
<td>All references to Frew v. Janek are changed to Frew v. Traylor. Definition for Abuse, Neglect, or Exploitation is modified to update the citations. Definition for Clinical Prior Authorization or Clinical PA is added. Definition for DFPS Texas Comprehensive CANS assessment is added. Definition for Self-employed Direct Provider is added. Definition for Texas Medicaid Provider Procedures Manual is modified to remove the publication frequency. Section 3.07 is modified to update the UMCM references. Section 4.12 &quot;E-Verify System&quot; is renamed &quot;Employment Verification&quot; and the requirements updated. Section 10.16 “Non-Risk Payments for Second Generation Direct Acting Antivirals for Hepatitis C” is renamed “Non-Risk Payments for Certain Drugs” and the language is clarified.</td>
</tr>
<tr>
<td></td>
<td>Revision 2.3</td>
<td>September 1, 2016</td>
<td>All references to Frew v. Traylor are changed to Frew v. Smith. Definition for Adaptive Aid is added. Definition for Breach is added. Definition for Change in Condition is added. Definition for Community Based Services is added. Definition for Daily Notification File (DNF) is modified to clarify the categories. Definition for Discovery/Discovered is added.</td>
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<td>Definition for DFPS Texas Comprehensive CANS assessment or CANS assessment is modified to update the name and to clarify the definition.</td>
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<td>Definition for Dual Eligibles is added.</td>
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<td>Definition for Effective Date of Coverage is modified to clarify the categories.</td>
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<td>Definition for Employment Assistance is added.</td>
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<td>Definition for Family Strengths and Needs Assessment (FNSA) is added.</td>
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<td>Definition for Financial Management Services is added.</td>
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<td>Definition for HHSC Administrative Services Contractor (or ASC) is modified to remove the FFCHE program.</td>
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<td>Definition for Home and Community Support Services Agency (HCSSA) is added.</td>
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<td>Definition for Long-Term Services and Supports (LTSS) is added.</td>
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<td>Definition for Main Dental Home Provider, Main Dentist, or Dental Home is modified to include RHCs.</td>
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<td>Definition for Medically Dependent Children Program (MDCP) is added.</td>
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<td>Definition for Member is modified to remove the FFCHE program.</td>
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<td>Definition for Minor Home Modifications is added.</td>
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<td>Definition for Personal Care Services (PCS) is added.</td>
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<td>Definition for Prescribed Pediatric Extended Care Center (PPECC) is added.</td>
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<td>Definition for Respite is added.</td>
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<td>Definition for Screening and Assessment Instrument (SAI) is added.</td>
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<td>Definition for Supported Employment is added.</td>
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<td>Definition for Target Population is modified to remove the FFCHE program.</td>
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<td>Definition for Transition Planning is added.</td>
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### DOCUMENT HISTORY LOG

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| Revision | 2.4                 | March 1, 2017    | Definition for "Court-Ordered Commitment" is modified to add a reference to the Texas Code of Criminal Procedure, Chapter 46B.  
Definition for “National CLAS Standards” is added.  
Section 4.02 (c) is modified to specify notification must be in writing.  
Section 7.02 is modified to add a reference to CFR Part 4.8 in (a)(4), to remove reference (a)(8) regarding Alberto N, and to add item (d) regarding the precedence of the CFR. All subsequent subsections are re-lettered.  
Section 7.04 is modified to add new language to comply with new CMS managed Care Rules. See CFR 438.3(d) and (f).  
Section 9.02 (b) is modified to add item 4 Inspection and subsequent items are renumbered. |
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| Revision| 2.5                | September 1, 2017    | Definition for “Complaint and Internal MCO Appeal System” is added as a result of changes to 42 CFR §438.400.  
Definition for "Appeal" is modified to comply with 42 CFR §438.400.  
Definition for "Indian Health Care Provider" is added to comply with 42 CFR §438.14.  
Definition for "Inquiry" is added to reflect the HHS Circular C-052.  
Definition for "Limited English Proficient (LEP)" is added.  
Definition for "Local Behavioral Health Authority" is added to comply with Texas Health and Safety Code §533.0356.  
Definition for "Person-Centered" is added.  
Definition for "Post-Stabilization Care Services" is modified to comply with 42 C.F.R. §438.114.  
Definition for "Prevalent Language" is added.  
Definition for "Readily Accessible" is added.  
Definition for "Fair Hearing" is renamed "State Fair Hearing" to comply with 42 CFR §438.400.  
Section 4.03 is modified to correct a capitalization error.  
Article 5 is modified to change the title from "Member Eligibility & Enrollment" to "Member Eligibility, Enrollment, and Disenrollment".  
Section 5.01 is modified to change the title from "Eligibility Determination" to "Eligibility Determination and Disenrollment" and to add requirements to comply with 42 C.F.R. §438.3(c).  
Section 7.03 "TDI licensure/ANHC certification and solvency" is deleted in its entirety.  
Article 9 is modified to add "and Litigation Hold" to the title.  
Section 9.01 is modified to extend the retention period to ten years to comply with 42 C.F.R. §438.230 and to add language requiring MCOs to
**DOCUMENT HISTORY LOG**

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<tr>
<td>Revision</td>
<td>2.6</td>
<td>March 1, 2018</td>
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</table>

- maintain documents subject to litigation hold beyond regular retention schedules.
- Section 11.09 is deleted in its entirety and replaced with modified language.
- Section 14.04 is modified to comply with 42 CFR § 438.116.

- Definition for “Action” for Medicaid is modified.
- Definition for “Auxiliary Aids” is modified to comply with 1115 Waiver and the MDCP 1915(c) Waiver.
- Definition for “Breach” is modified to harmonize obligations for the MCO and to add clarification.
- Definition for “Complaint” for Medicaid is modified.
- Definition for “Encounter Data” is modified to clarify MCO expectations.
- Definition for “Expedited Appeal” is modified to “Expedited MCO Internal Appeal”
- Definition for Integrated Care Coordination (ICC) is added.
- Definition for Integrated Care Coordination (ICC) Vendor is added.
- Definition for “Internal MCO or Dental Contractor Appeal (Medicaid only)” is removed.
- Definition for “Legally Authorized Representative (LAR)” is added.
- Definition for “MCO Internal Appeal” for Medicaid is added
- Definition for “Prevalent Language” is modified to elaborate on significant number of percentage and properly cite the CFR.
- Definition for “Retaliation” is added.
- Definition for “Urban County” is modified.
- Definitions for “Family Group Conference, Member Hotline, Nurse Hotline, PCP Team, Pre-Appeal and Service Coordination” is modified to add ICC Vendor Staff.
- Section 4.02 is modified to harmonize obligations for the MCO and to add clarification.
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<td>Revision</td>
<td>2.7</td>
<td>September 1, 2018</td>
<td>Section 4.02 is modified to add ICC Vendor staff. Section 4.06 is modified to comply with 42 CFR § 438.230. Section 4.09 is modified to comply with 42 C.F.R § 438.230, and clarifies the different mandatory provisions. Section 10.05 is modified to comply with 42 CFR 438.3(e). Section 10.16 is modified to add two drugs to non-risk based category. Sections 11.02, 11.09, 11.09.1, and 11.09.2 are modified to harmonize obligations for the MCO and to add clarification. The following changes were made throughout the attachment: Capitalize defined terms and un-capitalize terms which are not defined. Definition for “Agency Sensitive Information” is added. Definition for “Assisted Living Facility (ALF)” is added. Definition for “Case-by-case Services” is added. Definition for “Community Services Specialist Provider” (CSSP) is modified to clarify who can be a CSSP. Definition for “Confidential Information” is modified to comply with Tex. Admin. Code Rule §202.1. Definition for “Financial Management Services Agency (FMSA)” is added. Definition for “FSR Reporting Period 16” is deleted. Definition for “Information Resources” is added. Definition for “Non-Urban County (Rural County)” is deleted. Definition for “Performance Indicator Dashboard” is updated. Definition for “Program” is modified to align with STAR Health Contract.</td>
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<td>Definition for “Qualified Mental Health Professional for Community Services” (QMHP-CS) is added.</td>
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<td>Definition for “Urban County” is deleted.</td>
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<td>Section 4.12 is modified to address corrective action requested by CMS audit.</td>
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<td>Section 7.02 is modified to provide reference to applicable laws and codes for EVV, including section 12006 of the 21st Century Cures Act (Public Law 114-255) and 1 Tex. Admin. Code § 354.1177(d).</td>
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<tr>
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<td>Section 11.08 is modified to include all state and federal regulations for vendors who create, receive, maintain, use, disclose, or have access to HHS Information Resources or data.</td>
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<td>Section 11.09.1 is modified to comply with Tex. Admin. Code Rule § 202.1.</td>
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<tr>
<td>Revision</td>
<td>2.8</td>
<td>January 1, 2019</td>
<td>Definition for “Court-Ordered Commitment” is deleted.</td>
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<td>Definition for “Emergency Behavioral Health Condition” is modified</td>
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<tr>
<td>Revision</td>
<td>2.9</td>
<td>March 1, 2019</td>
<td>Section 10.16 is modified to comply with citation.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.10</td>
<td>September 1, 2019</td>
<td>Global change for the phrase, “substance abuse” to “substance use disorder.”</td>
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<tr>
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<td></td>
<td>Global change for the phrase, “substance abuser” to a “person with a substance use disorder.”</td>
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<td>Definition for “Action” is renamed “Adverse Benefit Determination.”</td>
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<td>Global change for the term “Action” is replaced with “Adverse Benefit Determination.”</td>
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<td>Definition for “Adverse Determination” is deleted.</td>
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<td>Definition for “Clean Claim” is modified to remove language and add to Section 8.1.24.5.</td>
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<td>Definition for “Complaint” is modified to align with MCO appeal standards.</td>
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<td>Definition for “Discharge” is added.</td>
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<tr>
<td>Revision</td>
<td>1.11</td>
<td>March 1, 2020</td>
<td>Contract amendment did not revise Attachment A, “STAR Health Managed Care Contract Terms and Conditions.”</td>
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<tr>
<td>Revision</td>
<td>2.12</td>
<td>September 1, 2020</td>
<td>Global Change to correct the references to UMCM Global change to correct the program name from “ImmTrac” to “ImmTrac2,” the new program name. STAR Health Managed Care Contract modified to make a global change for the phrase “DADS” to “HHSC”. DADS services were transferred to HHSC. Definition for “Adoption Assistance(AA)” is added Definition for “Adoption Assistance Program” is added Definition for “External Medical Review (EMR)” is added Definition for “Independent Review Organization (IRO)” is added Definition for “Overpayment” is added Definition for “Permanency Care Assistance (PCA)” is added. Definition for “Permanency Care Assistance Program” is added. Definition “Pre-Appeal” removed.</td>
</tr>
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¹ Status
² Document Revision
³ Description
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<td>Definition Readiness Review is modified to be consistent with all other contracts.</td>
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<td>Definition “Subcontractor” is modified to clarify that providers of Medicaid and CHIP services are not considered subcontractors, which aligns with federal rule.</td>
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<td>Definition for Target Population” modified to align with HB 72 requirements.</td>
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<td>Definition for “Texas Health Steps Outreach and Informing Unit” is added</td>
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<td>Definition for “Transition Phase” is modified to provide clarity and expectations when contracts are terminated merged or acquired.</td>
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<td>Definition for “Transition Plan” is added.</td>
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<td>Definition for “Turnover Phase” is modified to provide clarity and expectations when contracts are terminated merged or acquired.</td>
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<td>Definition for “URAC/American Accreditation Health Care Commission is modified to be consistent across all contracts.</td>
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<td>Section 5.01 is modified to comply with 42 C.F.R. § 438.3(c.) and extend das from 5 BD’s to 10 BD’s.</td>
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<td>Section 5.02.1 is added to align with other contracts</td>
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<td>Section 5.02.2 is added to align with HB72 from the 86th(R) legislative session.</td>
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<td>Article 12 has been modified to align with newly awarded STAR+PLUS contract.</td>
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<td>Section 12.03 is modified to comply with 42 CFR §438.710(b).</td>
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<td>Section 12.15 is deleted in its entirety.</td>
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<td>Section 17.02 is modified to comply with TX Insurance Code.</td>
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<td>Section 17.03 is modified to comply with TDI Fidelity Bond.</td>
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| Revision | 2.13              | March 1, 2021  | Section 1.07 is added to recite language required by a CMS letter issued on September 4, 2020, to all State Medicaid Directors.  
Section 4.11 is modified to remove the option for the MCO to receive authorization or approval for performance of any work or maintenance of any information outside of the United States. As the language reads now, the MCO is forbidden from performing any work or maintaining any information related to or obtained pursuant to the Agreement to occur outside the United States.  
Section 11.08 is modified to remove the option for the MCO to allow a contractor to obtain express prior written permission from HHSC and comply with HHSC conditions for safeguarding offshore HHSC information. As the language reads now, the MCO’s information and security and privacy program must prohibit the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside of the United States. |
| Revision | 2.14              | June 1, 2021   | Global Changes for NEMT Carve-in:  
House Bill (H.B.) 1576, 86th Legislature, Regular Session, 2019, makes the following changes to the delivery of non-emergency medical transportation (NEMT) services:  
• Increases opportunities for Transportation Network Companies (TNCs) to deliver NEMT Services.  
• Requires MCOs to provide NMT Services.  
• Moves the responsibility to provide NEMT Services from managed transportation organizations (MTOs) to managed care organizations (MCOs) for Members.  
This amendment implements changes to the following sections:  
Definitions:  
Covered Services is modified;  
Healthcare Services is modified;  
Material Subcontract is modified; |
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<tr>
<td>Revision</td>
<td>2.15</td>
<td>September 1, 2021</td>
<td>NEMT Attendant is added; Network or Provider Network is modified; Network Provider or Provider is modified; Non-emergency Medical Transportation (NEMT) Services is added; Nonmedical Transportation Services is added; Provider or Network Provider is modified; Provider Contract is modified; Provider Network or Network is modified; Transportation Network Company (TNC) is added; and Section 10.01 Calculation of monthly Capitation Payment is modified.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.16</td>
<td>March 1, 2022</td>
<td>Definition Peer-to-Peer is added. Definition Public Health Entity is modified to add language to strengthen coordination between programs Section 10.08 (b) is modified to add Experience Rebate for SFY 2022 only. Section 10.19 Non-risk Payments for Certain Autism Services is added for clarification of payment for new autism services.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.17</td>
<td>September 1, 2022</td>
<td>Contract amendment did not revise Attachment A, “STAR Health Managed Care Contract Terms and Conditions.” Definition “Assisted Living Facility (ALF)” is modified to comply with the regulations at 42 CFR §441.301(c)(4), §441.530, and §441.710(4)(i). The Centers for Medicare &amp; Medicaid Services (CMS) Definition &quot;Behavioral Health&quot; is added to align with the TAC §353.2 Definition &quot;Behavioral Health Services&quot; is modified to align with the TAC §353.2</td>
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<tr>
<td>Revision</td>
<td>2.18</td>
<td>March 1, 2023</td>
<td>Contract amendment did not revise Attachment A, “STAR Health Managed Care Contract Terms and Conditions.”</td>
</tr>
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</table>

1 Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions

2 Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.

- Definition “Certified Community Behavioral Health Clinic (CCBHC)” is added to align with the Tex. Admin, Code §353.1320.
- Definition “Collaborative Care Model (CoCM)” is added to align with the TAC §353.2
- Definition “Critical Incident Management System (CIMS)” is added to align with the TAC §353.2 definition
- Definition “ECI” is modified due to TAC rules the program having been moved to new section
- Definition “Electronic Visit Verification (EVV)” is added to be consistent across contracts.
- Definition “Person-Centered Planning” is added due to a prior UMCC amendment, that was not implemented in the STAR Health contract, that contained additional requirements for the HCSP.
- Definition “Substance Use Disorder” is added to align with the TAC §353.2
- Section 7.02(a) is modified to strengthen existing language
- Section 10.08 (b) is modified to update Fiscal Year.
- Section 10.18 is modified to clarify the specific services covered by Medicaid MCOs.
- Section 17.01(c)(1)(A) is modified to strengthen existing language.
### TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Article 1. Introduction</th>
<th>.................................................................................................................. 1</th>
</tr>
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<tbody>
<tr>
<td>Section 1.01 Purpose</td>
<td>.................................................................................................................. 1</td>
</tr>
<tr>
<td>Section 1.02 Risk-based contract</td>
<td>.................................................................................................................. 1</td>
</tr>
<tr>
<td>Section 1.03 Inducements</td>
<td>.................................................................................................................. 1</td>
</tr>
<tr>
<td>Section 1.04 Construction of the Contract</td>
<td>.................................................................................................................. 1</td>
</tr>
<tr>
<td>Section 1.05 No implied authority</td>
<td>.................................................................................................................. 1</td>
</tr>
<tr>
<td>Section 1.06 Legal Authority</td>
<td>.................................................................................................................. 2</td>
</tr>
<tr>
<td>Section 1.07 Loss of Program Authority</td>
<td>.................................................................................................................. 2</td>
</tr>
<tr>
<td><strong>Article 2. Definitions</strong></td>
<td>.................................................................................................................. 2</td>
</tr>
<tr>
<td>Article 3. General Terms</td>
<td>.................................................................................................................. 19</td>
</tr>
<tr>
<td>Section 3.01 Contract elements</td>
<td>.................................................................................................................. 19</td>
</tr>
<tr>
<td>Section 3.02 Term of the Contract</td>
<td>.................................................................................................................. 19</td>
</tr>
<tr>
<td>Section 3.03 Funding</td>
<td>.................................................................................................................. 20</td>
</tr>
<tr>
<td>Section 3.04 Delegation of authority</td>
<td>.................................................................................................................. 20</td>
</tr>
<tr>
<td>Section 3.05 No waiver of sovereign immunity</td>
<td>.................................................................................................................. 20</td>
</tr>
<tr>
<td>Section 3.06 Force majeure</td>
<td>.................................................................................................................. 20</td>
</tr>
<tr>
<td>Section 3.07 Publicity</td>
<td>.................................................................................................................. 20</td>
</tr>
<tr>
<td>Section 3.08 Assignment</td>
<td>.................................................................................................................. 20</td>
</tr>
<tr>
<td>Section 3.09 Cooperation with other vendors and prospective vendors</td>
<td>.................................................................................................................. 21</td>
</tr>
<tr>
<td>Section 3.10 Renegotiation and reprocurement rights</td>
<td>.................................................................................................................. 21</td>
</tr>
<tr>
<td>Section 3.11 RFP errors and omissions</td>
<td>.................................................................................................................. 21</td>
</tr>
<tr>
<td>Section 3.12 Attorneys’ fees</td>
<td>.................................................................................................................. 21</td>
</tr>
<tr>
<td>Section 3.13 Preferences under service contracts</td>
<td>.................................................................................................................. 21</td>
</tr>
<tr>
<td>Section 3.14 Ensuring timely performance</td>
<td>.................................................................................................................. 21</td>
</tr>
<tr>
<td>Section 3.15 Notice</td>
<td>.................................................................................................................. 21</td>
</tr>
<tr>
<td><strong>Article 4. Contract Administration and Management</strong></td>
<td>.................................................................................................................. 21</td>
</tr>
<tr>
<td>Section 4.01 Qualifications, retention, and replacement of MCO employees</td>
<td>.................................................................................................................. 21</td>
</tr>
<tr>
<td>Section 4.02 MCO’s Key Personnel</td>
<td>.................................................................................................................. 21</td>
</tr>
<tr>
<td>Section 4.03 Executive Director</td>
<td>.................................................................................................................. 22</td>
</tr>
<tr>
<td>Section 4.04 Medical Director</td>
<td>.................................................................................................................. 23</td>
</tr>
<tr>
<td>Section 4.05 This Section is Intentionally Left Blank</td>
<td>.................................................................................................................. 23</td>
</tr>
<tr>
<td>Section 4.06 Responsibility for MCO personnel and Subcontractors</td>
<td>.................................................................................................................. 23</td>
</tr>
<tr>
<td>Section 4.07 Cooperation with HHSC and state administrative agencies</td>
<td>.................................................................................................................. 24</td>
</tr>
<tr>
<td>Section 4.08 Conduct of MCO personnel</td>
<td>.................................................................................................................. 24</td>
</tr>
<tr>
<td>Section 4.09 Subcontractors and Agreements with Third Parties</td>
<td>.................................................................................................................. 24</td>
</tr>
<tr>
<td>Section 4.10 HHSC’s ability to contract with Subcontractors</td>
<td>.................................................................................................................. 26</td>
</tr>
<tr>
<td>Section 4.11 Prohibition Against Performance Outside the United States</td>
<td>.................................................................................................................. 26</td>
</tr>
<tr>
<td>Section 4.12 Employment Verification</td>
<td>.................................................................................................................. 27</td>
</tr>
<tr>
<td><strong>Article 5. Member Eligibility, Enrollment, and Disenrollment</strong></td>
<td>.................................................................................................................. 28</td>
</tr>
<tr>
<td>Section 5.01 Eligibility Determination and Disenrollment</td>
<td>.................................................................................................................. 28</td>
</tr>
<tr>
<td>Section 5.02 Member Enrollment and Disenrollment</td>
<td>.................................................................................................................. 28</td>
</tr>
<tr>
<td>Section 5.03 Span of Coverage</td>
<td>.................................................................................................................. 29</td>
</tr>
<tr>
<td><strong>Article 6. Service Levels and Performance Measurement</strong></td>
<td>.................................................................................................................. 30</td>
</tr>
<tr>
<td>Section 6.01 Performance measurement</td>
<td>.................................................................................................................. 30</td>
</tr>
<tr>
<td>Section 6.02 Service Management and Coordination Staffing</td>
<td>.................................................................................................................. 31</td>
</tr>
<tr>
<td><strong>Article 7. Governing Law and Regulations</strong></td>
<td>.................................................................................................................. 31</td>
</tr>
<tr>
<td>Section 7.01 Governing law and venue</td>
<td>.................................................................................................................. 31</td>
</tr>
<tr>
<td>Section 7.02 MCO responsibility for compliance with laws and regulations</td>
<td>.................................................................................................................. 31</td>
</tr>
<tr>
<td>Section 7.03 This Section Intentionally Left Blank</td>
<td>.................................................................................................................. 32</td>
</tr>
</tbody>
</table>
Section 7.04 Compliance with state and federal anti-discrimination laws ........................................... 32
Section 7.05 Environmental protection laws ......................................................................................... 33
Section 7.06 HIPAA ................................................................................................................................. 33
Section 7.07 Historically Underutilized Business Participation Requirements ........................................... 33
Section 7.08 Compliance with Fraud, Waste, and Abuse requirements .................................................... 34

Article 8. Amendments and Modifications .............................................................................................. 34
Section 8.01 Mutual agreement ................................................................................................................ 34
Section 8.02 Changes in law or contract .................................................................................................. 34
Section 8.03 Modifications as a remedy .................................................................................................... 34
Section 8.04 Modifications upon renewal or extension of Contract .......................................................... 34
Section 8.05 Modification of HHSC Uniform Managed Care Manual ...................................................... 34
Section 8.06 CMS approval of Contracts ................................................................................................. 35
Section 8.07 Required compliance with amendment and modification procedures ..................................... 35

Article 9. Audit and Financial Compliance and Litigation Hold .......................................................... 35
Section 9.01 Financial record retention and audit ..................................................................................... 35
Section 9.02 Access to records, books, and documents ............................................................................ 35
Section 9.03 General Access to Accounting Records .............................................................................. 36
Section 9.04 Audits and Inspections of Services and Deliverables ................................................................ 36
Section 9.05 SAO Audit ............................................................................................................................ 37
Section 9.06 Response/compliance with audit or inspection findings ........................................................... 37
Section 9.07 Notification of Legal and Other Proceedings and Related Events ........................................... 37

Article 10. Terms of Payment ................................................................................................................. 37
Section 10.01 Calculation of monthly Capitation Payment ........................................................................ 37
Section 10.02 Time and Manner of Payment ............................................................................................. 38
Section 10.03 Certification of Capitation Rates .......................................................................................... 38
Section 10.04 Modification of Capitation Rates .......................................................................................... 38
Section 10.05 Capitation Structure ........................................................................................................... 38
Section 10.06 MCO input during rate-setting process .............................................................................. 38
Section 10.07 Adjustments to Capitation Payments .................................................................................... 39
Section 10.08 Experience Rebate .............................................................................................................. 39
Section 10.09 Payment by Members ......................................................................................................... 43
Section 10.10 Restriction on assignment of fees ...................................................................................... 44
Section 10.11 Liability for taxes ................................................................................................................ 44
Section 10.12 Liability for employment-related charges and benefits ......................................................... 44
Section 10.13 No additional consideration ................................................................................................. 44
Section 10.14 Federal Disallowance ........................................................................................................ 44
Section 10.15 Pass-through Payments for Provider Rate Increases ........................................................... 44
Section 10.16 Non-risk Payments for Certain Drugs .................................................................................. 44
Section 10.17 Payment/Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee ....................................................................................................................... 45
Section 10.18 Supplemental Payments for Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products .......................................................................................................................... 45

Article 11. Disclosure and Confidentiality of Information ......................................................................... 46
Section 11.01 Confidentiality .................................................................................................................... 46
Section 11.02 Disclosure of HHSC’s Confidential Information ................................................................. 47
Section 11.03 Member Records ................................................................................................................ 47
Section 11.04 Requests for public information ........................................................................................... 47
Section 11.05 Privileged Work Product .................................................................................................... 47
Section 11.06 Unauthorized acts ............................................................................................................... 48
Section 11.07 Legal action .......................................................................................................................... 48
Section 11.08 Information Security and Privacy Requirements ...................................................................... 48
Section 11.09 MCO’s Incident and Breach Notice, Reporting and Mitigation .............................................. 49

Article 12. Remedies & Disputes ............................................................................................................. 51
Article 1. Introduction

Section 1.01 Purpose.
The purpose of this Contract is to set forth the terms for the MCO’s participation as a managed care organization in the STAR Health Program administered by HHSC. Under the terms of this Contract, MCO will provide comprehensive healthcare services to qualified Program recipients through a managed care delivery system.

Section 1.02 Risk-based contract.
This is a Risk-based contract.

Section 1.03 Inducements.
In making the award of this Contract, HHSC relied on MCO’s assurances of the following:
   (1) MCO is a health maintenance organization, Approved Non-Profit Health Corporation (ANHC), or Exclusive Provider Organization that arranges for the delivery of Healthcare Services, and either (1) has received Texas Department of Insurance (TDI) licensure or approval as one of these entities and is fully authorized to conduct business in the Service Area, or (2) will receive TDI licensure or approval as one of these entities and be fully authorized to conduct business in the Service Area no later than 60 Days after HHSC executes this Contract;
   (2) MCO and the MCO Administrative Service Subcontractors have the skills, qualifications, expertise, financial resources and experience necessary to provide the Services and Deliverables described in the RFP, MCO’s Proposal, and this Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities;
   (3) MCO has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP, and has had the opportunity to review and fully understand HHSC’s current Program and operating environment for the activities that are the subject of the Contract and HHSC’s needs and requirements during the Contract term;
   (4) MCO has had the opportunity to review and understand HHSC’s stated objectives in entering into this Contract and, based on this review and understanding, MCO currently has the capability to perform in accordance with the terms and conditions of this Contract;
   (5) MCO also has reviewed and understands the risks associated with the Program as described in the RFP, including the risk of non-appropriation of funds.

Accordingly, on the basis of the terms of this Contract, HHSC engages MCO to perform the Services and provide the Deliverables described in this Contract.

Section 1.04 Construction of the Contract.
(a) Scope of Introductory Article.
The provisions of any introductory article to the Contract are intended to be a general introduction and are not intended to expand the scope of the Parties’ obligations under the Contract or to alter the plain meaning of the terms of the Contract.
(b) References to the “State.”
References in the Contract to the “state” mean the State of Texas unless otherwise specifically indicated and will be interpreted, as appropriate, to mean or include HHSC and other agencies of the State of Texas that may participate in the administration of the Program, provided, however, that no provision will be interpreted to include any entity other than HHSC as the contracting agency.
(c) Severability.
If any provision of this Contract is for any reason held to be unenforceable, the rest of it remains fully enforceable.
(d) Survival of terms.
Termination or expiration of this Contract for any reason will not release either Party from any liabilities or obligations set forth in this Contract that:
   (1) The Parties have expressly agreed will survive any termination or expiration; or
   (2) Arose prior to the effective date of termination and remain to be performed or by their nature would be intended to be applicable following any termination or expiration.
(e) Headings.
The article, section, and paragraph headings in this Contract are for reference and convenience only and may not be considered in the interpretation of this Contract.
(f) Global drafting conventions.
   (1) The terms “include,” “includes,” and “including” are terms of inclusion and enlargement, and where used in this Contract, should be read as if followed by the phrase “without limitation.”
   (2) Any references to “sections,” “appendices,” “exhibits,” or “attachments” are references to sections, appendices, exhibits or attachments to this Contract.
   (3) Any references to laws, rules, regulations, and manuals in this Contract are references to these documents as amended, modified, or supplemented from time to time during the term of this Contract.

Section 1.05 No implied authority.
The authority delegated to MCO by HHSC is limited to the terms of this Contract. HHSC is the state agency designated by the Texas Legislature to administer the Program, and no other state agency
grants MCO any authority related to this Program unless directed through HHSC. MCO may not rely upon implied authority, and specifically, is not delegated authority under this Contract to:

(1) make public policy;
(2) promulgate, amend, or disregard administrative regulations or program policy decisions made by state and federal agencies responsible for administration of HHSC Programs; or
(3) unilaterally communicate or negotiate with any state or federal agency or the Texas Legislature on behalf of HHSC regarding the HHSC Programs.

MCO is required to cooperate to the fullest extent possible to assist HHSC in communications and negotiations with state and federal governments and agencies concerning matters relating to the scope of the Contract and the MCO Program, as directed by HHSC.

Section 1.06 Legal Authority.

(a) HHSC is authorized to enter into this Contract under Tex. Gov’t Code Chapters 531 and 533 and Section 2155.144. MCO is authorized to enter into this Contract under the authorization of its governing board or controlling owner or officer.

(b) Any person signing and executing this Contract on behalf of the Parties, or representing signatory authority on behalf of the Parties, warrant and guarantee that he or she is authorized to execute this Contract and to validly and legally bind the Parties to all of its terms, performances, and provisions.

Section 1.07 Loss of Program Authority.

Should any part of the Scope of Work 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. HHSC must adjust Capitation Rates, or non-risk payments as applicable, 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 HHSC 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 should be returned to HHSC. However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and HHSC 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.

Article 2. Definitions

As used in this Contract, the following terms are defined below:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Medicaid Programs or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare. It also includes Member practices that result in unnecessary cost to the Programs.

Abuse, Neglect, or Exploitation has the meaning assigned in 26 Tex. Admin. Code Chapter 711 (for Adult Protective Services provider investigations).

Acute Care means preventive care, primary 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.

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 or control the environment in which he or she lives.

Adjudicate means to deny or pay a Clean Claim.

Administrative Services means to HHSC.

Administrative Services Contractor means a Medicaid Program or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare. It also includes Member practices that result in unnecessary cost to the Programs.

Adjective means to deny or pay a Clean Claim.

Administrative Services means HHSC.

Administrative Services Contractor means a Medicaid Program or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare. It also includes Member practices that result in unnecessary cost to the Programs.

Adoption Assistance (AA) Member means a Member in STAR or STAR Kids who is the subject of an adoption assistance agreement under the adoption assistance program as described in 40 Tex. Admin. Code Chapter 700, Subchapter H (Adoption Assistance Program).

Adoption Assistance Program is the program administered by the Department of Family and Protective Services under 40 Tex. Admin. Code Chapter 700, Subchapter H (Adoption Assistance Program). The Adoption Assistance Program provides Medicaid coverage for the adopted Member.

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 an 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 5.0% or greater interest in the MCO (either directly or through one or more intermediaries); 2) in which the MCO owns or holds a 5.0% 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.

Agency Sensitive Information means information that is not subject to specific legal, regulatory, or other external requirements, but is considered HHSC sensitive and is not readily available to the public. "Agency Sensitive Information" could be subject to disclosure under the Texas Public Information Act, but disclosure should be controlled due to sensitivity.

Agreement see Contract.

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 the HHSC’s UMC MCM Chapter 6

AAP means the American Academy of Pediatrics.

Approved Non-profit Health Corporation (ANHC) means an organization formed in compliance with Chapter 844 of the Texas Insurance Code and licensed by TDI to provide services as a health plan. See also MCO.

Assisted Living Facility (ALF) has the meaning under Section 247.002, Health and Safety Code.

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 MDCP 1915(c) waiver.

Behavioral Health means mental, emotional, or Substance Use Disorders, or a combination thereof.

Behavioral Health (BH) Hotline means the toll-free number operated by the MCO to handle routine behavioral-health 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.

Breach means the unauthorized acquisition, access, use, or disclosure of protected health information as described in 45 C.F.R. § 164.402.

Business Continuity Plan (or BCP) means a plan that provides for a quick and smooth restoration of 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.

Business Day means any day other than a Saturday, Sunday, or a state or federal holiday on which HHSC’s offices are closed, unless the context clearly indicates otherwise.

CAHPS means the Consumer Assessment of Healthcare Providers and Systems. This survey is conducted annually by the EQRO.

Call Coverage means arrangements made by a facility or an attending physician with an appropriate
level of healthcare provider who agrees to be available on an as-needed basis to provide medically appropriate services for routine, high risk, or Emergency Medical Conditions or Emergency Behavioral Health Conditions that present without being scheduled 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 Attachment B-2, however, services required by EPSDT are not considered Case-by-case Services.

**Case Head** means the head of the household that is applying for Medicaid.

**Case Management Services** means the provision of Case Management Services by DFPS or its contractors to a Member for whom DFPS has been appointed temporary or permanent managing conservator. Case Management Services include caseworker-Member visits, family visits, the convening of Family Group Conferences, the development and revision of the Case Plan, the coordination and monitoring of services needed by the Member and family, and the assumption of court-related duties, including preparing court reports, attending judicial hearings and permanency hearings, and ensuring that the Member is progressing toward permanency within state and federal mandates.

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

**Case Plan** means the plan developed in accordance with 40 Tex. Admin. Code §700.1319–§ 700.1325 and related law. The purpose of the Case Plan, which includes the Member’s service plan and the family’s service plan if applicable, is to establish a structured, time-limited plan for providing services and to ensure that activities and services progress as quickly as possible toward achieving the most appropriate permanent placement for the Member. DFPS Staff are responsible for developing the Case Plan.

**Certified Community Behavioral Health Clinic (CCBHC)** means a clinic certified by the State of Texas in accordance with federal criteria and with the requirements of the Protecting Access to Medicare Act of 2014 (PAMA). See 1 Tex. Admin. Code §353.1320 (b)(2).


**Change in Condition** means a significant change in a Member’s health or functional status that will not normally resolve itself without further intervention and requires review of and revision to the current Individual Service Plan (ISP) and/or overall Plan of Care (POC).

**Chemical Dependency Treatment** means treatment provided for a chemical dependency condition by a Chemical Dependency Treatment facility, chemical dependency counselor or Hospital.

**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

**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. The Clinical PA is used for verifying that a Member’s medical condition matches the clinical criteria for dispensing a requested drug.
**CMS** means the Centers for Medicare and Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

**Collaborative Care Model (CoCM)** means a systematic approach to the treatment of Behavioral Health conditions for persons of all ages in primary care settings. The model integrates the services of a Behavioral Health care manager (BHCM) and a consulting psychiatrist with primary care provider oversight to proactively manage Behavioral Health conditions as chronic diseases, rather than treating acute symptoms. CoCM services include outreach and engagement, completion of an initial assessment, development of an individualized and person-centered plan of care, monitoring and tracking a person’s progress using a registry, providing brief interventions and other focused treatments, and conducting weekly caseload reviews with the psychiatric consultant.

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

**Community First Choice (CFC)** means personal assistance services; acquisition, maintenance and enhancement of skills; emergency response services and support management provided in a community setting for eligible Medicaid Members in STAR Health who have received a Level of Care (LOC) determination from an HHSC-authorized entity.

**Community Health Worker** 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. A Community Health Worker, also called a promotor (a), helps people gain access to needed services, increase health knowledge, and become self-sufficient through outreach, Member navigation and follow-up, community health education and information, 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 individual 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 individual problems.

**Community Services Specialist Provider (CSSP)** means a staff member of a Local Mental Health Authority who has documented full-time experience in the provision of Mental Health Targeted Case Management and Mental Health Rehabilitative Services prior to August 31, 2004. The provider who meets the following minimum requirements: (1) high school diploma or high school equivalency, and (2) three continuous years of documented full-time experience in the provisions of Mental Health Rehabilitative Services and demonstrated competency in the provision and documentation of Mental Health Rehabilitative Services.

**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 the Member who filed the 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. Complaint has the same meaning as grievance, as provided 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 Need** means a condition or situation resulting in a need for coordination or access to services beyond what a PCP would normally provide, triggering the MCO’s determination that Care Coordination is required.

**Comprehensive Care Program**: See definition for Texas Health Steps.

**Confidential Information** means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to MCO or that MCO may create, receive, maintain, use, disclose or have access to on behalf of HHS that consists of or includes any or all of the following: 

(2) Federal Tax Information as defined in Internal Revenue Code § 6103 and Internal Revenue Service Publication 1075;

(3) Personal Identifying Information (PII) as defined in Texas Business and Commerce Code, Chapter 521;

(4) Protected Health Information (PHI) in any form including without limitation, Electronic Protected Health Information as defined in 45 C.F.R § 160.103 or Unsecured Protected Health Information as defined in 45 C.F.R. § 164.402;

(5) Sensitive Personal Information (SPI) as defined in Texas Business and Commerce Code, Chapter 521;

(6) Social Security Administration Data, including, without limitation, Medicaid information means disclosures of information made by the Social Security Administration or the Centers for Medicare and Medicaid Services from a federal system of records for administration of federally funded benefit programs under the Social Security Act, 42 U.S.C., Chapter 7;

(7) All privileged work product;

(8) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

CONNECTIONS 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.

Consolidated FSR Report or Consolidated Basis means FSR reporting results for all Programs and all Service Areas 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 Affiliates’ 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 means this formal, written, and legally enforceable contract between the Parties and any amendments.

Contract Period or Contract Term means the Initial Contract Period plus any and all Contract extensions.

Contract Year means one complete State Fiscal Year (i.e., September 1 to August 31 of the following calendar year) under the Contract.

Contractor see MCO.

Corrective Action Plan means the detailed written plan that may be required by HHSC to correct or resolve a deficiency, event, or breach causing the assessment of a remedy or damage against MCO.

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

Covered Services means Healthcare Services and NEMT 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 (see Contract Attachment B-2 relating to “Value-added Services”). Covered Services include, without limitation, Acute Care, Behavioral Health Services, dental services, pharmacy services, and vision 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. Abuse, Neglect, or Exploitation
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.
Critical Incident Management System (CIMS) is an online reporting system to report and track Incidents of abuse, neglect, and exploitation (ANE) allegations and Critical Events or Incidents.

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 STAR Health MCO concerning each new client that is taken into DFPS conservatorship (i.e., Members included in category 1 of the “Target Population” definition). The STAR Health MCO should 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 of the “Target Population” definition.

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

Day means a calendar day unless specified otherwise.

DADS means the Texas Department of Aging and Disability Services or its successor agency.

DARS means the Texas Department of Assistive and Rehabilitative Services or its successor agency.

Deliverable means a written or recorded work product or data prepared, developed, or procured by MCO as part of the Services under the Contract for the use or benefit of HHSC or the State of Texas.

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 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 readily 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.

Disaster Recovery Plan means the document developed by the MCO that outlines details for the restoration of the 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 (1) 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.

Discovery/Discovered has the meaning assigned by 45 C.F.R. § 164.410.

Disease Management 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.

DSHS means the Texas Department of State Health Services or its successor agency.

DSN means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, which is the American Psychiatric Association’s official classification of behavioral health 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.

ECI means Early Childhood Intervention, a federally mandated program for infants and toddlers under the age of three with developmental delays or disabilities. See 34 C.F.R. § 303.1 et seq. and 26 Tex. Admin.Code § 350.101 et seq. for further clarification.

EDI means electronic data interchange.

Effective Date means the effective date of this Contract.

Effective Date of Coverage means:

(1) the date the Member enters into DFPS conservatorship for Members included in category 1 of the “Target Population” definition; and

(2) the first day of the month that a Member is enrolled in the STAR Health Program for Members included in categories 2 and 3 of the “Target Population” definition. For Members in categories 2 and 3 of the “Target Population” definition, HHSC will follow prospective enrollment procedures.

Electronic Visit Verification (EVV) is a computer-based system that electronically documents and verifies service delivery information, such as the
date, time, service type and location for certain Medicaid service visits.

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

**Emergency Behavioral Health Condition** means any 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 Members would present an immediate danger to themselves or others, or
2. that renders Members incapable of controlling, knowing, or understanding the consequences of their actions.

Emergency Behavioral Health Conditions include Emergency Detentions as defined under Chapter 573, Subchapter A, of the Texas Health and Safety Code and under Chapter 462, Subchapter C, of the Texas Health and Safety Code.

**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 Behavioral Health 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 them 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/Enrollment File** means the daily or monthly list of Eligibles that are enrolled with an MCO as Members on the day or for the month the report is issued.

**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.

**Exclusive Provider Benefit Plan (EPP)** means a type of healthcare plan offered by an issuer that arranges for or provides benefits to covered persons through a network of exclusive providers, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or approved referral.

**Experience Rebate** means the portion of the MCO’s Net Income Before Taxes that is returned to the State in accordance with Section 10.09 of this document (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 or health or ability to attain, maintain, or regain maximum function.

**Expiration Date** means the expiration date of this Contract, as specified in HHSC’s Managed Care Contract document.

**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 MCO Programs.

**Family Group Conference (FGC)** is a planned, professionally facilitated meeting for the purpose of making decisions regarding a Member’s placement and permanency plan. FGC participants can include immediate and extended family members, friends, and significant people in the community, DFPS Staff, Single Source Continuum Contractor (SSCC) staff, ICC Vendor staff, and other professionals working with the family, and the Member, if appropriate.

**Family Partner** means a Mental Health Rehabilitative Service provider who meets the following minimum requirements: (1) high school diploma or high school equivalency, and (2) one cumulative year of participating in mental health services as the parent or legally authorized
representative of a child receiving mental health services.

**Family Strengths and Needs Assessment (FSNA)** means an assessment completed by DFPS to collect the strengths and needs of the Member’s parent(s). The assessment will assist DFPS with case planning and family reunification and will assist BH Providers with the completion of the Texas Comprehensive CANS 2.0 (child welfare). DFPS will submit a completed FSNA to Superior within 21 Days of a child entering conservatorship so it can be displayed in the Health Passport.

**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) and as in effect for the applicable budget period used to determine an individual’s eligibility in accordance with 42 C.F.R. § 435.603(h).

**Fee-for-Service (or 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 Texas Human Resources Code Chapter 32.

**Financial Management Services** means assistance provided to Members, Caregivers, and Medical Consenters who manage funds associated with self-directed service delivery options. The service includes 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 § 41.309(a) to an MCO to provide financial management services as described in 40 Tex. Admin. Code § 41.309(a) to an employer or designated representative.

**Financial Statistical Report** see FSR.

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

**Force Majeure Event** means any failure or delay in performance of a duty by a Party under this Contract that is caused by fire, flood, hurricane, tornadoes, earthquake, an act of God, an act of war, riot, civil disorder, or any similar event beyond the reasonable control of such Party and without the fault or negligence of such Party.

**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. FFCC Members may be enrolled in the STAR or STAR Health Program. The FFCC Member may be enrolled until the last day of the month of his or her 26th birthday.

**FQHC** means a Federally Qualified Health Center, certified by CMS to meet the requirements of 42 U.S.C. §§ 1395(aa)(3) and (4) as a federally qualified health center that is enrolled as a provider in the Texas Medicaid Program.

**Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

**FSR** means Financial Statistical Report. The FSR is a report designed by HHSC, and submitted to HHSC by the MCO in accordance with Contract requirements. 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.

**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 State Fiscal Year, 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 § 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 activities of daily living and instrumental activities of daily living.

**Healthcare Service Plan** means an individualized plan developed with and for Members with Special Healthcare Needs. The Healthcare Service Plan includes the following:

1. the Member’s history;
2. summary of current medical and social needs and concerns;
3. short and long-term needs and goals;
4. a treatment plan to address the Member’s physical, psychological, and emotional healthcare problems and needs including a list of services required, their frequency, and a description of who will provide these services.

The Healthcare Service Plan should incorporate as a component of the plan the Individual Family Service Plan (IFSP) for Members in the Early Childhood Intervention (ECI) program.

**Healthcare Services** means the Acute Care, Behavioral Healthcare, and health-related services
that an enrolled population might reasonably require in order to be maintained in good health, including, at a minimum, Emergency Services and inpatient and outpatient services. Healthcare Services do not include NEMT Services.

**Health and Human Services Commission (or HHSC)** means the administrative agency within the executive department of the State of Texas established under Texas Government Code Chapter 531. HHSC is the single state agency charged with administration and oversight of the Texas Medicaid Program, including Medicaid Managed Care.

**Health Passport** means an electronic health record system used to document information regarding medical 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.

**HEDIS** means the Healthcare Effectiveness Data and Information Set, which is a registered trademark of NCQA and is a set of standardized performance measures designed to reliably compare the performance of managed healthcare plans. HEDIS is sponsored, supported, and maintained by NCQA.

**HHS Agency** means any Texas health and human service agency subject to HHSC’s oversight under Texas Government Code Chapter 531, and any successor agency.

**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.

**HHSC Office of the Inspector General** means the entity contracted with DFPS to conduct HHSC’s oversight under Texas Government Code Chapter 531, and any successor agency.


**HITECH Act** means the Health Information Technology for Economic and Clinical Health Act, 42 U.S.C. §§ 17931–39.

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

**Hospital** means a licensed public or private institution as defined by Texas Health and Safety Code Chapter 241, Texas Health and Safety Code, or in Texas Health and Safety Code Chapters 571 to 578.

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

**Indian Health Care Provider (IHCP)** has the meaning assigned to it in 42 C.F.R. § 438.14, 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 Early Childhood Intervention (ECI) program and developed by an interdisciplinary team.

**Information Resources** means the procedures, equipment, and software that are employed, designed, built, operated, and maintained to collect, record, process, store, retrieve, display, and transmit information, and associated personnel including consultants and contractors as defined in § 2054.003(7), Texas Government Code “information resources”, and as defined in 44 U.S.C. § 3502, NIST SP 800-53 rev 4.

**Initial Contract Period** means the Effective Date of the Contract through August 31, 2018.

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

**Inquiry** a request by a consumer (Member or Provider) for information about HHS programs or services.

**Integrated Care Coordination (ICC)** means the coordination of the activities of all entities and individuals responsible for a Member’s medical, social and behavioral health case management

**Integrated Care Coordination (ICC) Vendor** means the entity contracted with DFPS to conduct ICC.

**Integrated Primary Care (IPC)** means an approach to care that integrates Behavioral Health Services into primary care during the regular provision or primary care services. IPC occurs at the same time
and by the same provider, or by the Behavioral Health Services provider seeing the Member in tandem with the PCP.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) means an Intermediate Care Facility for individuals with Intellectual Disability or related conditions that provides residential care and services for those individuals 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 I.D. 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.

Key MCO Personnel means the critical management and technical positions identified by the MCO in accordance with Article 4.

Legally Authorized Representative (LAR) means the Member’s representative defined by state or federal law, including Tex. Occ. Code § 151.002(6), Tex. Health & Safety Code § 166.164, and Tex. Estates Code Ch. 752.

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 (PA); registered nurse (RN); licensed vocational nurse (LVN); or pharmacists.

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; or
6. a licensed marriage and family therapist.

Limited English Proficient (LEP) has the meaning assigned to it in 42 CFR § 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 Texas Health and Safety Code § 533.0356.

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

Local Mental Health Authority (or LMHA) has the meaning assigned in Health and Safety Code § 531.002(10).

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 a Dental Home to Members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to Members, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as Main Dental Home Providers are FQHCs, RHCs, 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 Service Area served by the MCO.

Manded 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.

Material Subcontract means any contract, Subcontract, or agreement between the MCO and another entity that meets any of the following criteria:

1. the other entity is an Affiliate of the MCO;
2. the Subcontract is considered by HHSC to be for a key type of service or function, including:
a) Administrative Services (including third party administrator, Network administration, and claims processing);
b) delegated Networks (including behavioral health, dental, pharmacy, and vision);
c) management services (including management agreements with parent);
d) reinsurance or retrocession agreements;
e) Disease Management;
f) pharmacy benefit management (PBM) or pharmacy administrative services;
g) call lines (including nurse and medical consultation); or
h) delegated transportation networks; or
3. any other Subcontract that exceeds, or is reasonably expected to exceed, the lesser of: a) $500,000 per year, or b) 1% of the MCO’s annual Revenues under this Contract. Any Subcontracts between the MCO and a single entity that are split into separate agreements by time period, Program, or Service Area, etc., will be consolidated for the purpose of this definition.

For the purposes of this Agreement, Material Subcontracts do not include contracts with any non-Affiliates for any of the following, regardless of the value of the contract: utilities (e.g., water, electricity, telephone, Internet, trash), mail/shipping, office space, maintenance, security, or computer hardware.

Material Subcontractor (Major Subcontractor) means any entity with a Material Subcontract with the MCO. For purposes of this Agreement, Material Subcontracts do not include Providers in the MCO’s Provider Network. Material Subcontractors may include, without limitation, Affiliates, subsidiaries, and affiliated and unaffiliated third parties.

MCO means the managed care organization that is a party to this Contract.

MCO Administrative Services means the performance of services or functions, other than the direct delivery of Covered Services, necessary for the management of the delivery of and payment for Covered Services, including Network, utilization, clinical or quality management, service authorization, claims processing, management information systems operation and reporting. This term also includes the infrastructure development for, preparation of, and delivery of, all required Deliverables under the Contract, outside of the Covered Services.

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

MCO Internal Appeal and Complaint System means the process the MCO implements to handle MCO Internal Appeals of 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 means the medical assistance entitlement program authorized and funded under Title XIX, Social Security Act (42 U.S.C. § 1396 et seq.) and administered by HHSC.

Medicaid for Transitioning Foster Care Youth (MTFCY) Program means the Medicaid Program, administered in accordance with 1 Tex. Admin. Code Chapter 366, Subchapter F.

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

Medical Home has the meaning assigned to a patient-centered Medical Home in Texas Government 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 § 353.2.

Member means a person who:

(1) is entitled to benefits under Title XIX of the Social Security Act 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 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 Hotline means the toll-free telephone line operated by the MCO that responds to inquiries from Members, DFPS Staff, SSCC Staff, ICC Vendor 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 MCO Program. Member Materials include Member ID cards and Member Handbooks and Provider Directories.

Member Month means one Member enrolled with the MCO during any given month. 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 Special Healthcare Needs (MSHCN) means a Member, including a child enrolled in the DSHS 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.

Mental Health Rehabilitative Services are those 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 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 a standardized assessment (the Child and Adolescent Needs and Strengths (CANS) or 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.

MIS means Management Information System.

National CLAS Standards means The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards). These standards were developed by the U.S. Department of Health and Human Services - Office of Minority Health and are "intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services." Originally developed in 2000, the CLAS Standards were then updated in 2013. For the list of CLAS Standards, see the Think Cultural Health website.

National Committee for Quality Assurance (NCQA) means the independent organization that accredits MCOs and managed behavioral health organizations and accredits and certifies Disease Management programs. HEDIS and the Quality Compass are registered trademarks of NCQA.

NEMT Attendant means

1. for a Member under age 18, the Member’s parent, guardian, or another adult authorized in writing by the parent or guardian to accompany the Member;
2. an adult that accompanies a Member to provide necessary mobility, personal or language assistance to the Member during the time that transportation services are provided, including an adult serving as a personal attendant;
3. a service animal that accompanies a Member to provide necessary mobility or personal assistance to the Member during the time that transportation services are provided and who occupies a seat that would otherwise be filled with another Member; or
4. an adult that accompanies a Member because a health care provider has stated in writing that the Member requires an attendant.

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

Network means all Providers that have entered into Provider Contracts.

Network Provider see Provider.

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 Fee-for-Service basis. Non-capitated Services are identified in Attachment B-1 Section 8.

Non-emergency Medical Transportation (NEMT) Services means non-emergency transportation-related services available under the Medicaid state plan, including Nonmedical Transportation (NMT) Services.

Nonmedical Transportation (NMT) Services has the meaning assigned by Tex. Gov’t Code § 533.00258(a)(1).

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 Providers, Members, DFPS Staff, SSCC Staff, ICC Vendor 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.

**Open Panel** means Primary Care Providers who are accepting new Members for the MCO Program.

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

**Operations Phase** means the period of time when 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 Network Provider by a MCO, PIHP, or PAHP to which the Network Provider is not entitled under Title XIX or Title XXI of the Act or any payment to a MCO, PIHP, or PAHP by HHSC to which the MCO, PIHP, or PAHP is not entitled under Title XIX or Title XXI of the Act.

**Parties** means HHSC and MCO, collectively.

**Party** means either HHSC or MCO, individually.

**PCP Team** means a Member’s PCP, other Providers, and the Member’s Medical Consenter, who agree to function as an interdisciplinary team. If requested by the Member's Medical Consenter, the Member’s Caregiver, ICC Vendor Staff, and SSCC staff may be included in the PCP Team. The PCP Team may also include a Member’s DFPS caseworker and MCO Service Coordinator.

**Peer Provider** means a Mental Health Rehabilitative Service 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.

**Peer-to-Peer** means the discussion held between the physician requesting, ordering or intending to provide a service for which prior authorization is required and an MCOs Medical Director or his or her physician designee regarding the medical necessity, appropriateness, or the experimental or investigational nature of a healthcare service.

**Pended Claim** means a claim for payment that requires additional information before the claim can be adjudicated as a Clean Claim.

**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 Permanency Care Assistance Program.

**Permanency Care Assistance Program** is the program administered by the Department of Family and Protective Services under 40 Tex. Admin. Code Subchapter J, Division 2 (Permanency Care Assistance Program). The Permanency Care Assistance 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-Centered Planning** means the development of 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.

**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 activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health-maintenance activities.

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

**Population Risk Group** means a distinct group of members identified by age, age range, gender, type of Program, eligibility category, or other criteria established by HHSC.

**Post-stabilization Care Services** has the meaning assigned to it in 42 CFR § 438.114. 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.

**PPACA** means the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as
amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

**Pre-tax Income** (see Net Income Before Taxes above).

**Prescribed Pediatric Extended Care Center (PPECC)** means a facility under Texas Health and Safety Code § 248A.001 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 it in 42 CFR § 438.10 and 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 of the population in a Service Area speaks the non-English language.

**Primary Care Provider (or 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 the continuity of Member care, and initiating referral for care.

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

**Program** means the STAR Health program.

**Proposal** means the proposal submitted by the MCO in response to the RFP under which this Contract was awarded.

**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 for the delivery of Healthcare 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 STAR Health that are distributed to Network Providers.

**Provider Network** See Network.

**Proxy Claim Form** means a form submitted by Providers to document services delivered to Members under a capitated arrangement. It is not a claim for payment.

**Psychiatric Hospital** means a Hospital that provides inpatient mental health services to individuals with mental illness or with a substance use disorder 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 25 Tex. Admin. Code, Chapter 134.

**Public Health Entity** means a DSHS health service regional office in a Public Health Region administered by a regional director under Section 121.007, Health and Safety Code and acting in the capacity of a local public health entity; a Local Health Department established under Subchapter D, Chapter 121, Health and Safety Code; a Public Health District established under Subchapter E, Chapter 121 Health and Safety Code; a Local Health Unit described by Section 121.004, Health and Safety Code; or a Hospital District providing Covered Services to Medicaid Members.

**Public Information** means information that:

1. Is collected, assembled, or maintained under a law or ordinance or in connection with the transaction of official business by a governmental body or for a governmental body; and

2. The governmental body owns or has a right of access to.

**Qualified Mental Health Professional for Community Services (QMHP-CS)** means a staff member who has a Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, educational psychology, early childhood education, or early childhood intervention; or is a registered nurse, or a Licensed Practitioner of the Healing Arts.

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

**Rate Period 1** means the 12-month period beginning on September 1, 2015, and ending on August 31, 2016.

**Rate Period 2** means the 12-month period beginning on September 1, 2016, and ending on August 31, 2017.

**Readily Accessible** has the meaning assigned to it in 42 CFR § 438.10 and means electronic information and services which comply with modern accessibility standards such as section 508 guidelines and 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 CART, Communication Access Real-Time Translation) 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.

**Request for Proposals (RFP)** means the procurement solicitation instrument issued by HHSC under which this Contract was awarded and all RFP addenda, corrections or modifications, if any.

**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 Action of the MCO on behalf of a Member.

**Revenue** means all revenue received by the MCO under this Contract, including retroactive adjustments made by HHSC. Revenue includes any funds earned on Medicaid or CHIP managed care funds such as investment income and earned interest. Revenue excludes any reinsurance recoveries, which must be shown as a contra-cost, or reported offset to reinsurance expense. Revenues are reported at gross, and are not netted for any reinsurance premiums paid. See also UMCM Chapter 6.

**Risk** means the potential for loss as a result of expenses and costs of the MCO exceeding payments made by HHSC under the Contract.

**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 product 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 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 to help determine a Member’s eligibility for MDCP and CFC enrollment.

**SDX** means State Data Exchange.

**Self-employed Direct Provider** means an appropriately credentialed person who is self-employed and has a contract with the MCO for the delivery of one or more Covered Services.

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

**Service Coordination** is an Administrative Service performed by the MCO to coordinate services and information, such as medical information for court hearings, at the request of a Medical Consenter, Caregiver, Member, DFPS Staff, SSCC staff, ICC Vendor Staff, or PCP; coordinate Non-capitated Services.

**Service Coordinator(s)** perform the functions of Service Coordination.

**Service Management** is a clinical service performed by the MCO for Members with MSHCN and other Members when appropriate to facilitate development of a Healthcare Service Plan and coordination of clinical services among a Member’s PCP and specialty providers to ensure Members have access to, and appropriately utilize, Medically Necessary Covered Services.

**Service Manager(s)** perform the functions of Service Management.

**Services** mean the tasks, functions, and responsibilities assigned and delegated to the MCO under this Contract.

**Severe and Persistent Mental Illness (SPMI)** means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health 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 which cause severe disturbances in behavior, thinking and feeling.
**Significant Traditional Provider (STP)** means Primary Care Providers, long-term care providers, and pharmacy providers identified by HHSC as having provided a significant level of care to Fee-for-Service clients in Substitute Care. Disproportionate Share Hospitals (DSH) are also Medicaid STPs.

**Single Source Continuum Contractor (SSCC)** means the organization responsible for ensuring the full continuum of paid foster care and purchased services for children and youth in DFPS legal conservatorship is available in designated foster care redesign areas.

**Software** means all operating system and applications software used by the MCO to provide the Services under this Contract.

**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.


**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 regarding STAR Health. The STAR Health Liaison will coordinate with the MCO and DFPS to ensure effective and efficient response by the MCO to operational issues and other concerns of DFPS.

**STAR Health Program** means the managed care Program for the Target Population that is administered by HHSC and the subject matter of this Agreement.

**State Fair Hearing** means the process adopted and implemented by HHSC in 1 Tex. Admin. Code Chapter 357, in compliance with federal regulations and state rules relating to Medicaid State fair hearings.

**State Fiscal Year (SFY)** means a 12-month period beginning on September 1 and ending on August 31 the following year.

**Subcontract** means any agreement between the MCO and another party to fulfill the requirements of the Contract.

**Subcontractor** has the same meaning as assigned in 42 C.F.R. § 438.2.

**Subsidiary** means an Affiliate controlled by the MCO directly or indirectly through one or more intermediaries.

**Substance Use Disorder** means the use of one or more drugs or substances, including alcohol, which significantly and negatively impacts one or more major areas of life functioning and which meets the criteria for Substance Use Disorders as described in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance Use Disorders.

**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, adoption, 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 SSA under Title XVI of the Social Security Act. All persons who are certified as eligible for SSI in Texas are eligible for Medicaid. Local SSA claims representatives make SSI eligibility determinations. The transactions are forwarded to the SSA in Baltimore, who then notifies the states through the SDX.

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

**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 or the Individuals with Disabilities Education Act. For any Member receiving one of those waiver services, the MCO must document that the Employment Assistance service is not available to the Member in the Member’s HCSP.

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 means children and young adults in one of the following categories:

(1) DFPS conservatorship;

(2) young adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement;

(3) young adults aged 18 through the month of their 21st birthday, who are FFCC Members or who are participating in the MTFCY Program;

(4) an infant born to a mother who is enrolled in STAR Health;

(5) children through age 17 and young adults aged 18 through the month of their 21st birth who are receiving Supplemental Security Income (SSI) or who were receiving Supplemental Income before becoming eligible for AA or PCA; and

(6) children through age 17 and young adults aged 18 through the month of their 21st who are enrolled in a 1915(c) Medicaid Waiver and AA or PCA

TDD means telecommunication device for the deaf. It is interchangeable with the term teletype machine or TTY.

TDI means the Texas Department of Insurance.

Telemedicine has the meaning defined in 1 Tex. Admin. Code § 354.1430.

Texas Comprehensive Child and Adolescent Needs and Strengths (CANS) 2.0 (child welfare) assessment means the comprehensive and developmentally appropriate child welfare assessment required by Texas Family Code § 266.012. This assessment is not the same as the CANS assessment described in Attachment B-1, Section 8.1.17.8, “Mental Health Rehabilitative Services and Mental Health Targeted Case Management Services” or described in Attachment B-1, Section 8.1.38, “Community First Choice Services”. The assessment must include a trauma screening and interviews with available individuals having knowledge of the child’s needs. Upon direction from HHSC, the MCO must begin ensuring this assessment is completed for all Members in category 1 of the Target Population ages 3 and older within 30 Days of receipt of the DNF.

Texas Health Steps is the name adopted by the State of Texas for the federally mandated EPSDT Program. It includes the State’s Comprehensive Care Program 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 Chapter 33.

Texas Health Steps 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 means the policy and procedures 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.


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 (see 1 Tex. Admin. Code §§ 354.2301 et seq., relating to Third Party Resources).

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.

TJC (formerly JCAHO) means The Joint Commission.

Transfer means the movement of the Member from one (1) 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 Service Area 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 the Member for a successful transition out of STAR Health and into adulthood and independent living.

**Transportation Network Company (TNC)** has the meaning assigned by Tex. Occ. Code § 2402.001.

**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 an unusual-death that occurred during or after an unusual incident.

**Uniform Managed Care Manual (UMCM)** means the manual that contains policies and procedures required of an MCO participating in the Program. The UMCM, as amended or modified, is incorporated by reference into the Contract.

**URAC** means an independent, nonprofit accreditation entity that accredits health plans, case and disease management programs, pharmacy quality management programs as well as provider integration and coordination programs to increase healthcare quality.

**Urgent Behavioral Health Situation** means a behavioral health 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 Behavioral Health 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** 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.

**Value-added Services** means additional services for coverage beyond those specified in Attachment B-2. Value-added Services may be actual Healthcare Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve health outcomes among Members. Value-added Services 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 Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

**Waste** means practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services.

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

1. when the Dual Eligible Member has exceeded the Medicare coverage limit; or
2. that are not covered by Medicare.

**Article 3. General Terms**

**Section 3.01 Contract elements.**

(a) Contract documentation.

The Contract between the Parties will consist of the STAR Health Managed Care Contract and all attachments and amendments.

(b) Order of documents.

In the event of any conflict or contradiction between or among the contract documents, the documents will control in the following order of precedence:

1. The final executed STAR Health Managed Care Contract signature document, and all amendments;
2. Attachment A of the STAR Health Managed Care Contract document – “STAR Health Contract Terms,” and all amendments;
3. Attachment B of the STAR Health Managed Care Contract document, RFP “Scope of Work/Performance Measures,” and all attachments and amendments;
4. The HHSC Uniform Managed Care Manual (UMCM), and all attachments and amendments;

**Section 3.02 Term of the Contract.**

The term of the Contract will begin on the Effective Date and will conclude on the Expiration
Date. The Parties may renew the Contract for an additional period or periods, but the Contract Term may not exceed a total of eight operational years. All reserved contract extensions beyond the Expiration Date will be subject to good faith negotiations between the Parties and mutual agreement to the extensions.

Section 3.03 Funding.

This Contract is conditioned on the availability of state and federal appropriated funds. MCO will have no right of action against HHSC in the event that HHSC is unable to perform its obligations under this Contract as a result of the suspension, termination, or withdrawal of funding to HHSC, the failure to fund HHSC, or lack of sufficient funding of HHSC for any activities or functions contained within the scope of this Contract. If funds become unavailable, the provisions of Article 12 (Remedies and Disputes) will apply. HHSC will use all reasonable efforts to ensure that funds are available and will negotiate in good faith with MCO to resolve any MCO claims for payment that represent accepted Services or Deliverables that are pending at the time funds become unavailable. HHSC will use best efforts to provide reasonable written advance notice to MCO upon learning that funding for this Contract may be unavailable.

Section 3.04 Delegation of authority.

Whenever, by any provision of this Contract, any right, power, or duty is imposed or conferred on HHSC, the Executive Commissioner has the imposed or conferred right, power, or duty unless any right, power, or duty is specifically delegated to the duly appointed agents or employees of HHSC. If the Executive Commissioner delegates any authority, a written copy may be provided to MCO on request.

Section 3.05 No waiver of sovereign immunity.

The Parties agree that no provision of this Contract is in any way intended to constitute a waiver by HHSC or the State of Texas of any immunities from suit or from liability that HHSC or the State of Texas may have by operation of law.

Section 3.06 Force majeure.

Neither Party will be liable for any failure or delay in performing its obligations under the Contract if the failure or delay is due to any cause beyond the reasonable control of a Party, including unusually severe weather, strikes, natural disasters, fire, civil disturbance, epidemic, war, court order, or acts of God. The existence of these causes of delay or failure will extend the period of performance in the exercise of reasonable diligence until after the causes of delay or failure have been removed. Each Party must inform the other in writing with proof of receipt within five Business Days of the existence of a force majeure event or otherwise waive this right as a defense.

Section 3.07 Publicity.

(a) MCO may use the name of HHSC, the State of Texas, any HHS Agency, and the name of the HHSC MCO program in any media release, public announcement, or public disclosure relating to the Contract or its subject matter only if, at least seven Days prior to distributing the material, the MCO submits the information to HHSC for review and comment. The MCO may not use the submitted information without prior approval from HHSC. HHSC reserves the right to object to and require changes to the publication if, at HHSC’s sole discretion, it determines that the publication does not accurately reflect the terms of the Contract or the MCO’s performance under the Contract.

(b) MCO will provide HHSC with one electronic copy of any information described in Subsection 3.07(a) prior to public release. MCO will provide additional copies, including hard copies, at HHSC’s request.

(c) The requirements of Subsection 3.07(a) do not apply to:

(1) proposals or reports submitted to HHSC, an administrative agency of the State of Texas, or a governmental agency or unit of another state or the federal government;

(2) information concerning the Contract’s terms, subject matter, and estimated value:

(a) in any report to a governmental body to which the MCO is required by law to report the information, or

(b) that the MCO is otherwise required by law to disclose; and

(3) Member Materials (the MCO must comply with the provisions in UMCM Chapter 4 regarding the review and approval of Member Materials).

Section 3.08 Assignment.

(a) Assignment by MCO.

MCO must not assign all or any portion of its rights under or interests in the Contract without prior written consent of HHSC. Any written request for assignment must be accompanied by written acceptance by the party to whom the assignment is made. Except where otherwise agreed in writing by HHSC, assignment will not release MCO from its obligations under the Contract.

(b) Assignment by HHSC.

MCO understands and agrees HHSC may in one or more transactions assign, pledge, or transfer the Contract. This assignment will only be made to another State agency or a non-State agency that is contracted to perform agency support.

(c) Assumption.
Each party to whom an assignment is made (an “Assignee”) must assume all of the assigned interests in and responsibilities under the Contract and any documents executed with respect to the Contract, including its obligation for all or any portion of the purchase payments, in whole or in part.

Section 3.09 Cooperation with other vendors and prospective vendors.

HHSC may award supplemental contracts for work related to the Contract or any portion of the work. MCO will reasonably cooperate with these other vendors and will not commit or permit any act that may interfere with the performance of work by any other vendor.

Section 3.10 Renegotiation and reprocurement rights.

(a) Renegotiation of Contract terms.

Notwithstanding anything in the Contract to the contrary, HHSC may at any time during the term of the Contract exercise the option to notify MCO that HHSC has elected to renegotiate certain terms of the Contract. Upon MCO’s receipt of any notice mentioned in this Section, MCO and HHSC will undertake good faith negotiations of the subject terms of the Contract, and may execute an amendment to the Contract in accordance with Article 8 (Amendments and Modifications) of this document.

(b) Reprocurement of the services or procurement of additional services.

Notwithstanding anything in the Contract to the contrary, whether or not HHSC has accepted or rejected MCO’s Services or Deliverables provided during any period of the Contract, HHSC may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the Scope of Work covered by the Contract or Scope of Work similar or comparable to the Scope of Work performed by MCO under the Contract.

(c) Termination rights upon reprocurement.

If HHSC elects to procure the Services or Deliverables or any portion of the Services or Deliverables from another vendor in accordance with this Section, HHSC will have the termination rights noted in Article 12 (Remedies and Disputes).

Section 3.11 RFP errors and omissions.

MCO will not take advantage of any errors or omissions in the RFP or the resulting Contract. MCO must promptly notify HHSC of any errors or omissions that are discovered.

Section 3.12 Attorneys’ fees.

In the event of any litigation, appeal, or other legal action to enforce any provision of the Contract, MCO agrees to pay all reasonable expenses of that action, including attorneys’ fees and costs, if HHSC is the prevailing Party.

Section 3.13 Preferences under service contracts.

MCO is required in performing the Contract to purchase products and materials produced in the State of Texas when they are available at a price and time comparable to products and materials produced outside the State.

Section 3.14 Ensuring timely performance.

The Parties acknowledge the need to ensure uninterrupted and continuous performance of the Scope of Work under the Contract, therefore, HHSC may terminate this Contract or apply any other remedy as noted in Article 12 (Remedies and Disputes) if MCO performance is not timely.

Section 3.15 Notice

(a) Any notice or other legal communication required or given by either Party under the Contract will be in writing and in English, and will be deemed to have been given:

   (1) Three Business Days after the date of mailing if sent by registered or certified U.S. mail, postage prepaid, with return receipt requested;

   (2) When transmitted if sent by facsimile, provided a confirmation of transmission is produced by the sending machine; or

   (3) When delivered if delivered personally or sent by express courier service.

(b) The notices described in this Section may not be sent by electronic mail.

(c) All notices must be sent to the Project Manager identified in this Contract. In addition, legal notices must be sent to the Legal Contact identified in this Contract.

(d) Administrative and routine communications will be provided in a manner agreed to by the Parties.

Article 4. Contract Administration and Management

Section 4.01 Qualifications, retention, and replacement of MCO employees.

MCO agrees to maintain the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under this Contract. The personnel MCO assigns to perform the duties and responsibilities under this Contract will be properly trained and qualified for the functions they will perform. Notwithstanding transfer or turnover of personnel, MCO remains obligated to perform all duties and responsibilities under this Contract without degradation and in accordance with the terms of this Contract.

Section 4.02 MCO’s Key Personnel.

(a) Designation of Key Personnel.

MCO must designate key management and technical personnel who will be assigned to the
Contract. For the purposes of this requirement, Key Personnel are those with management responsibility or principal technical responsibility for the following functional areas included within the scope of the Contract:

1. Member Services;
2. Management Information Systems;
3. Health Passport Management;
4. Claims Processing;
5. Provider Network Development and Management;
6. Benefit Administration and Prior Authorization;
7. Service Management;
8. Service Coordination;
9. Quality Improvement;
10. Behavioral Health Services;
11. Dental Services;
12. Financial Functions;
13. Reporting;
14. Security Official as required in 45 C.F.R. § 164.308(a)(2) and Privacy Official as required in 45 C.F.R. § 164.530(a)(2);
15. Executive Director as defined in Section 4.03 (Executive Director);
16. Medical Director as defined in Section 4.04 (Medical Director); and
17. STAR Health Liaison Director as defined in Section 4.05 (STAR Health Liaisons).

(b) Support and Replacement of Key Personnel.

The MCO must maintain, throughout the Contract Term, the ability to supply its Key Personnel with the required resources necessary to meet Contract requirements and comply with applicable law. The MCO must ensure project continuity by timely replacement of Key Personnel, if necessary, with a sufficient number of persons having the requisite skills, experience, and other qualifications. Regardless of specific personnel changes, the MCO must maintain the overall level of expertise, experience, and skill reflected in the Key MCO Personnel job descriptions and qualifications included in the MCO’s proposal.

(c) Notification of replacement of Key Personnel.

MCO must notify HHSC in writing within 15 Business Days of any change in Key Personnel. Hiring or replacement of Key Personnel must conform to all Contract requirements. If HHSC determines that a satisfactory working relationship cannot be established between certain Key Personnel and HHSC, it will notify the MCO in writing. Upon receipt of HHSC’s notice, HHSC and MCO will attempt to resolve HHSC’s concerns on a mutually agreeable basis.

d) Dedicated Staff

The MCO agrees to maintain staff dedicated exclusively to serving the STAR Health Program in the following areas:

1. Regional staff:
   A) Behavioral Health and physical health Service Managers and Service Coordinators;
   B) STAR Health Liaisons;
   C) CONNECTIONS staff; and
   D) Member Advocates;
2. Member and Nurse Hotline staff;
3. Behavioral Health Hotline staff;
4. Complaints and Appeals staff;
5. Health Passport staff; and
6. Regional Internal Trainers.

e) Training for dedicated staff

Staff identified in Section 4.02(d) (MCOs Key Personnel) must receive foster care-specific training during employee orientation, and as needed thereafter. Training curriculum must include the following components, at a minimum:

1. differences and similarities between managing the care for a child in foster care and managing the care for the other Medicaid populations;
2. vital timelines in the evaluation and delivery of services to Members;
3. the roles and responsibilities of MCO staff in interfacing with DFPS Staff, SSCC staff, ICC Vendor Staff, and the court system;
4. the legacy foster care medical and behavioral health management system and how it changed with the STAR Health Program;
5. roles and responsibilities of the ICC Vendor generally and the specific ICC Vendors awarded a contract;
6. Foster Care Redesign and the roles and responsibilities of the SSCC generally and each specific SSCC with an awarded contract within the different designated areas; and
7. symptoms and treatment of childhood medical and behavioral health conditions commonly seen in the foster care population, such as the effect of abuse and neglect on the developing brain, fetal alcohol syndrome, and shaken baby syndrome.

Section 4.03 Executive Director.

(a) The MCO must employ a qualified individual to serve as the Executive Director for the STAR Health Program. The Executive Director must be employed full-time by the MCO, be primarily dedicated to STAR Health Program, and must hold a
Senior Executive or Management position in the MCO’s organization, except that the MCO may propose an alternate structure for the Executive Director position, subject to HHSC’s prior review and written approval.

(b) The Executive Director must be authorized and empowered to represent the MCO regarding all matters pertaining to the Contract prior to such representation. The Executive Director must act as liaison between the MCO and the HHSC and must have responsibilities that include the following:

(1) ensuring the MCO’s compliance with the terms of the Contract, including securing and coordinating resources necessary for compliance;

(2) receiving and responding to all inquiries and requests made by HHSC related to the Contract, in the time frames and formats specified by HHSC. Where practicable, HHSC will consult with the MCO to establish time frames and formats reasonably acceptable to the Parties;

(3) attending and participating in regular HHSC and MCO Executive Director meetings or conference calls;

(4) attending and participating in regular HHSC Regional Advisory Committees (RACs) for managed care; the Executive Director may designate key personnel to attend a RAC if the Executive Director is unable to attend;

(5) making best efforts to promptly resolve any issues identified either by the MCO or HHSC that may arise and are related to the Contract;

(6) meeting with HHSC representatives on a periodic or as needed basis to review the MCO’s performance and resolve issues, and

(7) meeting with HHSC at the time and place requested by HHSC, if HHSC determines that the MCO is not in compliance with the requirements of the Contract.

Section 4.04 Medical Director.

(a) The MCO must have a qualified individual to serve as the Medical Director for its HHSC MCO Program(s). The Medical Director must be currently licensed in Texas by the Texas Medical Board as an M.D. or D.O. with no restrictions or other license limitations. The Medical Director must comply with the requirements of 28 Tex. Admin. Code § 11.1606 and all applicable federal and state statutes and regulations.

(b) The Medical Director, or his or her designee, must be available by telephone 24 hours a Day, seven Days a week, for Utilization Review decisions. The Medical Director, and his or her designee, must either possess expertise with Behavioral Health Services, or have ready access to that expertise to ensure timely and appropriate medical decisions for Members, including after regular business hours.

(c) The Medical Director, or his or her designee, must be authorized and empowered to represent the MCO regarding clinical issues, Utilization Review, and quality of care inquiries. The Medical Director, or his or her physician designee, must exercise independent medical judgment in all decisions relating to medical necessity. The MCO must ensure that its decisions relating to medical necessity are not adversely influenced by fiscal management decisions. HHSC may conduct reviews of decisions relating to medical necessity upon reasonable notice.

(d) For purposes of this section, the Medical Director’s designee must be a physician that meets the qualifications for a Medical Director, as described in Section 4.04 (a) through (c).

(e) The requirements of this Section do not apply to Prior Authorization determinations for outpatient pharmacy services made by a Texas licensed pharmacist. These determinations must comply with Attachment B-1, Section 8.1.8.

Section 4.05 This Section is Intentionally Left Blank

Section 4.06 Responsibility for MCO personnel and Subcontractors.

(a) MCO’s employees and Subcontractors are not employees of HHSC or the State of Texas, but are considered the MCO’s employees or its Subcontractor’s employees, as applicable, for all purposes under the Contract.

(b) Except as provided in this Contract, neither MCO nor any of MCO’s employees or Subcontractors may act as agents or representatives of HHSC or the State of Texas.

(c) MCO agrees that anyone employed by MCO to fulfill the terms of the Contract is an employee of MCO and remains under MCO’s sole direction and control. MCO assumes sole and full responsibility for its acts and the acts of its employees and Subcontractors.

(d) MCO agrees that any claim on behalf of any person arising out of employment or alleged employment by the MCO, including claims of discrimination against MCO, its officers, or its agents is the sole responsibility of MCO and not the responsibility of HHSC. MCO will indemnify the State and hold it harmless from any and all claims asserted against the State arising out of employment or alleged employment by the MCO. MCO understands that any person who alleges a claim arising out of employment or alleged employment by MCO will not be entitled to any compensation, rights, or benefits from HHSC, including tenure rights, medical and hospital care, sick and annual or vacation leave, severance pay, or retirement benefits.
(e) MCO agrees to be responsible for the following in respect to its employees:

(1) Damages incurred by MCO’s employees within the scope of their duties under the Contract; and

(2) Determination of the hours to be worked and the duties to be performed by MCO’s employees.

(f) MCO agrees and will inform its employees and Subcontractor(s) that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to them by MCO under this Contract or any judgment rendered against the MCO. HHSC’s liability to the MCO’s employees, agents, and Subcontractors, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code § 101.001 et seq.).

(g) MCO understands that HHSC does not assume liability for the actions of, or judgments rendered against, the MCO, its employees, agents, or Subcontractors. MCO agrees that it has no right to indemnification or contribution from HHSC for any of these judgments rendered against MCO or its Subcontractors.

Section 4.07 Cooperation with HHSC and state administrative agencies.

(a) Cooperation with Other MCOs.

MCO agrees to reasonably cooperate with and work with the other MCOs in the HHSC MCO Programs, Subcontractors, and third-party representatives as requested by HHSC. To the extent permitted by HHSC’s financial and personnel resources, HHSC agrees to reasonably cooperate with MCO and to use its best efforts to ensure that other HHSC contractors reasonably cooperate with the MCO.

(b) Cooperation with state and federal administrative agencies.

MCO must ensure that MCO personnel will cooperate with HHSC or other state or federal administrative agency personnel at no charge to HHSC for purposes relating to the administration of HHSC Programs including the following purposes:

(1) The investigation and prosecution of Fraud, Waste, and Abuse in the HHSC Programs;

(2) Audit, inspection, or other investigative purposes; and

(3) Testimony in judicial or quasi-judicial proceedings relating to the Services or Deliverables under this Contract or other delivery of information to HHSC or other agencies’ investigators or legal staff.

Section 4.08 Conduct of MCO personnel.

(a) While performing the Scope of Work, MCO’s personnel and Subcontractors must:

(1) Comply with applicable state and federal rules and regulations and HHSC’s requests regarding personal and professional conduct; and

(2) Otherwise conduct themselves in a businesslike and professional manner.

(b) If HHSC determines in good faith that a particular employee or Subcontractor is not conducting himself or herself in accordance with this Contract, HHSC may provide MCO with notice and documentation concerning this conduct. If MCO receives this notice, MCO must promptly investigate the matter and take appropriate action that may include:

(1) Removing the employee from the project;

(2) Providing HHSC with written notice of the removal; and

(3) Replacing the employee with a similarly qualified individual acceptable to HHSC.

(c) Nothing in the Contract will prevent MCO, at the request of HHSC, from replacing any personnel who are not adequately performing their assigned responsibilities or who, in the reasonable opinion of HHSC’s Project Manager, after consultation with MCO, are unable to work effectively with HHSC’s or DFPS’s staff. In this event, MCO will provide replacement personnel with equal or greater skills and qualifications as soon as reasonably practicable. Replacement of Key Personnel will be subject to HHSC review. The Parties will work together in any replacement so the overall project schedule is not disrupted.

(d) MCO agrees that anyone employed by MCO to fulfill the terms of the Contract remains under MCO’s sole direction and control.

(e) MCO must have policies regarding disciplinary action for all employees who have failed to comply with federal or state laws and the MCO’s standards of conduct, policies and procedures, and Contract requirements. MCO must have policies regarding disciplinary action for all employees who have engaged in illegal or unethical conduct.

Section 4.09 Subcontractors and Agreements with Third Parties.

(a) MCO remains fully responsible for the obligations, services, and functions performed by its Subcontractors to the same extent as if these obligations, services, and functions were performed by MCO’s employees, and for purposes of this Contract, any work is deemed work performed by MCO. The MCO must ensure its contracts with Subcontractors comply with all of the requirements of 42 C.F.R. § 438.230. HHSC reserves the right to
require the replacement of any Subcontractor that HHSC finds unacceptable and unable to meet the requirements of the Contract. HHSC may also object to the selection of any Subcontractor.

(b) MCO must:

(1) actively monitor the quality of care and services, as well as the quality of reporting data, provided under a Subcontract;

(2) provide HHSC with a copy of TDI filings of delegation agreements;

(3) unless otherwise provided in this Contract, provide HHSC with written notice no later than:

   (i) three Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Subcontract;

   (ii) 180 Days prior to the termination date of a Material Subcontract for MIS systems operation or reporting;

   (iii) 90 Days prior to the termination date of a Material Subcontract for non-MIS Administrative Services; and

   (iv) 30 Days prior to the termination date of any other Material Subcontract.

HHSC may grant a written exception to these notice requirements if, in HHSC’s reasonable determination, MCO has shown good cause for a shorter notice period.

(4) the MCO must demonstrate that a Material Subcontractor assuming delegated functions satisfies all requirements of a pre-delegation audit before the applicable functions can be delegated. The MCO must conduct the audit, which must include: a standard audit tool approved by HHSC, site visit, file review, if applicable, staff interviews, and scoring to ensure compliance is achieved.

(c) During the Contract Period, Readiness Reviews by HHSC or its designated agent may occur if:

   (1) a new Material Subcontractor is employed by MCO;

   (2) an existing Material Subcontractor provides services in a new Service Area;

   (3) an existing Material Subcontractor provides services for a new MCO Program;

   (4) an existing Material Subcontractor changes locations or changes its MIS and or operational functions;

   (5) an existing Material Subcontractor changes one or more of its MIS subsystems, claims processing, or operational functions; or

   (6) a Readiness Review is requested by HHSC.

The MCO must submit information required by HHSC for each proposed Material Subcontractor as indicated in Attachment B-1 Section 7.3.7, “Transition Phase Schedule and Tasks.” Refer to Attachment B-1 Section 8.1.1.1, “Additional Readiness Reviews and Monitoring Efforts,” and Attachment B-1 Section 8.1.24, “Management Information System (MIS) Requirements,” for additional information regarding MCO Readiness Reviews during the Contract Period.

(d) MCO must not disclose Confidential Information of HHSC, the State of Texas, or the federal government to a Subcontractor unless that Subcontractor has agreed in writing to protect the confidentiality of the Confidential Information in the manner required of MCO under this Contract.

(e) MCO must identify any Subcontractor that is a subsidiary or entity formed after the Effective Date of the Contract, whether or not an Affiliate of MCO, substantiate the proposed Subcontractor’s ability to perform the subcontracted Services and certify to HHSC that no loss of service will occur as a result of the performance of such Subcontractor. The MCO will assume responsibility for all contractual responsibilities whether or not the MCO performs them. Further, HHSC considers the MCO to be the sole point of contact with regard to contractual matters, including payment.

(f) Except as provided in this section, all Subcontracts must be in writing and must provide HHSC the right to examine the Subcontract and all Subcontractor records relating to the Contract and the Subcontract. This requirement does not apply to agreements with non-Affiliate utility or mail service providers.

If the MCO intends to report compensation or any other payments paid to any third party (including an Affiliate) as an Allowable Expense under this Contract and the amounts paid to the third party exceed $200,000, or are reasonably anticipated to exceed $200,000, in a State Fiscal Year (or in any contiguous twelve-month period), then the MCO’s agreement with the third party must be in writing. The agreement must provide HHSC the right to examine the agreement and all records relating to the agreement.

For any third-party agreements not in writing valued under $200,000 per State Fiscal Year that are reported as Allowable Expenses, the MCO still must maintain standard financial records and data sufficient to verify the accuracy of those expenses in accordance with the requirements of Article 9, "Audit
Section 4.10 HHSC’s ability to contract with Subcontractors.

The MCO may not limit or restrict, through a covenant not to compete, employment contract or other contractual arrangement, HHSC’s ability to contract with Subcontractors or former employees of the MCO.

Section 4.11 Prohibition Against Performance Outside the United States.

(a) Findings.

(1) HHSC finds the following:

(A) HHSC is responsible for administering several public programs that require the collection and maintenance of information relating to persons who apply for and receive services from HHSC programs. This information consists of, among other things, personal financial and medical information and information designated “Confidential Information” under state and federal law and this Agreement. Some of this information may, within the limits of the law and this Agreement, be shared from time to time with MCO or a Subcontractor for purposes of performing the Services or providing the Deliverables under this Agreement.

(B) HHSC is legally responsible for maintaining the confidentiality and integrity of information relating to applicants and recipients of HHSC services and ensuring that any person or entity that receives this information—including MCO and any Subcontractor—is similarly bound by these obligations.

(C) HHSC also is responsible for the development and implementation of computer software and hardware to support HHSC Programs. These items are paid for, in whole or in part, with state and federal funds. The federal agencies that fund these items maintain a limited interest in the developed or acquired software and hardware.

(D) Some of the software used or developed by HHSC may also be subject to statutory restrictions on the export of technology to foreign nations, including the Export Administration Regulations, 15 C.F.R. Parts 730-774.

(2) In view of these obligations, and to ensure accountability, integrity, and the security of the information maintained by or for HHSC and the work performed on behalf of HHSC, HHSC and Financial Compliance.” Any agreements that are, or could be interpreted to be, with a single party, must be in writing if the combined total is more than $200,000. This would include payments to individuals or entities that are related to each other.

(g) A Subcontract or any other agreement in which the MCO receives rebates, recoupments, discounts, payments, incentives, fees, free goods, bundling arrangements, retrocession payments (as described in UMCM Chapter 6) or any other consideration from a Subcontractor or any other third party (including without limitation Affiliates) as related to this Contract must be in writing and the MCO must allow HHSC and the Office of the Attorney General to examine the Subcontract or agreement and all related records.

(h) All Subcontracts or agreements described in subsections (f) and (g) must show the dollar amount or the value of any consideration that MCO pays to or receives from the Subcontractor or any other third party.

(i) The MCO must submit a copy of each Material Subcontract and any agreement covered under subsection (g) executed prior to the Effective Date of the Contract to HHSC no later than 30 Days after the Effective Date of the Contract. For Material Subcontracts or Section 4.08(g) agreements executed or amended after the Effective Date of the Contract, the MCO must submit a copy to HHSC no later than 5 Business Days after execution.

(j) Provider Contracts must include the requirement that subcontractors comply with the same requirements that the MCO must comply with in Article 7 “Governing Law and Regulations,” Sections 7.02(a) and (b) of this document, including the UMCM Chapter 8.

(k) HHSC reserves the right to reject any Subcontract or require changes to any provisions that do not comply with the requirements or duties and responsibilities of this Contract or create significant barriers for HHSC in monitoring compliance with this Contract.

(l) MCO must comply with the requirements of Section 6505 of PPACA, entitled “Prohibition on Payments to Institutions or Entities Located Outside of the United States.”

(m) Provider payment must comply with the requirements of Section 2702 of PPACA, entitled “Payment Adjustment for Health Acquired Conditions.”

(n) The MCO and its Subcontractors must provide all information required under Section 4.09 to HHSC, or to the Office of the Attorney General, if requested, at no cost.
determines that it is necessary and appropriate to require that:

(A) All work performed under this Agreement must be performed exclusively within the United States; and

(B) All information obtained by MCO or a Subcontractor under this Agreement must be stored and maintained within the United States.

(3) Further, HHSC forbids the performance of any work or the maintenance of any information relating or obtained under this Agreement to occur outside of the United States.

(b) Meaning of “within the United States” and “outside the United States.”

(1) As used in this Section 4.11, the term “within the United States” means any location inside the territorial boundaries comprising the United States of America, including any of the 48 contiguous states, the states of Alaska and Hawaii, and the District of Columbia.

(2) Conversely, the phrase “outside the United States” means any location that is not within the territorial boundaries comprising the United States of America, including any of the 48 contiguous states, the states of Alaska and Hawaii, and the District of Columbia.

(c) Maintenance of Confidential Information.

(1) MCO and all Subcontractors, vendors, agents, and service providers of or for MCO must not allow any Confidential Information that MCO receives from or on behalf of HHSC to be moved outside the United States by any means (physical or electronic) at any time, for any period of time, for any reason.

(2) MCO and all Subcontractors, vendors, agents, and service providers of or for MCO must not permit any person to perform work under this Agreement from a location outside the United States.

(e) Exceptions.

(1) COTS Software. The foregoing requirements will not preclude the acquisition or use of commercial off-the-shelf software that is developed outside the United States or hardware that is generically configured outside the United States.

(2) Foreign-made Products and Supplies. The foregoing requirements will not preclude MCO from acquiring, using, or reimbursing products or supplies that are manufactured outside the United States, provided such products or supplies are commercially available within the United States for acquisition or reimbursement by HHSC.

(f) Disclosure.

MCO must disclose all Services and Deliverables under or related to this Agreement that MCO intends to perform or has performed outside the United States, whether directly or via Subcontractors, vendors, agents, or service providers.

(g) Remedy.

(1) MCO’s violation of this Section 4.11 will constitute a material breach in accordance with Article 12. MCO will be liable to HHSC for all monetary damages, in the form of actual, consequential, direct, indirect, special, or liquidated damages in accordance with this Agreement.

(2) HHSC may also terminate this Agreement if the MCO violates Section 4.11 constituting a material breach. HHSC will give the MCO notice of at least one calendar Day before the effective date of the termination.

Section 4.12 Employment Verification

(a) MCOs must confirm the eligibility of all persons employed by the MCO to perform duties
within Texas and all persons, including subcontractors, assigned by the MCO to perform work pursuant to the Contract.

(b) The MCO may not knowingly have a relationship with the following:

(1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in (b) (1) of this section.

A relationship as described in this section is as follows:

(1) A director, officer, or partner of the MCO.

(2) A subcontractor of the MCO as governed by 42 C.F.R. § 438.230.

(3) A person with ownership of five percent or more of the MCO.

(4) A person with an employment, consulting or other arrangement with the MCO for the provision of items and services that relate to the MCO’s obligations under its contract with the State.

(c) The MCO must confirm the identity and determine the exclusion status of any subcontractor of the MCO, (as governed by 42 C.F.R § 438.230), as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO as defined in subsection (b) of this section upon contract execution and through checks of federal databases that include the:

(1) U.S. Department of Health and Human Services, Office of Inspector General’s List of Excluded Individuals and Entities (LEIE);

(2) System for Awards Management (SAM) [the successor to the Excluded Parties List System (EPLS)];

(3) Social Security Administration’s Death Master File (SSA-DMF); and the

(4) National Plan & Provider Enumeration System.

(d) The MCO must consult the databases upon contracting and no less frequently than monthly thereafter. If the MCO finds a party that is excluded, it must promptly notify the entity and take action consistent with 42 C.F.R. § 438.610(c).

(e) The MCO must maintain records demonstrating compliance with this section in accordance with Section 9.01 below.

Article 5. Member Eligibility, Enrollment, and Disenrollment

Section 5.01 Eligibility Determination and Disenrollment

The State 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. If an MCO becomes aware that a Member has moved outside of the MCOs service area or that a Member is no longer Medicaid-eligible, for example the Member has moved outside of the state or is deceased, the MCO must inform HHSC within 10 Business Days.

Section 5.02 Member Enrollment and Disenrollment

(a) For Members who are in DFPS conservatorship or have signed voluntary agreements (categories 1 and 2 of the definition of “Target Population”), DFPS will enroll and disenroll eligible individuals in the Program. The MCO is not allowed to induce or accept disenrollment from a Member. The MCO must refer Members or potential Members to DFPS.

(b) DFPS will electronically transmit to the MCO new Member information and change information applicable to active Members on a daily basis via the Daily Notification File. The Daily Notification File will be uploaded by the MCO seven Days a week, inclusive of holidays. DFPS will send the MCO information concerning these new Members on a daily basis, including the Member’s name, social security number if known, and name and address of the Member’s Caregiver or Medical Consenter. For these Members, the HHSC Administrative Services Contractor will electronically transmit the official Medicaid Member identification numbers on the Medicaid eligibility files.

(c) 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 its Member base, and therefore, cannot sell or transfer this base to another entity.

(d) For Members who are not in DFPS conservatorship or do not have signed voluntary agreements (category 3 of the definition of “Target Population,”) HHSC’s Administrative Services Contractor will electronically transmit new Member information and change information applicable to active Members on standard Medicaid eligibility files.
or capitation or capitation adjustment files. These files are collectively called the “eligibility files,” and are generated on daily or monthly intervals. The Medicaid eligibility files will contain the Member’s official Medicaid identification number.

(e) Members will be enrolled in the MCO on the Effective Date of Coverage. Individuals already eligible for Texas Medicaid managed care or Fee-for-Service Programs 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.

(f) The HHSC Administrative Services Contractor will notify Members in the Target Population categories 2 and 3 of their right to disenroll from the MCO and receive services through the STAR Program.

(g) A Member’s disenrollment from the MCO will be effective on the Date of Disenrollment, except as provided in Section 5.03(c).

(h) The MCO must assign each Member a PCP within one Day of receiving notification of the Member's enrollment via the Daily Eligibility File. DFPS, the Member’s Medical Consenter, or the Member can change the PCP designation at any time.

(i) 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.

Section 5.02.1 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, the HHSC Administrative Service Contractor will enroll the newborn into the MCO’s STAR Health product. All rules related to STAR Health newborn enrollment will apply to the newborn.

Section 5.02.2 Enrollment and disenrollment for children transitioning to Adoption Assistance or Permanency Care Assistance

Members in AA or PCA who are receiving Supplemental Security Income (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.

Section 5.03 Span of Coverage

(a) General

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.

(b) Inpatient Hospital.

(1) The following table describes 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):

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Hospital Facility Charge</th>
<th>All Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Member moves from FFS to STAR Health</td>
<td>FFS</td>
<td>STAR Health MCO</td>
</tr>
<tr>
<td>2. Member moves from STAR, STAR Kids, or STAR+PLUS to STAR Health</td>
<td>Former STAR, STAR Kids, or STAR+PLUS MCO</td>
<td>New STAR Health MCO</td>
</tr>
<tr>
<td>3. Member moves from STAR Health to FFS</td>
<td>Former STAR Health MCO</td>
<td>FFS</td>
</tr>
<tr>
<td>4. Member moves from STAR Health to STAR, STAR Kids, or STAR+PLUS</td>
<td>Former STAR Health MCO</td>
<td>New STAR, STAR Kids, or STAR+PLUS MCO</td>
</tr>
</tbody>
</table>

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 extended stay Days, as described in the Texas Medicaid Provider Procedures Manual.

(2) The following table describes payment responsibility for Medicaid enrollment changes that occur during a stay in a residential substance use disorder treatment facility or residential detoxification for substance use...
disorder treatment facility (collectively, CDTF), beginning on the Member’s Effective Date of Coverage with the receiving MCO (New MCO).

<table>
<thead>
<tr>
<th>Scenario</th>
<th>CDTF Charge</th>
<th>All Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Member moves from FFS to STAR Health</td>
<td>FFS</td>
</tr>
<tr>
<td>2</td>
<td>Member moves from STAR, STAR Kids, or STAR+PLUS to STAR Health</td>
<td>Former STAR, STAR Kids, or STAR+PLUS MCO</td>
</tr>
<tr>
<td>3</td>
<td>Member moves from STAR Health to FFS</td>
<td>Former STAR Health MCO</td>
</tr>
<tr>
<td>4</td>
<td>Member moves from STAR Health to STAR, STAR Kids, or STAR+PLUS</td>
<td>Former STAR Health MCO</td>
</tr>
</tbody>
</table>

(3) If the Member is receiving services through a commercial insurer, or the Texas Children’s Health Insurance Program (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.

(c) nursing facilities.

Medicaid recipients in a nursing facility are not included in the Model. Members who enter a nursing facility will be disenrolled on the date of entry into a nursing facility.

(d) Custom DME and Augmentive Devices

(1) If the Member has an existing prior authorization in place for custom DME from Texas Medicaid Fee-For Service, Texas Children’s Health Insurance Program (CHIP) MCO or exclusive provider organization, 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, STAR Kids, or STAR+PLUS MCO is responsible for payment.

(3) If the Member has an existing prior authorization in place for custom DME from the STAR Health MCO, and prior to the delivery of the product, and is disenrolled from the STAR Health MCO and enrolled in FFS or in a STAR, STAR Kids, or STAR+PLUS MCO, the STAR Health MCO is responsible for payment.

(e) 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. All such external vendors must contract with the State and obtain eligibility information from the State.

(f) Effective Date of SSI Status:

When an adult STAR Health Member becomes qualified for SSI, the Member will move to STAR+PLUS or the Dual Demonstration. SSI status is effective on the date the State’s eligibility system identifies a STAR Health Program Member as an SSI client. HHSC is responsible for updating the State’s eligibility system within 45 Days of official notice of the Member’s Federal SSI status by the Social Security Administration (SSA). Once HHSC has updated the State’s eligibility system to identify the Member as an SSI client, following standard eligibility cut-off rules, HHSC will enroll the Member in STAR + PLUS or the Dual Demonstration.

HHSC will not retroactively disenroll a Member from the STAR Health Program.

Article 6. Service Levels and Performance Measurement

Section 6.01 Performance Measurement

Satisfactory performance of this Contract will be measured by:

(a) Adherence to this Contract, including all representations and warranties;
(b) Delivery of the Services and Deliverables described in the RFP;
(c) Results of audits performed by HHSC or its representatives in accordance with Article 9 (Audit and Financial Compliance);
(d) Timeliness, completeness, and accuracy of required reports; and
(e) Achievement of performance measures developed by MCO and HHSC and as modified from time to time by written agreement during the term of this Contract.
Section 6.02 Service Management and Coordination Staffing.

(a) During the first 12-month period following the Operational Start Date, HHSC and the MCO will meet at least quarterly to review the adequacy of the MCO’s staffing of the Service Management and Service Coordination functions. After the first 12 months, the Parties will negotiate the frequency of these staffing reviews; however, the reviews must occur at least annually.

(b) As a result of the staffing reviews described in Section 6.02(a), the Parties may mutually agree to increase, decrease, reallocate, or reassign MCO staff. In addition, should a review reveal that the MCO’s performance is not satisfactory, as measured by Section 6.01, HHSC may require the MCO to make reasonable adjustments in staffing, including increasing, reallocating, or reassigning MCO staff.

Article 7. Governing Law and Regulations

Section 7.01 Governing law and venue.

This Contract is governed by the laws of the State of Texas and interpreted in accordance with those laws. Provided MCO first complies with the procedures set forth in Section 12.13 (Dispute Resolution), proper venue for claims arising from this Contract will be in the State District Court of Travis County, Texas.

Section 7.02 MCO responsibility for compliance with laws and regulations.

(a) MCO must comply, to the satisfaction of HHSC, with all Contract provisions, all provisions of state and federal laws, rules, regulations, policies, guidelines, as well as federal waivers, state policy guidance memos, and any court-ordered consent decrees, settlement agreements, or other court orders that govern the performance of the Scope of Work including all of the following:

1. Title XIX of the Social Security Act;
2. Tex. Gov’t Code Chapters 531 and 533;
3. 42 C.F.R. Parts 417, 438, and 457, as applicable;
4. 45 C.F.R. Parts 74 and 92;
5. 48 C.F.R. Part 31, and 2 C.F.R. Part 200;
6. 1 Tex. Admin. Code Chapters 361, 370, 371, 391, and 392;
8. Texas Human Resources Code Chapters 32 and 36;
9. Texas Penal Code Chapter 35A (Medicaid Fraud);
10. 1 Tex. Admin. Code Chapter 353;
11. 1 Tex. Admin. Code Chapter 354, Subchapters B, J, and F, with the exception of the following provisions in Subchapter F: 1 Tex. Admin. Code § 354.1865, § 354.1867, § 354.1873, and Division 6, “Pharmacy Claims; and § 354.3047;
12. 1 Tex. Admin. Code Chapter 354, Subchapters I and K, as applicable;
13. The Patient Protection and Affordable Care Act (“PPACA”; Public Law 111-148);
15. Clinical Laboratory Improvement Amendments (CLIA, 42 C.F.R. Part 493) (for purposes of the Contract, the MCO must require its Providers to agree that the MCO and HHSC are “authorized persons”);
16. The Immigration and Nationality Act (8 U.S.C. §§ 1101 et seq.) and all subsequent immigration laws and amendments;
17. all administrative rules governing the Program that are adopted in the Texas Administrative Code; and
18. MCO must comply with laws regarding the use of Electronic Visit Verification, including Section 12006 of the 21st Century Cures Act (Public Law 114-255) and 1 Tex. Admin. Code § 354.1177(d).

(b) The Parties acknowledge that the federal or state laws, rules, regulations, policies, or guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that affect the performance of the Scope of Work may change from time to time or be added, judicially interpreted, or amended by competent authority. MCO acknowledges that the MCO Programs will be subject to continuous change during the term of the Contract and, except as provided in Section 8.02 (Changes in law or contract), MCO has provided for or will provide for adequate resources, at no additional charge to HHSC, to reasonably accommodate these changes. The Parties further acknowledge that MCO was selected, in part, because of its expertise, experience, and knowledge concerning applicable federal or state laws, regulations, policies, or guidelines that affect the performance of the Scope of Work. In keeping with HHSC’s reliance on this knowledge and expertise, MCO is responsible for identifying the impact of changes in applicable federal or state legislative enactments and regulations that affect the
performance of the Scope of Work or the state’s use of the Services and Deliverables. MCO must timely notify HHSC of these changes and must work with HHSC to identify the impact of these changes on how the state uses the Services and Deliverables.

(c) HHSC will notify MCO of any changes in applicable law, regulation, policy, or guidelines that HHSC becomes aware of in the ordinary course of its business.

(d) The MCO is responsible for compliance with changes in federal and state law that occur during the course of the contract term. If there are any conflicts between rules promulgated by CMS, including the C.F.R., and this Contract, then the federal rule takes precedence over the Contract and the MCO must comply with the C.F.R unless CMS has waived applicability of the C.F.R. provision to Texas Medicaid via a waiver.

(e) MCO is responsible for any fines, penalties, or disallowances imposed on the state or MCO arising from any noncompliance with the laws and regulations relating to the delivery of the Services or Deliverables by the MCO, its Subcontractors, or agents.

(f) MCO is responsible for ensuring each of its employees, agents, or Subcontractors who provide Services under the Contract is properly licensed, certified, or has proper permits to perform any activity related to the Services or Deliverables.

(g) MCO warrants that the Services and Deliverables will comply with all applicable federal, state, and county laws, regulations, codes, ordinances, guidelines, and policies. MCO will indemnify HHSC from and against any losses, liability, claims, damages, penalties, costs, fees, or expenses arising from or in connection with MCO’s failure to comply with or violation of any law, regulation, code, ordinance, or policy.

Section 7.03 This Section Intentionally Left Blank

Section 7.04 Compliance with state and federal anti-discrimination laws.

(a) MCO agrees to comply with state and federal anti-discrimination laws, including without limitation:

(1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000d et seq.);
(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794);
(3) Americans with Disabilities Act of 1990 (42 U.S.C. §§ 12101 et seq.);
(4) Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107);
(5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688 regarding education programs and activities);
(6) Food and Nutrition Act of 2008 (7 U.S.C. §§ 2011 et seq.); and
(7) HHSC’s administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

MCO agrees to comply with all amendments to the above-referenced laws and all requirements imposed by any corresponding regulations. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to discrimination.

(b) MCO agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15, prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its Programs, benefits, or activities on the basis of national origin. Applicable state and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. MCO agrees to ensure that its policies do not have the effect of excluding or limiting the participation of persons in its Programs, benefits, and activities on the basis of national origin. MCO also agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to Programs, benefits, and activities.

(c) MCO agrees to comply with Section 1557 of the Patient Protection and Affordable Care Act;

(d) MCO agrees to comply with Executive Order 13279 and it's implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16. These provide in part that any organization that participates in programs funded by direct financial assistance from the United States Department of Agriculture or the United States Department of Health and Human Services will not, in providing services, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

(e) Upon request, MCO will provide HHSC with copies of all of the MCO’S civil rights policies and procedures.
(f) MCO must notify HHSC’s Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must be delivered no more than 10 Days after receipt of a complaint. For this section’s purposes, notice must be directed to:

HHSC Civil Rights Office
701 W. 51st Street, Mail Code W206
Austin, Texas 78751
Phone Toll Free: (888) 388-6332
Phone: (512) 438-4313
TTY Toll Free: (877) 432-7232
Fax: (512) 438-5885.

Section 7.05 Environmental protection laws.
MCO must comply with the applicable provisions of federal environmental protection laws as described in this Section:

(a) Pro-Children Act of 1994.
MCO must comply with the Pro-Children Act of 1994 (20 U.S.C. §§ 6081 et seq.), as applicable, regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products.

(b) National Environmental Policy Act of 1969.
MCO must comply with any applicable provisions relating to the institution of environmental quality control measures contained in the National Environmental Policy Act of 1969 (42 U.S.C. §§ 4321 et seq.) and Executive Order 11514 (“Protection and Enhancement of Environmental Quality”).

(c) Clean Air Act and Water Pollution Control Act regulations.
MCO must comply with any applicable provisions relating to required notification of facilities violating the requirements of Executive Order 11738 (“Providing for Administration of the Clean Air Act and the Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, or Loans”).

(d) State Clean Air Implementation Plan.
MCO must comply with any applicable provisions requiring conformity of federal actions to State (Clean Air) Implementation Plans under § 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§ 740 et seq.).


Section 7.06 HIPAA.
(a) MCO must comply with applicable provisions of HIPAA. This includes the requirement that the MCO’s MIS system comply with applicable certificate of coverage and data specification and reporting requirements promulgated under HIPAA. MCO must comply with HIPAA EDI requirements.

(b) Additionally, MCO must comply with HIPAA notification requirements, including those set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. §§ 17931, et seq. If, in HHSC’s determination, MCO has not provided notice in the manner or format prescribed by HIPAA or the HITECH Act, then HHSC may require the MCO to provide proper notice.

(c) MCO must notify HHSC of all breaches or potential breaches of unsecured protected health information, as that term is defined by the HITECH Act. As noted in Article 2, “Definitions,” Confidential Information includes HIPAA-defined protected health information. Therefore, any breach of that information is also subject to the requirements, including notice requirements, in Article 11, “Disclosure & Confidentiality of Information.”

(d) The MCO must use or disclose protected health information as authorized and in response to another HIPAA-covered entity’s inquiry about a Member for authorized purposes of treatment, payment, healthcare operations, or as required by law under HIPAA.

(e) The MCO must comply with rights of individual access by a Member or a Member’s Legally Authorized Representative to Member’s protected health information. The MCO may permit limited disclosures of protected health information as permissible under HIPAA for a family member, other relative, or close personal friends of the Member or anyone identified in the Member’s protected health information directly relevant to the Member’s involvement with the Member's healthcare or payment related to the Member's healthcare. The MCO should refer to 45 C.F.R. § 164.510(b) and related regulatory guidance for additional information.

Section 7.07 Historically Underutilized Business Participation Requirements.
(a) Definitions.
For purposes of this Section:

(1) “Historically Underutilized Business” or “HUB” means a minority or women-owned business as defined by Texas Government Code, Chapter 2161.

(2) “HSP” means a HUB Subcontracting Plan.

(b) HUB Requirements.

(1) In accordance with Attachment B-1 Section 8.1.23.1, “Financial Reporting Requirements,” the MCO must submit an HSP...
(2) MCO must report to HHSC’s contract manager and HUB Office monthly, in the format required by UMCM Chapter 5.4.4.5, “HUB Progress Assessment Report Instructions,” of the, its use of HUB subcontractors to fulfill the subcontracting opportunities identified in the HSP.

(3) MCO must obtain prior written approval from the HHSC HUB Office before making any changes to the HSP. The proposed changes must comply with HHSC’s good faith effort requirements relating to the development and submission of HSPs.

(i) The MCO must submit a revised HSP to the HHSC HUB Office when it: changes the dollar amount of, terminates, or modifies an existing Subcontract for MCO Administrative Services; or enters into a new Subcontract for MCO Administrative Services. All proposed changes to the HSP must comply with the requirements of this Agreement.

(4) HHSC will determine if the value of Subcontracts to HUBs meet or exceed the HUB subcontracting provisions specified in the MCO’s HSP. If HHSC determines that the MCO’s subcontracting activity does not demonstrate a good faith effort, the MCO may be subject to provisions in the Vendor Performance and Debarment Program (34 Tex. Admin. Code § 20.105), and subject to remedies for Breach.

Section 7.08 Compliance with Fraud, Waste, and Abuse requirements.
MCO, MCO’s personnel, and all Subcontractors must comply with all Fraud, Waste, and Abuse requirements found in HHS Circular C-027. The MCO must comply with Circular C-027 requirements in addition to other fraud, waste, and abuse provisions in the contract and in state and federal law.

Article 8. Amendments and Modifications
Section 8.01 Mutual agreement.
This Contract may be amended at any time by mutual agreement of the Parties. The amendment must be in writing and signed by individuals with authority to bind the Parties.

Section 8.02 Changes in law or contract.
If federal or state laws, rules, regulations, policies, or guidelines are adopted, promulgated, judicially interpreted or changed, or if contracts are entered or changed, and the effect of which alters the ability of either Party to fulfill its obligations under this Contract, the Parties will promptly negotiate in good faith appropriate modifications or alterations to the Contract and any schedule(s) or attachment(s) made a part of this Contract. Any modifications or alterations must be in writing and signed by individuals with authority to bind the parties, must equitably adjust the terms of this Contract, and must be limited to those provisions of this Contract affected by the change.

Section 8.03 Modifications as a remedy.
This Contract may be modified under the terms of Article 12 (Remedies and Disputes).

Section 8.04 Modifications upon renewal or extension of Contract.
(a) If HHSC seeks modifications to the Contract as a condition of any Contract extension, HHSC’s notice to MCO will specify those modifications to the Scope of Work, the Contract pricing terms, or other Contract terms.

(b) MCO must respond to HHSC’s proposed modification within the time frame specified by HHSC, generally within 30 Days of receipt. Upon receipt of MCO’s response to the proposed modifications, HHSC may enter into negotiations with MCO to arrive at mutually agreeable Contract amendments. In the event that HHSC determines that the Parties will be unable to reach agreement on mutually satisfactory contract modifications, then HHSC will provide written notice to MCO of its intent not to extend the Contract beyond the Contract Term then in effect.

Section 8.05 Modification of HHSC Uniform Managed Care Manual.
(a) HHSC will provide MCO with at least 30 Days’ advance written notice before implementing a substantive and material change in the UMCM (a change that materially and substantively alters the MCO’s ability to fulfill its obligations under the Contract). The UMCM, and all subsequent versions of the chapters that make up the UMCM, are incorporated by reference into this Contract. HHSC will provide MCO with a reasonable amount of time to comment on substantive and material changes, generally at least 10 Business Days. HHSC is not required to provide advance written notice of changes that are not material and substantive in nature, such as corrections of clerical errors or policy clarifications (including policy guidance memos).

(b) The Parties agree to work in good faith to resolve disagreements concerning material and substantive changes to the UMCM. If the Parties are unable to resolve issues relating to material and substantive changes, then either Party may terminate the agreement in accordance with Article 12 (Remedies and Disputes).

(c) Changes will be effective on the date specified in HHSC’s written notice, which will not be earlier than the MCO’s response deadline, and the
changes will be incorporated into the **UMCM**. If the MCO has raised an objection to a material and substantive change to the **UMCM** and submitted a notice of termination in accordance with **Section 12.04(d)**, HHSC will not enforce the policy change during the period of time between the receipt of the notice and the date of Contract termination.

**Section 8.06 CMS approval of Contracts.**

The implementation of amendments, modifications, and changes to the Contract is subject to the approval of the Centers for Medicare and Medicaid Services (CMS).

**Section 8.07 Required compliance with amendment and modification procedures.**

No different or additional services, work, or products will be authorized or performed except as authorized by this Article. No waiver of any term, covenant, or condition of this Contract will be valid unless executed in compliance with this Article. MCO will not be entitled to payment for any services, work, or products that are not authorized by a properly executed Contract amendment or modification.

**Article 9. Audit and Financial Compliance and Litigation Hold**

**Section 9.01 Financial record retention and audit.**

The State, CMS, the OIG, the Comptroller, the Attorney General and their designees have the right to audit records or documents, related to this Contract of the MCO or MCOs subcontractor for ten years from the final date of the contract period or from the date of any audit, whichever is later.

MCO agrees to maintain, and require its Subcontractors to maintain, records, books, documents, and information (collectively "records") that are adequate to document that services are provided and payments are made in accordance with **UMCM** Chapter 18 and applicable Federal and State requirements. The records must be retained by MCO and its Subcontractors for a period of ten years after the Contract Expiration Date or until the resolution of all litigation, claims, financial management reviews, or audits pertaining to this Contract, whichever is longer.

The MCO and the MCO’s subcontractor must retain, as applicable, enrollee grievance and appeal records under 42 C.F.R. § 438.16, base data in 42 C.F.R. § 438.5(c), MLR reports under 42 C.F.R. § 438.8(k), and the data, information, and documentation specified under 42 C.F.R. § 438.604, § 438.606, § 438.608, and § 438.610 for a period no less than ten years from the expiration date of this Contract or from the date of the completion of any audit, whichever is later.

Additionally, MCO agrees to, and require its Subcontractors to, retain all records in accordance with any litigation hold that is provided to them by HHSC and actively participate in the discovery process if required to do so, at no additional charge to HHSC. Litigation holds may require the MCO or its Subcontractors to keep the records longer than other records retention schedules. The MCO will be required to retain all records subject to the litigation hold until notified by HHSC when the litigation hold ends and then other approved records retention schedule(s) may resume. If MCO or its Subcontractors fail to retain the pertinent records after receiving a litigation hold from HHSC, the MCO agrees to pay to HHSC all damages, costs, and expenses incurred by HHSC arising from such failure to retain.

**Section 9.02 Access to records, books, and documents.**

(a) Upon reasonable notice, MCO must provide, and cause its Subcontractors to provide, at no cost to the officials and entities identified in this Section prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the scope of this Contract.

(b) MCO and its Subcontractors must provide the access described in this Section upon HHSC’s request. This request may include the following purposes:

(1) examination;
(2) audit;
(3) investigation;
(4) inspection;
(5) contract administration; or
(6) the making of copies, excerpts, or transcripts.

(c) The access required must be provided to the following officials or entities:

(1) The United States Department of Health and Human Services, HHS-OIG, or either’s designee;
(2) The Comptroller General of the United States or its designee;
(3) MCO Program personnel from HHSC or its designee;
(4) The Health and Human Services Commission Office of Inspector General;
(5) The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;
(6) Any independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;
(7) The Office of the State Auditor of Texas or its designee;
(8) A state or federal law enforcement agency;
(9) A special or general investigating committee of the Texas Legislature or its designee; and
(10) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

(d) MCO agrees to provide the access described in this Section wherever MCO maintains any books, records, and supporting documentation. MCO further agrees to provide access in reasonable comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this Section. MCO will require its Subcontractors to provide comparable access and accommodations.

(e) Upon request, the MCO must provide copies of the information described in this Section free of charge to HHSC and the entities described in subsection (c).

(f) In accordance with Texas Government Code § 533.012(e), any information submitted to HHSC or the Texas Attorney General's Office under Texas Government Code § 533.012(a)(1) is confidential and is not subject to disclosure under the Texas Public Information Act.

Section 9.03 General Access to Accounting Records

(a) The MCO must provide authorized representatives of the state and federal governments full access to all financial and accounting records related to performance of the Contract.

(b) The MCO 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 governments full access, during normal business hours, to the accounting records that the state and federal governments reasonably determine are relevant to the Contract. This 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. Except in the case of unannounced inspections or audits, the state or federal government will provide reasonable advance written notice of the inspections or audits, as determined by the state or federal government.

(3) At the MCO’s expense, make copies of any accounting records or supporting documentation relevant to the MCO available to HHSC or its agents within ten Business Days of receiving a written request from HHSC for specified records or information. If the MCO does not produce the documentation as requested, the MCO agrees to reimburse HHSC 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(s) of the accounting records or supporting documentation.

(4) Pay any and all additional costs incurred by the state or federal government 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.

Section 9.04 Audits and Inspections of Services and Deliverables.

(a) Upon reasonable notice from HHSC, MCO will provide, and will cause its Subcontractors to provide, auditors and inspectors that HHSC may designate from time to time, with access to:

(1) service locations, facilities, or installations;

(2) records; and

(3) Software and Equipment.

Reasonable notice may include time-limited or immediate requests for information.

(b) The access described in this Section will be for the purpose of examining, auditing, or investigating:

(1) MCO’s capacity to bear the risk of potential financial losses;

(2) the Services and Deliverables provided;

(3) a determination of the amounts payable under this Contract;

(4) a determination of the allowability of costs reported under this contract;

(5) detection of fraud, waste, or abuse;

(6) an examination of Subcontract terms or transactions;

(7) an assessment of financial results under this Contract; or

(8) will be for other purposes HHSC determines it needs to perform its regulatory function or to enforce the provisions of this Contract.

(c) MCO must provide, as part of the Scope of Work, any assistance that the auditors and inspectors reasonably may require to complete their audits or inspections.
(d) If, as a result of an audit or review of payments made to the MCO, HHSC discovers a payment error or overcharge, HHSC will notify the MCO of that error or overcharge. HHSC will be entitled to recover those funds as an offset to future payments to the MCO, or to collect the funds directly from the MCO. MCO must return funds owed to HHSC within 30 Days after receiving notice of the error or overcharge, or interest will accrue on the amount due. HHSC will calculate interest at 12% per annum, compounded daily. In the event that an audit reveals that errors in reporting by the MCO have resulted in errors in payments to the MCO or errors in the calculation of the Experience Rebate, the MCO will indemnify HHSC for any losses resulting from these errors, including the cost of audit. 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.

Section 9.05 SAO Audit
The MCO understands that acceptance of funds under this Contract acts as acceptance of the authority of the State Auditor's Office (SAO), or any successor agency, to conduct an investigation in connection with those funds. The MCO further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost. The MCO will ensure that this clause concerning the authority to audit funds received indirectly by Subcontractors through MCO and the requirement to cooperate is included in any Subcontract it awards, and in any third-party agreements described in Section 4.09.

Section 9.06 Response/compliance with audit or inspection findings.

(a) MCO must ensure it or any Subcontractor corrects any finding of noncompliance with any law, regulation, audit requirement, cost principles, or generally accepted accounting principle relating to the Services and Deliverables or any other deficiency contained in any audit, review, or inspection conducted under this Article. This action will include the MCO (or any Subcontractor) coming into compliance and the MCO’S delivery to HHSC, for HHSC’S approval, a Corrective Action Plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) within 30 Days of the close of the audit(s), review(s), or inspection(s).

(b) MCO must bear the expense of compliance with any finding of noncompliance under this Article that is:

(1) Required by state or federal law, regulation, rule or other audit requirement relating to MCO's business;

(2) Performed by MCO as part of the Services or Deliverables; or

(3) Necessary due to MCO's noncompliance with any law, regulation, rule, or audit requirement imposed on MCO.

(c) As part of the Scope of Work, MCO must provide to HHSC, upon request, a copy of those portions of MCO’s and its Subcontractors' internal audit reports relating to the Services and Deliverables provided to HHSC under the Contract.

Section 9.07 Notification of Legal and Other Proceedings and Related Events.
The MCO must notify HHSC of all proceedings, actions, and events as specified in the UMCM Chapter 5.

Article 10. Terms of Payment

Section 10.01 Calculation of monthly Capitation Payment.

(a) 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.

(b) 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.

(c) 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.

(d) 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;
(3) an amount for the MCO’s Risk margin; and  
(4) an amount for NEMT Services provided during the month.

HHSC will employ or retain qualified actuaries to perform data analysis and calculate the Capitation Rates for each Rate Period.

(e) 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.

Section 10.02 Time and Manner of Payment.

(a) 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.

(b) The MCO must accept Capitation Payments by direct deposit into the MCO’s account.

(c) 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 12 (Remedies and Disputes).

(d) 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 8 (Amendments and Modifications);

(2) HHSC will allow the MCO to review and comment on data used by HHSC to determine base Capitation Rates. During the rate-setting process, HHSC will conduct at least 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 for response. HHSC will not consider comments received after the deadline in its rate analysis.

(3) MCO must provide certified Encounter Data and financial data as described in the UMCM. The required information may include: claims lag information, capitation expenses, and stop loss reinsurance expenses. HHSC may request clarification or additional financial information from the MCO. HHSC will notify the MCO of the deadline for submitting a response, which will include a reasonable amount of time for response.

(4) HHSC will allow the MCO to review and comment on data used by HHSC to determine base Capitation Rates. This will include Fee-for-Service data for Rate Periods 1 and 2. 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 comments received after the deadline in its rate analysis.

(b) Value-added Services.

Value-added Services will not be included in the rate-setting process.

(c) Case-by-case services.

Case-by-case services will not be included in the rate-setting process.

Section 10.05 Capitation Structure.

(a) Capitation Rate development: Capitation Rates after Rate Period 1.

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.

(b) Value-added Services.

Value-added Services will not be included in the rate-setting process.

(c) Case-by-case services.

Case-by-case services will not be included in the rate-setting process.

Section 10.06 MCO input during rate-setting process.

(1) MCO must provide certified Encounter Data and financial data as described in the UMCM. The required information may include: claims lag information, capitation expenses, and stop loss reinsurance expenses. HHSC may request clarification or additional financial information from the MCO. 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 comments received after the deadline in its rate analysis.

(2) During the rate-setting process, HHSC will conduct at least 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.

Section 10.07 Adjustments to Capitation Payments.

(a) Adjustment. 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.

(b) Appeal of adjustment. The MCO may appeal the adjustment of capitation payments in the above circumstances using the HHSC dispute resolution process in Section 12.12, (Dispute Resolution).

Section 10.08 Experience Rebate.

(a) MCO’s duty to pay.

(1) General. 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 10.08 (b). 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 Admin Cap, or the Reinsurance Cap.

(2) Basis of consolidation. 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 Service Areas, with the exception of the Dual Demonstration.

(b) Graduated Experience Rebate Sharing Method.

For the limited period beginning September 1, 2021, through August 31, 2023, the following Graduated Experience Rebate Sharing Method will be utilized to calculate the Experience Rebate:

<table>
<thead>
<tr>
<th>Pre-tax Income as a % of Revenues</th>
<th>MCO Share</th>
<th>HHSC Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 3%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>&gt; 3% and ≤ 5%</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>&gt; 5% and ≤ 7%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>&gt; 7% and ≤ 9%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>&gt; 9% and ≤ 12%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>&gt; 12%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

HHSC and the MCO will share the consolidated Net Income Before Taxes for its HHSC Programs as follows:

(1) The MCO will retain all the Net Income Before Taxes that is equal to or less than 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 3% and less than or equal to 5% of the total Revenues received, with 80% to the MCO and 20% to HHSC.

(3) HHSC will be paid the entire portion of the Net Income Before Taxes that exceeds 5% of the total Revenues.

Beginning September 1, 2023, the Graduated Experience Rebate Sharing Method will revert to the following:

<table>
<thead>
<tr>
<th>Pre-tax Income as a Percentage of Revenues</th>
<th>MCO Share</th>
<th>HHSC Share</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>&gt; 5% and ≤ 7%</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>&gt; 7% and ≤ 9%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>&gt; 9% and ≤ 12%</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>&gt; 12%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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 Reward in accordance with Attachment B-1 Section 6, “Premium Payment Incentives and Disincentives,” and UMCM Chapter 6:

(1) The MCO will retain all the Net Income Before Taxes that is equal to or less than 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 3% and less than or equal to 5% of the total Revenues.
Revenues received, with 80% to the MCO and 20% to HHSC.

(3) HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 5% and less than or equal to 5% of the total Revenues received, with 60% to the MCO and 40% to HHSC.

(4) HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 7% and less than or equal to 7% of the total Revenues received, with 40% to the MCO and 60% to HHSC.

(5) HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 9% and less than or equal to 9% of the total Revenues received, with 20% to the MCO and 80% to HHSC.

(6) HHSC will be paid the entire portion of the Net Income Before Taxes that exceeds 12% of the total Revenues.

(c) Net income Before taxes.

(1) The MCO must compute the Net Income Before Taxes in accordance with applicable federal regulations and UMCM Chapters 6 and 5 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 the UMCM Chapters 6 and 5 in accordance with Section 8.05, “Modification of HHSC Uniform Managed Care Manual.”

(2) For purposes of calculating Net Income Before Taxes, certain items are omitted from the calculation as they are not Allowable Expenses; these include:

(i) the payment of an Experience Rebate;

(ii) any interest expense associated with late or underpayment of the Experience Rebate;

(iii) financial incentives; and

(iv) financial disincentives, including without limitation the liquidated damages described in Attachment B-2.

See UMCM Chapter 6

(3) 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.

(4) 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.

(d) Carry forward of prior FSR Reporting Period losses.

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 this 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 10.08.1(f), “Administrative Expense Cap.”

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) Basis of 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.

(e) Settlements for payment.

(1) There may be one or more MCO payment(s) of HHSC’s share 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% of HHSC's share of the 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 Article, 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.

(2) 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 10.08(f) (Experience Rebate) 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 10.08(f) (Experience Rebate). For any nonscheduled payments prior to the 334-Day FSR, the MCO is not 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)."

(3) 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:

(i) the date of the management representation letter resulting from the audit; or

(ii) 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 10.08(f) (Experience Rebate).

(4) 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 UMCM Chapters 6 and 5 and the Federal Acquisition Regulations (FAR), or other applicable federal or state regulations. HHSC has final authority in auditing and determining the amount of the Experience Rebate.

(f) Interest on Experience Rebate.

(1) 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 10.08(e)(1), (Experience Rebate). 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 runout (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.

(2) If an audit or adjustment determines a downward revision of income after an interest payment has previously been required for the same State Fiscal Year, then HHSC will recalculate the interest and, if necessary, issue a full or partial refund or credit to the MCO.

(3) Any interest obligations that are incurred under Section 10.08 that are not timely paid will be subject to accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

(4) All interest assessed under Section 10.08 (Experience Rebate) 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 under Section 10.08(f) (Experience Rebate) will not stop 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.

(5) If the MCO incurs an interest obligation under Section 10.08 (Experience Rebate) for an Experience Rebate payment, HHSC will assess that interest at 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.

(6) Any interest expense incurred under Section 10.08 (Experience Rebate) is not an Allowable Expense for reporting purposes on the FSR.

(g) 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 good faith negotiations to develop reasonable financial incentives for the MCO’s Providers for the following Rate Period.

Section 10.08.1 Administrative Expense Cap

(a) General requirement.

The calculation methodology of Experience Rebates described in Section 10.08 (Experience Rebate) will be adjusted by an Administrative Expense Cap (Admin Cap). The 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. 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 Financial Statistical Reports (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 this Contract will be subject to limitations on total deductible administrative expenses.

The limitations will be calculated as follows:

(b) 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 (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.

If 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.

(c) 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:

(i) the percentage rate to apply against the total premiums paid (the “percentage of premium” within the administrative expenses),

(ii) the dollar rate per Member Month (the “fixed amount” within the administrative expenses), and

(iii) 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 MCOs 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, under “Rate Analysis for 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.”

(3) 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.

(d) 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):
   • $8.00 x 70,000 = $560,000.

2. Multiply the predetermined percent of premiums in the administrative expense rate structure (for example, 5.75%), by the actual aggregate premiums earned by the MCO during the FSR Reporting Period (for example, $6,000,000).
   • 5.75% 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):
   • $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:
   • ($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.

(e) 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 Service Areas, 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 the UMCM.

(f) Impact on Loss carry-forward.

For Experience Rebate calculation purposes, the calculation of any loss carry-forward, as described in Section 10.08(d) (Experience Rebate), will be based on the allowable pre-tax loss as determined under the Admin Cap.

(g) Unforeseen events.

If, in HHSC’s sole discretion, it determines that unforeseen events have created significant hardships for one or more MCOs, HHSC may revise or temporarily suspend the Admin Cap as necessary.

Section 10.09 Payment by Members.

MCOs and their Network Providers are prohibited from billing or collecting any amount from a Member for Healthcare Services covered by this Contract. MCO must inform Members of costs for non-covered services, and must require its Network 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.

Section 10.09.1 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% 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 UMCM Chapter 6.

Section 10.10 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.

Section 10.11 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.

Section 10.12 Liability for employment-related charges and benefits.

MCO shall perform work under this Contract as an independent contractor and not as an 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.

Section 10.13 No additional consideration.

(a) 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.

(b) 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 Agreement.

(c) MCO is not entitled by virtue of the Contract to consider 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.

Section 10.14 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.

Section 10.15 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. 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. Additional information regarding these requirements is located in Attachment B-1 Section 8.1.4.9.2. “Supplemental Payments for Qualified Providers.”

Section 10.16 Non-risk Payments for Certain Drugs

The capitation rates do not include the costs of certain clinician-administered and pharmacy drugs as identified in UMCM Chapter 2. For providing these drugs to Members, HHSC will make non-risk payments to the MCO based on Encounter Data received by HHSC’s Administrative Services Contractor during an encounter reporting period.

For drugs dispensed by a pharmacy, the first 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’s Administrative Services Contractor has processed the Encounter Data. Non-risk payments will be limited to the actual amounts MCOs paid to pharmacy providers for these drugs as represented in “Net Amount Due” field (Field 281) on the National Council for Prescription Drug Programs (NCPDP) encounter transaction up to the Fee-for-Service 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 UMCM Chapter 2 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 Administrative Services Contractor 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 Fee-for-Service reimbursement amount.

Section 10.17 Payment/Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee

The following applies only to MCOs that are covered entities under Section 9010 of the PPACA, and thus required to pay the Health Insurance Providers Fee (“HIP Fee”) for United States health risks.

Beginning in calendar year 2014, the PPACA requires the MCO to pay the HIP Fee no later than September 30th (as applicable to each relevant year, the “HIP Fee Year”) with respect to premiums paid to the MCO in the preceding calendar year (as applicable to each relevant year, the “HIP Data Year”), and continuing similarly in each successive year. In order to satisfy the requirement for actuarial soundness set forth in 42 C.F.R. § 438.4 with respect to amounts paid by HHSC under this Agreement, the parties agree that HHSC will make a retroactive adjustment to capitation to the MCO for the full amount of the HIP Fee allocable to this Agreement, as follows:

Amount and method of payment: For each HIP Fee Year, HHSC will make an adjustment to capitation to the MCO for that portion of the HIP Fee that is attributable to the Capitation Payments paid by HHSC to the MCO for risks in the applicable HIP Data Year under the Agreement, less any applicable exclusions and appropriate credit offsets. This capitation adjustment will be determined by HHSC and will include the following:

- The amount of the HIP Fee attributable to this Agreement;
- The federal income tax liability, if any, that the MCO incurs as a result of receiving HHSC’s payment for the amount of the HIP Fee attributable to this Agreement; and
- Any Texas state premium tax attributable to the capitation adjustment.

The amount of the HIP Fee will not be determinable until after HHSC establishes the regular Capitation Rates for a rate period. HHSC therefore will perform an actuarial calculation to account for the HIP Fee within actuarially sound Capitation Rates each year, and apply this Capitation Rate adjustment to the regular Capitation Rates already paid to the MCO.

The MCO’s federal income tax rate will not be known prior to the end of the tax year. As a result, HHSC will make a tax rate assumption for purposes of developing the capitation adjustment. If the tax rate assumption later proves to be higher than the actual tax rate for one or more MCOs, HHSC may re-determine the capitation adjustment for those MCOs using the lower tax rate and reconcile the capitation amount paid.

Documentation Requirements: HHSC will pay the MCO after it receives sufficient documentation, as determined by HHSC, detailing the MCO’s Texas Medicaid and CHIP-specific liability for the HIP Fee. The MCO will provide documentation that includes the following:

- The preliminary and final versions of the IRS Form 8963;
- Texas Medicaid/CHIP-specific premiums included in the premiums reported on Form 8963; and
- The preliminary and final versions of the Fee statement provided by the IRS.

Payment by HHSC is intended to put the MCO in the same position as the MCO would have been had no HIP Fee been imposed upon the MCO.

This provision will survive the termination of the Agreement.

Section 10.18 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, as described in Attachment B-1, Section 8.1.43. HHSC will make supplemental payments to the MCO for
these Medicaid Wrap-Around Services, based on encounter data received by HHSC’s Administrative Services Contractor 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’s Administrative Services Contractor 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 National Council for Prescription Drug Programs (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.

Section 10.19 Non-Risk Payments for Certain Autism Services

Capitation Rates do not include the costs of delivering applied behavior analysis (ABA) services to Medicaid Members age 20 and under or the costs of interdisciplinary team meetings to identify needed services and formulate individualized treatment plans for these eligible Medicaid Members, as described in the TMPPM.

For providing these services to eligible Medicaid Members, HHSC will make non-risk payments to the MCO based on Encounter Data received by HHSC’s Administrative Services Contractor during an Encounter reporting period. HHSC will reimburse for services provided to eligible Medicaid Members as documented in both the invoice and Encounter Data on a non-risk basis subject to the non-risk upper payment limit in 42 CFR § 447.362.

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, generally no later than 95 Days after HHSC’s Administrative Services Contractor has processed the Encounter Data. Non-risk payments for these services require MCO adherence to all applicable requirements, including those specified in the TMPPM.

Non-risk payments will be limited to the actual amounts MCOs paid to providers for these services up to the Fee-for-Service reimbursement amount. The non-risk payments will cover only the cost of the covered ABA services and interdisciplinary team meetings to identify needed services and formulate individualized treatment plans for these eligible Medicaid Members.

Article 11. Disclosure and Confidentiality of Information

Section 11.01 Confidentiality

(a) MCO and all Subcontractors, consultants, or agents must treat all information that is obtained through performance of the Services under the Contract, including information relating to applicants or recipients of HHSC Programs as Confidential Information to the extent that confidential treatment is provided under law and regulations.

(b) MCO is responsible for understanding the degree to which information obtained through performance of this Contract is confidential under state and federal law, regulations, or administrative rules.

(c) MCO and all Subcontractors, consultants, or agents under the Contract may not use any information obtained through performance of this Contract in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Contract.

(d) MCO must have a system in effect to protect all records and all other documents deemed confidential under this Contract maintained in connection with the activities funded under the Contract. Any disclosure or transfer of Confidential Information by MCO, including information required by HHSC, will be in accordance with applicable law. If the MCO receives a request for information deemed confidential under this Contract, the MCO will immediately notify HHSC of such request, and will make reasonable efforts to protect the information from public disclosure.

(e) In addition to the requirements expressly stated in this Section, MCO must comply with any policy, rule, or reasonable requirement of HHSC that relates to the safeguarding or disclosure of information relating to Members, MCO’s operations, or MCO’s performance of the Contract.

(f) In the event of the expiration of the Contract or termination of the Contract for any reason, all Confidential Information disclosed to and all copies of any Confidential Information made by the MCO must be returned to HHSC or, at HHSC’s option, erased or destroyed. MCO must provide HHSC certificates evidencing this erasure or destruction.

(g) The obligations in this Section do not restrict any disclosure by the MCO under any applicable law or by order of any court or government agency. However, HHSC must be notified promptly, as dictated by the circumstances or law, but not later than 24 hours in any circumstance.

(h) With the exception of confidential Member information, information provided under this Agreement by one Party (the “Furnishing Party”) to
another Party (the "Receiving Party") will not be considered Confidential Information if the data was:

1. Already known to the Receiving Party without restrictions at the time of its disclosure by the Furnishing Party;
2. Independently developed by the Receiving Party without reference to the Furnishing Party’s Confidential Information;
3. Rightfully obtained by the Receiving Party without restriction from a third party after its disclosure to a third party by the Furnishing Party;
4. Publicly available other than through the fault or negligence of the Receiving Party; or
5. Lawfully released without restriction to anyone.

Section 11.02 Disclosure of HHSC’s Confidential Information.

(a) MCO will report to HHSC any and all unauthorized disclosures or uses of HHSC’s Confidential Information of which it or its Subcontractor(s), consultant(s), or agent(s) is aware or has knowledge in accordance with Section 11.09 of this Contract. MCO acknowledges that any publication or disclosure of HHSC’s Confidential Information to others may cause immediate and irreparable harm to HHSC and may constitute a violation of state or federal laws. If MCO, its Subcontractor(s), consultant(s), or agent(s) should publish or disclose such Confidential Information to others without authorization, HHSC will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. HHSC will have the right to recover from MCO all damages and liabilities caused by or arising from MCO’s, its Subcontractor’s, consultant’s, or agents’ failure to protect HHSC’s Confidential Information. MCO will defend with counsel approved by HHSC, indemnify and hold harmless HHSC from all damages, costs, liabilities, and expenses (including without limitation reasonable attorneys’ fees and costs) caused by or arising from MCO’s, its Subcontractor’s, consultants’, or agents’ failure to protect HHSC’s Confidential Information. HHSC will not unreasonably withhold approval of counsel selected by the MCO.

(b) MCO will require its Subcontractor(s), consultant(s), and agent(s) to comply with the terms of this provision.

Section 11.03 Member Records

(a) MCO must comply with the requirements of state and federal laws, including the HIPAA requirements set forth in Section 7.06 (HIPAA), regarding the transfer of Member Records.

(b) If at any time during the Contract Term this Contract is terminated, HHSC may require the transfer of Member Records, upon written notice to MCO, to another entity, as consistent with federal and state laws and applicable releases.

(c) The term “Member Record” for this Section means only those administrative, enrollment, case management, and other records maintained by MCO and is not intended to include Member records maintained by participating Network Providers.

Section 11.04 Requests for public information.

(a) HHSC agrees that it will promptly notify MCO of a request for disclosure of information filed in accordance with the Texas Public Information Act, Texas Government Code Chapter 552 that consists of the MCO’S confidential information, including information or data to which MCO has a proprietary or commercial interest. HHSC will deliver a copy of the request for public information to MCO.

(b) With respect to any information that is the subject of a request for disclosure, MCO is required to demonstrate to the Texas Office of Attorney General the specific reasons why the requested information is confidential or otherwise excepted from required public disclosure under law. MCO will provide HHSC with copies of all of these communications.

(c) MCO must make information defined as public information not otherwise excepted from disclosure under the Texas Public Information Act, Texas Government Code Chapter 552, available to HHSC in a format accessible by the public and at no additional charge to HHSC.

(d) To the extent authorized under the Texas Public Information Act, HHSC agrees to safeguard from disclosure information received from MCO that the MCO believes to be confidential information. MCO must clearly mark such information as confidential information or provide written notice to HHSC that it considers the information confidential.

Section 11.05 Privileged Work Product.

(a) MCO acknowledges that HHSC asserts that privileged work product may be prepared in anticipation of litigation and that MCO is performing the Services with respect to privileged work product as an agent of HHSC. All matters related to this performance of Services are protected from disclosure by the Texas Rules of Civil Procedure, Texas Rules of Evidence, Federal Rules of Civil Procedure, or Federal Rules of Evidence.

(b) HHSC will notify MCO of any privileged work product to which MCO has or may have access. After the MCO is notified or otherwise becomes aware that these documents, data, databases, or communications are privileged work product, only MCO personnel, for whom access is necessary for the purposes of providing the Services, may have access to privileged work product.
(c) If MCO receives notice of any judicial or other proceeding seeking to obtain access to HHSC’s privileged work product, MCO will:
   (1) Immediately notify HHSC; and
   (2) Use all reasonable efforts to resist providing access.

(d) If MCO resists disclosure of HHSC’s privileged work product in accordance with this Section, HHSC will, to the extent authorized under Civil Practices and Remedies Code or other applicable state law, have the right and duty to:
   (1) represent MCO in the resistance; or
   (2) to retain counsel to represent MCO.

(e) If a court of competent jurisdiction orders MCO to produce documents, disclose data, breach the confidentiality obligations imposed in the Contract, or otherwise breach the Contract with respect to maintaining the confidentiality, proprietary nature, and secrecy of privileged work product, MCO will not be liable for a Contract breach when ordered to do so by the court.

**Section 11.06 Unauthorized acts.**

Each Party agrees to:

1. Notify the other Party promptly of any unauthorized possession, use, or knowledge, or attempted possession, use, or knowledge, by any person or entity that may become known to the Party, of any HHSC Confidential Information or any information identified by the MCO as confidential or proprietary;

2. Promptly furnish to the other Party full details of the unauthorized possession, use, or knowledge, or attempted possession, use, or knowledge, and use reasonable efforts to assist the other Party in investigating or preventing the reoccurrence of any unauthorized possession, use, or knowledge, or attempted possession, use, or knowledge, of Confidential Information;

3. Cooperate with the other Party in any litigation and investigation determined to be necessary against third Parties to protect that Party’s proprietary rights; and

4. Promptly prevent a reoccurrence of any unauthorized possession, use, or knowledge, or attempted possession, use, or knowledge, of the information.

**Section 11.07 Legal action.**

The MCO may not commence any legal action or proceeding in respect to any unauthorized possession, use, or knowledge, or attempted possession, use, or knowledge by any person or entity of HHSC’s Confidential Information without HHSC’s consent. Also, the MCO must notify HHSC of any legal action or proceeding in respect to any unauthorized possession, use, or knowledge, or attempted possession, use, or knowledge by any person or entity of information identified by the MCO as confidential or proprietary that is related to the fulfillment of any duties under this contract but is not considered Confidential Information as defined by this Contract.

**Section 11.08 Information Security and Privacy Requirements**

(a) Compliance.

The MCO agrees to comply with all applicable state and federal security and privacy requirements, governing the creation, collection, access, use, storage, maintenance, disclosure, safeguarding and destruction of Texas HHS data including Agency Sensitive Information and Confidential Information.

(b) Protection.

The MCO will implement, maintain, document, and use appropriate administrative, technical and physical security measures to protect all Texas HHS Information Resources and data, including Agency Sensitive Information and Confidential Information.

(c) Reviews.

The MCO must comply with security and privacy controls compliance assessments, updates, and monitoring by Texas HHS as required by state and federal law or by Texas HHS’s discretion. The security and privacy controls will be based on the National Institute of Standards and Technology (NIST) Special Publication 800-53 from the applicable state and federal requirements. The Texas HHS process is described in the Information Security Risk Assessment and Monitoring Procedures (IS-RAMP) that is published on the Texas HHS Internet website.

(d) Workforce.

The MCO must ensure that their workforce, including Subcontractors, who are granted specified Texas HHS authorized access to internal Texas HHS Information Resources, comply with the Texas HHS Acceptable Use Policy (AUP) and sign the Acceptable Use Agreement (AUA) prior to access, in accordance with 1 Tex. Admin. Code Chapter 202.22.

(e) Information Security and Privacy Officials.

The MCO must designate an Information Security Official and a Privacy Official who will be responsible for managing its security and privacy programs and Texas HHS requirements. The MCO will provide Texas HHS the names, phone numbers and email addresses of these officials. The Information Security Official and Privacy Official roles may be performed by the same individual.

(f) Program.

The MCO must establish an information security and privacy program and maintain information...
security and privacy policies and standards that are updated at least annually with respect to the management or handling of Texas HHS Information Resources or data. The program will:

1. comply with all applicable legal and regulatory requirements for Texas HHS data protection;

2. comply with Texas HHS Information Security Office's published or provided policies, standards, and controls available at Doing Business with HHS;

3. ensure the integrity, availability, and confidentiality by implementing technical, administrative and physical safeguards for Texas HHS Agency Sensitive Information and Confidential Information;

4. protect against any anticipated threats or hazards to the security or integrity of such information;

5. protect and monitor against unauthorized access to or use of such information that could result in harm to the person that is the subject of such information both logically and physically;

6. routinely review, monitor, and remove unnecessary accounts that have access to Texas HHS Agency Sensitive Information or Confidential Information;

7. coordinate with Texas HHS to determine the Texas HHS data types accessed, transmitted, stored, or maintained by the system and identify applicable state, federal and regulatory requirements;

8. encrypt the Texas HHS Agency Sensitive Information and Confidential Information on end-user devices, on portable devices, in transit over public networks, and while stored in the cloud;

9. ensure FIPS 140-2 validated encryption will be used for federal protected data and access to Texas HHS Confidential Information and Agency Sensitive Information will be controlled and monitored;

10. prohibit the use of free cloud services with Texas HHS Agency Sensitive Information or Confidential Information;

11. prohibit the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside the United States;

12. provide the workforce security and privacy training, conduct appropriate background checks, ensure individual accountability, and implement appropriate sanctions for non-compliance;

13. establish a secure method of assigning and selecting passwords, or use of unique identifier technologies, such as biometrics or token devices;

14. keep current on security update/patch releases and maintain up-to-date anti-virus/malware protection;

15. ensure security will be integrated into all phases including planning, development, and implementation and will include security testing and remediation of security vulnerabilities prior to production especially for online websites, applications and mobile applications;

16. establish standards and methods to securely return, destroy or dispose of Texas HHS Agency Sensitive Information or Confidential Information;

17. provide documentation of information security and privacy policies/standards to Texas HHS Information Security if requested;

18. develop and implement methods that ensure security for all components, including:

   i. environmental security;

   ii. physical site security;

   iii. computer hardware security;

   iv. computer software security;

   v. application security;

   vi. data access and storage;

   vii. client/user security;

   viii. secure processes and procedures;

   ix. telecommunications and network security; and

   x. general support systems (GSS) security;

Section 11.09 MCO's Incident and Breach Notice, Reporting and Mitigation

The MCO's obligation begins at discovery of any unauthorized disclosure of Confidential Information or any privacy or security incident that may compromise Confidential Information (collectively "Incident") and continues until all effects of the Incident are resolved to HHSC's satisfaction, hereafter referred to as the "Incident Response Period". For each Incident, the MCO must perform a risk analysis in accordance with HIPAA requirements to determine the probability of compromise of the Confidential Information.
Section 11.09.1 Notification to HHSC.

(a) The MCO must notify HHSC within the timeframes set forth in Section (c) below unless HHSC has agreed in writing to an alternate timeframe for notification.

(b) The MCO must require that its Subcontractors and Providers take the necessary steps to assure that the MCO can comply with all of the following Incident notice requirements.

(c) Incident Notice:

1. Initial Notice.
   Within 24 hours of discovery of an Incident that the MCO’s risk analysis has determined has more than a low probability of compromise, the MCO must preliminarily report on the occurrence of an Incident to the HHSC Privacy Officer via email at: privacy@HHSC.state.tx.us using the Potential Privacy/Security Incident Form which is available on the HHSC website. This initial notice must, at a minimum, contain (1) all information reasonably available to MCO about the Incident, (2) confirmation that the MCO has met any applicable federal Breach notification requirements and (3) a single point of contact for the MCOs for HHSC communications both during and outside of business hours during the Incident Response Period.

2. Formal Notice.
   No later than three Business Days after discovery of an Incident that the MCO’s risk analysis has determined has more than a low probability of compromise, or when the MCO should have reasonably discovered such Incident, the MCO must provide written formal notification to HHSC using the Potential Privacy/Security Incident Form which is available on the HHSC website. The formal notification must include all available information about the Incident, and the MCO’s investigation of the Incident.

3. Annual Notice
   For an Incident that the MCO’s risk analysis has determined has a low probability of compromise or only involves unauthorized disclosure of a single individual’s Confidential Information to a single unauthorized recipient, the MCO must provide notice to HHSC of such Incident no later than 60 Days after the end of the calendar year in which the Incident occurred.

   No later than 60 Days after the end of each calendar year, MCO’s must provide the HHS Privacy Office with a comprehensive list of all incidents involving HHSC confidential information that were reported to the US Office for Civil Rights in accordance with the obligations under HIPAA.

Section 11.09.2 MCO Investigation, Response and Mitigation.

The MCO must fully investigate and mitigate, to the extent practicable and as soon as possible or as indicated below, any Incident. At a minimum, the MCO will:

1. Immediately commence a full and complete investigation;
2. Cooperate fully with HHSC in its response to the Incident;
3. Complete or participate in an initial risk analysis;
4. Provide a final risk analysis;
5. Submit proposed corrective actions to HHSC for review and approval;
6. Commit necessary and appropriate staff and resources to expeditiously respond;
7. Report to HHSC as required by HHSC and all applicable federal and state laws for Incident response purposes and for purposes of HHSC’s compliance with report and notification requirements, to the satisfaction of HHSC;
8. Fully cooperate with HHSC to respond to inquiries and/or proceedings by federal and state authorities about the Incident;
9. Fully cooperate with HHSC’s efforts to seek appropriate injunctive relief or to otherwise prevent or curtail such Incidents;
10. Recover, or assure destruction of, any Confidential Information impermissibly disclosed during or as a result of the Incident; and
11. Provide HHSC with a final report on the Incident explaining the Incident’s resolution.

Section 11.09.3 Breach Notification to Individuals and Reporting to Authorities.

(A) MCO must provide Breach notification, in accordance with 45 C.F.R. §§ 164.400-414.

(B) The MCO must assure that the time, manner and content of any Breach notification required by this Section meets all federal and state regulatory requirements. Breach notice letters must be in the MCO’s name and on the MCO’s letterhead and must contain contact information to obtain additional information, including the name and
title of the MCO’s representative, an email address and a toll-free telephone number.

(C) The MCO must provide HHSC with copies of all distributed communications related to the Breach notification at the same time the MCO distributes the communications.

The MCO must demonstrate to the satisfaction of HHSC that any Breach notification required by applicable law was timely made. If there are delays outside of the MCO’s control, the MCO must provide written documentation to HHSC of the reasons for the delay.

Article 12. Remedies & Disputes

Section 12.01 Understanding and expectations.

The remedies described in this Section are directed to MCO’s timely and responsive performance of the Services and production of Deliverables, and the creation of a flexible and responsive relationship between the Parties. The MCO is expected to meet or exceed all HHSC objectives and standards, as set forth in the Contract. All areas of responsibility and all Contract requirements will be subject to performance evaluation by HHSC. Performance reviews may be conducted at the discretion of HHSC at any time and may relate to any responsibility and/or requirement. Any and all responsibilities and/or requirements not fulfilled may be subject to remedies set forth in the Contract.

Section 12.02 Tailored remedies.

(a) Understanding of the Parties.

MCO agrees and understands that HHSC may pursue tailored contractual remedies for noncompliance with the Contract. At any time and at its discretion, HHSC may impose or pursue one or more remedies for each item of noncompliance and will determine remedies on a case-by-case basis. HHSC’s pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that HHSC may have at law or equity.

(b) Notice and opportunity to cure for non-material breach.

(1) HHSC will notify MCO in writing of specific areas of MCO performance that fail to meet performance expectations, standards, or schedules set forth in the Contract, but that, in the determination of HHSC, do not result in a material deficiency or delay in the implementation or operation of the Services.

(2) MCO will, within five (5) Business Days (or another date approved by HHSC) of receipt of written notice of a non-material deficiency, provide the HHSC Project Manager a written response that:

(i) Explains the reasons for the deficiency, MCO’s plan to address or cure the deficiency, and the date and time by which the deficiency will be cured; or

(ii) If MCO disagrees with HHSC’s findings, its reasons for disagreeing with HHSC’s findings.

(3) MCO’s proposed cure of a non-material deficiency is subject to the approval of HHSC. MCO’s repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by HHSC as a material deficiency and entitle HHSC to pursue any other remedy provided in the Contract or any other appropriate remedy HHSC may have at law or equity.

(c) Corrective Action Plan.

(1) At its option, HHSC may require MCO to submit to HHSC a written plan (the "Corrective Action Plan") to correct or resolve a material breach of the Contract, as determined by HHSC.

(2) The Corrective Action Plan must provide:

(i) A detailed explanation of the reasons for the cited deficiency;

(ii) MCO’s assessment or diagnosis of the cause; and

(iii) A specific proposal to cure or resolve the deficiency.

(3) The Corrective Action Plan must be submitted by the deadline set forth in HHSC’s request for a Corrective Action Plan. The Corrective Action Plan is subject to approval by HHSC, which will not unreasonably be withheld.

(4) HHSC will notify MCO in writing of HHSC’s final disposition of HHSC’s concerns. If HHSC accepts MCO’s proposed Corrective Action Plan, HHSC may:

(i) Condition such approval on completion of tasks in the order or priority that HHSC may reasonably prescribe;

(ii) Disapprove portions of MCO’s proposed Corrective Action Plan; or

(iii) Require additional or different corrective action(s).

Notwithstanding the submission and acceptance of a Corrective Action Plan, MCO remains responsible for achieving all written performance criteria.

(5) HHSC’s acceptance of a Corrective Action Plan under this Section will not:

(i) Excuse MCO’s prior substandard performance;

(ii) Relieve MCO of its duty to comply with performance standards; or
(iii) Prohibit HHSC from assessing additional tailored remedies or pursuing other appropriate remedies for continued substandard performance.

(d) Administrative remedies.

(1) At its discretion, HHSC may impose one or more of the following remedies for each item of material noncompliance and will determine the scope and severity of the remedy on a case-by-case basis:

   (i) Assess liquidated damages in accordance with Attachment Liquidated Damages Matrix;

   (ii) Conduct accelerated monitoring of the MCO. Accelerated monitoring includes more frequent or more extensive monitoring by HHSC or its agent;

   (iii) Require additional, more detailed, financial and/or programmatic reports to be submitted by MCO;

   (iv) Decline to renew or extend the Contract;

   (v) Appoint temporary management under the circumstances described in 42 C.F.R. § 438.706;

   (vi) Initiate disenrollment of a Member or Members;

   (vii) Suspend enrollment of Members;

   (viii) Withhold or recoup payment to MCO;

   (ix) Require forfeiture of all or part of the MCO’s bond; or

   (x) Terminate the Contract in accordance with Section 12.03, (“Termination by HHSC”).

(2) For purposes of the Contract, an item of material noncompliance means a specific action of MCO that:

   (i) Violates a material provision of the Contract;

   (ii) Fails to meet an agreed measure of performance; or

   (iii) Represents a failure of MCO to be reasonably responsive to a reasonable request of HHSC relating to the Services for information, assistance, or support within the timeframe specified by HHSC.

(3) HHSC will provide notice to MCO of the imposition of an administrative remedy in accordance with this Section, with the exception of accelerated monitoring, which may be unannounced. HHSC may require MCO to file a written response in accordance with this Section.

(4) The Parties agree that a State or Federal statute, rule, regulation, or Federal guideline will prevail over the provisions of this Section unless the statute, rule, regulation, or guidelines can be read together with this Section to give effect to both.

(e) Damages.

(1) HHSC will be entitled to actual and consequential damages resulting from the MCO’S failure to comply with any of the terms of the Contract. In some cases, the actual damage to HHSC or State of Texas as a result of MCO’s failure to meet any aspect of the responsibilities of the Contract and/or to meet specific performance standards set forth in the Contract are difficult or impossible to determine with precise accuracy. Therefore, liquidated damages will be assessed in writing against and paid by the MCO in accordance with and for failure to meet any aspect of the responsibilities of the Contract and/or to meet the specific performance standards identified by the HHSC in “Deliverables/Liquidated Damages Matrix.” Liquidated damages will be assessed if HHSC determines such failure is the fault of the MCO, including the MCO’s Subcontractors and/or consultants, and is not materially caused or contributed to by HHSC or its agents. If at any time, HHSC determines the MCO has not met any aspect of the responsibilities of the Contract and/or the specific performance standards due to mitigating circumstances, HHSC reserves the right to waive all or part of the liquidated damages. All such waivers must be in writing, contain the reasons for the waiver, and be signed by the appropriate executive of HHSC.

(2) The liquidated damages prescribed in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HHSC’s projected financial loss and damage resulting from the MCO’s nonperformance, including financial loss as a result of project delays. Accordingly, in the event MCO fails to perform in accordance with the Contract, HHSC may assess liquidated damages as provided in this Section.

(3) If MCO fails to perform any of the Services described in the Contract, HHSC may assess liquidated damages for each occurrence of a liquidated damages event, to the extent consistent with HHSC’s tailored approach to remedies and Texas law.

(4) HHSC may elect to collect liquidated damages:

   (i) Through direct assessment and demand for payment delivered to MCO; or

   (ii) By deduction of amounts assessed as liquidated damages as set-off against payments then due to MCO or that become due at any time after assessment of the liquidated damages. HHSC will make deductions until the full amount payable by the MCO is received by HHSC.

(f) Equitable Remedies.
(1) MCO acknowledges that, if MCO breaches (or attempts or threatens to breach) its material obligation under the Contract, HHSC may be irreparably harmed. In such a circumstance, HHSC may proceed directly to court to pursue equitable remedies.

(2) If a court of competent jurisdiction finds that MCO breached, or attempted or threatened to breach any such obligations, MCO agrees that without any additional findings of irreparable injury or other conditions to injunctive relief, it will not oppose the entry of an appropriate order compelling performance by MCO and restraining it from any further breaches or attempted or threatened breaches.

(g) Suspension of Contract.

(1) HHSC may suspend performance of all or any part of the Contract if:

(i) HHSC determines that MCO has committed a material breach of the Contract;

(ii) HHSC has reason to believe that MCO has committed, assisted in the commission of Fraud, Waste, or Abuse, malfeasance, misfeasance, or nonfeasance by any party concerning the Contract;

(iii) HHSC determines that the MCO knew, or should have known, of Fraud, Waste, or Abuse, malfeasance, misfeasance, or nonfeasance by any party concerning the Contract; or

(vi) HHSC determines that suspension of the Contract in whole or in part is in the best interests of the State of Texas or the HHSC Programs.

(2) HHSC will notify MCO in writing of its intention to suspend the Contract in whole or in part. Such a notice will:

(i) Be delivered in writing to MCO;

(ii) Include a concise description of the facts or matter leading to HHSC’s decision; and

(iii) Unless HHSC is suspending the contract for convenience, request a Corrective Action Plan from MCO or describe actions that MCO may take to avoid the contemplated suspension of the Contract.

Section 12.03 Termination by HHSC.

Prior to completion of the Contract Period, all or a part of the Contract may be terminated for any of the following reasons:

(a) Termination in the best interest of HHSC.

HHSC may terminate the Contract without cause at any time when, in its sole discretion, HHSC determines that termination is in the best interests of the State of Texas. HHSC will provide reasonable advance written notice of the termination, as it deems appropriate under the circumstances. The termination will be effective on the date specified in HHSC’s notice of termination.

(b) Termination for cause.

Except as otherwise provided by the U.S. Bankruptcy Code, or any successor law, HHSC may terminate the Contract, in whole or in part, upon the following conditions:

(1) Assignment for the benefit of creditors, appointment of receiver, or inability to pay debts.

HHSC may terminate the Contract at any time if MCO:

(i) Makes an assignment for the benefit of its creditors;

(ii) Admits in writing its inability to pay its debts generally as they become due; or

(iii) Consents to the appointment of a receiver, trustee, or liquidator of MCO or of all or any part of its property.

(2) Failure to adhere to laws, rules, ordinances, or orders.

HHSC may terminate the Contract if a court of competent jurisdiction finds MCO failed to adhere to any laws, ordinances, rules, regulations, or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of MCO’s duties under the Contract. HHSC will provide at least 30 Days’ advance written notice such of termination.

(3) Breach of confidentiality.

HHSC may terminate the Contract at any time if MCO breaches confidentiality laws with respect to the Services and Deliverables provided under the Contract.

(4) Failure to maintain adequate personnel or resources.

HHSC may terminate the Contract if, after providing notice and an opportunity to correct, HHSC determines that MCO has failed to supply personnel or resources and such failure results in MCO’s inability to fulfill its duties under the Contract. HHSC will provide at least 30 Days’ advance written notice of such termination.

(5) Termination for gifts and gratuities.

(i) HHSC may terminate the Contract at any time following the determination by a competent judicial or quasi-judicial authority and MCO’s exhaustion of all legal remedies that MCO, its employees, agents or representatives have either offered or given anything of value to an officer or employee of
HHSC or the State of Texas in violation of state law.

(ii) MCO must include a similar provision in each of its Subcontracts and shall enforce this provision against a Subcontractor who has offered or given anything of value to any of the persons or entities described in this Section, whether or not the offer or gift was in the MCO's behalf.

(iii) Termination of a Subcontract by MCO pursuant to this provision will not be a cause for termination of the Contract unless:

(a) MCO fails to replace such terminated Subcontractor within a reasonable time; and

(b) Such failure constitutes cause, as described in this Subsection 12.03(b).

(iv) For purposes of this Section, a "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to holders of public office or candidates for public office that are paid and reported in accordance with State and/or Federal law.

(6) Termination for non-appropriation of funds.

Notwithstanding any other provision of the Contract, if funds for the continued fulfillment of the Contract by HHSC are at any time not forthcoming or are insufficient, through failure of any entity to appropriate funds or otherwise, then HHSC will have the right to terminate the Contract at no additional cost and with no penalty whatsoever by giving prior written notice documenting the lack of funding. HHSC will provide at least 30 Days’ advance written notice of such termination. HHSC will use reasonable efforts to ensure appropriated funds are available.

(7) Judgment and execution.

(i) HHSC may terminate the Contract at any time if judgment for the payment of money in excess of $500,000.00 that is not covered by insurance, is rendered by any court or governmental body against MCO, and MCO does not:

(a) Discharge the judgment or provide for its discharge in accordance with the terms of the judgment;

(b) Procure a stay of execution of the judgment within 30 Days from the date of entry thereof; or

(c) Perfect an appeal of such judgment and cause the execution of such judgment to be stayed during the appeal, providing such financial reserves as may be required under generally accepted accounting principles.

(ii) If a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the property of MCO, and such writ or warrant of attachment or any similar process is not released or bonded within 30 Days after its entry, HHSC may terminate the Contract in accordance with this Section.

(8) Termination for MCO’S material breach of the Contract.

HHSC will have the right to terminate the Contract in whole or in part if HHSC determines, at its sole discretion, that MCO has materially breached the Contract. HHSC will provide at least 30 Days’ advance written notice of such termination.

(9) Termination for Criminal Conviction

HHSC will have the right to terminate the Contract in whole or in part, or require the replacement of a Material Subcontractor, if the MCO or a Material Subcontractor is convicted of a criminal offense in a state or federal court:

(i) Related to the delivery of an item or service;

(ii) Related to the neglect or abuse of Members in connection with the delivery of an item or service;

(iii) Consisting of a felony related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct, or

(iv) Resulting in a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

(c) Pre-termination Process

The following process will apply when HHSC terminates the Contract for any reason set forth in Section 12.03(b), “Termination for Cause,” other than Subpart 6, “Termination for Non-appropriation of Funds."

In accordance with 42 C.F.R. §438.710, before terminating the Contract, HHSC will provide the MCO with 30 Days advance written notice of its intent to terminate. The pre-termination notice will include the following information; the reason for the proposed termination; the proposed effective date of the termination; and the time and place of the pre-termination hearing. During the hearing, the MCO may present written information explaining why HHSC
should not terminate the Contract. After the pre-termination hearing, the State Medicaid Director will provide the MCO with a written notice of HHSC’s final affirming or reversing the proposed termination of the Contract and the effective date of termination if applicable.

HHSC’s final decision to terminate the Contract is binding and is not subject to review by the State Office of Administrative Hearings under Chapter 2260, Texas Government Code.

The pre-termination process described herein will not limit or otherwise reduce the MCO’s rights and the Parties’ responsibilities under Section 12.13, “Dispute Resolution.”

**Section 12.04 Termination by MCO.**

(a) Failure to pay.

MCO may terminate the Contract if HHSC fails to pay the MCO undisputed charges when due as required under the Contract. Retaining premium, recoupment, sanctions, or penalties that are allowed under the Contract or that result from the MCO’s failure to perform or the MCO’s default under the terms of the Contract is not cause for termination. Termination for failure to pay does not release HHSC from the obligation to pay undisputed charges for services provided prior to the termination date.

If HHSC fails to pay undisputed charges when due, then the MCO may submit a notice of intent to terminate for failure to pay in accordance with the requirements of Section 12.04(e). If HHSC pays all undisputed amounts then due within 30 Days after receiving the notice of intent to terminate, the MCO cannot proceed with termination of the Contract under this Article.

(b) Change to HHSC Uniform Managed Care Manual.

MCO may terminate this agreement if the Parties are unable to resolve a dispute concerning a material and substantive change to the UMCM (a change that materially and substantively alters the MCO’s ability to fulfill its obligations under the Contract). MCO must submit a notice of intent to terminate due to a material and substantive change in the UMCM no later than 30 Days after the effective date of the policy change. HHSC will not enforce the policy change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(c) Change to Capitation Rate.

If HHSC proposes an initial Capitation Rate or a modification to the Capitation Rate that is unacceptable to the MCO, the MCO may terminate the Contract. MCO must submit a written notice of intent to terminate due to a change in the Capitation Rate no later than 30 Days after HHSC’s notice of the proposed change. HHSC will not enforce the rate change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(d) Expiration of Contract.

If MCO rejects, or intends to reject, an amendment extending the term of the Contract, MCO is subject to the requirements of Section 12.04(e).

(e) Notice of intent to terminate or to allow the Contract to expire.

If the MCO intends to terminate the Contract pursuant to this Section or allow the Contract to expire, MCO must give HHSC at least 90 Days’ written notice of intent to terminate or intent to allow the Contract to expire. The termination date will be calculated as the last day of the month following 90 Days from the date the notice of intent is received by HHSC.

In the event the MCO fails to comply with this notice requirement, the Contract shall be extended under the same terms, conditions, and rates, for the period of time necessary to satisfy this notice requirement.

**Section 12.05 Termination by mutual agreement.**

The Contract may be terminated by mutual written agreement of the Parties.

**Section 12.06 Effective date of termination.**

Except as otherwise provided in the Contract, termination will be effective as of the date specified in the notice of termination. The Turnover obligations of the MCO will continue to apply after the effective date of the Contract termination.

**Section 12.07 Extension of termination effective date.**

The Parties may extend the effective date of termination one or more times by mutual written agreement.

**Section 12.08 Payment and other provisions at Contract termination.**

(a) In the event of termination pursuant to this Article, HHSC will pay the Capitation Payment for Services and Deliverables rendered through the effective date of termination. All pertinent provisions of the Contract will form the basis of settlement.

(b) MCO must provide HHSC all reasonable access to records, facilities, and documentation as is required to efficiently and expeditiously close out the Services and Deliverables provided under the Contract.
(c) MCO must prepare a Turnover Plan, which is acceptable to and approved by HHSC. The Turnover Plan will be implemented during the time period between receipt of notice and the termination date.

Section 12.09 Modification of Contract in the event of remedies.

HHSC may propose a modification of the Contract in response to the imposition of a remedy under this Article. Any modifications under this Section must be reasonable, limited to the matters causing the exercise of a remedy, in writing, and executed in accordance with Article 8. MCO must negotiate such proposed modifications in good faith.

Section 12.10 Turnover assistance.

Upon receipt of notice of termination of the Contract by HHSC or by the MCO, MCO will provide any turnover assistance reasonably necessary to enable HHSC or its designee to effectively close out the Contract and move the work to another vendor or to perform the work itself.

During the Turnover Phase, MCO must continue performing under the Contract, including rendering all contracted Services, until such time HHSC determines that the MCO has completed all requirements in accordance with the Turnover Plan.

Section 12.11 Rights upon termination or expiration of Contract.

In the event that the Contract is terminated for any reason, or upon its expiration, HHSC will, at HHSC’s discretion, retain ownership of any and all associated work products, Deliverables, or documentation in whatever form that they exist.

Section 12.12 MCO responsibility for associated costs.

If HHSC terminates the Contract for Cause, the MCO will be responsible to HHSC for all reasonable costs incurred by HHSC, the State of Texas, or any of its administrative agencies to replace the MCO. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to MCO’s failure to perform any Service in accordance with the terms of the Contract.

Section 12.13 Dispute resolution.

(a) General agreement of the Parties.

The Parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the Parties employ all reasonable and informal means to resolve any dispute under the Contract. The Parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b) Duty to negotiate in good faith.

Any dispute that in the judgment of any Party to the Contract may materially or substantially affect the performance of any Party will be reduced to writing and delivered to the other Party. The Parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the Parties shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by Contract between the Parties shall be reduced to writing and delivered to all Parties within 10 Business Days.

(c) Claims for breach of Contract.

(1) General requirement. MCO’s claim for breach of the Contract will be resolved in accordance with the dispute resolution process established by HHSC in accordance with Chapter 2260, Texas Government Code.

(2) Negotiation of claims. The Parties expressly agree that the MCO’s claim for breach of the Contract that the Parties cannot resolve in the ordinary course of business or through the use of all reasonable and informal means will be submitted to the negotiation process provided in Chapter 2260, Subchapter B, Texas Government Code.

(i) To initiate the process, MCO must submit written notice to HHSC that specifically states that MCO invokes the provisions of Chapter 2260, Subchapter B, Texas Government Code. The notice must comply with the requirements of Title 1 Chapter 392, Subchapter B of the Texas Administrative Code.

(ii) The Parties expressly agree that the MCO’s compliance with Chapter 2260, Subchapter B, Texas Government Code, will be a condition precedent to the filing of a contested case proceeding under Chapter 2260, Subchapter C, of the Texas Government Code.

(3) Contested case proceedings. The contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be MCO’s sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by HHSC if the Parties are unable to resolve their disputes under Subsection (c)(2) of this Section.

The Parties expressly agree that compliance with the contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be a condition precedent to seeking consent to sue from the Texas Legislature under Chapter 107, Civil Practices & Remedies Code. Neither the execution of the Contract by HHSC nor any other conduct of any representative of HHSC relating to the Contract will be considered a waiver of HHSC’s sovereign immunity to suit.

(4) HHSC rules. The submission, processing, and resolution of MCO’s claim is governed by the
rules adopted by HHSC pursuant to Chapter 2260, Texas Government Code, found at Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(5) MCO’s duty to perform. Neither the occurrence of an event constituting an alleged breach of contract nor the pending status of any claim for breach of contract is grounds for the suspension of performance, in whole or in part, by MCO of any duty or obligation with respect to the performance of the Contract. Any changes to the Contract as a result of a dispute resolution will be implemented in accordance with Article 8 (“Amendments and Modifications”).

Section 12.14 Liability of MCO.

(a) MCO bears all risk of loss or damage to HHSC or the State due to:
   (1) Defects in Services or Deliverables;
   (2) Unfitness or obsolescence of Services or Deliverables; or
   (3) The negligence or intentional misconduct of MCO or its employees, agents, Subcontractors, or representatives.

(b) MCO must, at the MCO’s own expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC and State employees, officers, directors, contractors and agents from and against any losses, liabilities, damages, penalties, costs, fees, including without limitation reasonable attorneys’ fees, and expenses from any claim or action for property damage, bodily injury or death, to the extent caused by or arising from the negligence or intentional misconduct of the MCO and its employees, officers, agents, or Subcontractors. HHSC will not unreasonably withhold approval of counsel selected by MCO.

(c) MCO will not be liable to HHSC for any loss, damages, or liabilities attributable to or arising from the failure of HHSC or any state agency to perform a service or activity in connection with the Contract.

Article 13. Assurances and Certifications

Section 13.01 Proposal certifications.

MCO acknowledges its continuing obligation to comply with the requirements of the certifications contained in its Proposal, and will immediately notify HHSC of any changes in circumstances affecting these certifications.

Section 13.02 Conflicts of interest.

(a) Representation.

MCO agrees to comply with applicable state and federal laws, including 41 U.S.C. § 423, rules, and regulations regarding conflicts of interest in the performance of its duties under this Contract. MCO warrants that it has no interest and will not acquire any direct or indirect interest that would conflict in any manner or degree with its performance under this Contract.

(b) General duty regarding conflicts of interest.

MCO will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. MCO will operate with complete independence and objectivity without actual, potential, or apparent conflict of interest with respect to the activities conducted under this Contract with the State of Texas.

Section 13.03 Organizational conflicts of interest.

(a) Definition.

An organizational conflict of interest is a set of facts or circumstances, a relationship, or other situation under which an MCO, or a Subcontractor has past, present, or currently planned personal or financial activities or interests that either directly or indirectly:

   (1) Impairs or diminishes the MCO’s, or Subcontractor’s ability to render impartial or objective assistance or advice to HHSC; or
   (2) Provides the MCO or Subcontractor an unfair competitive advantage in future HHSC procurements (excluding the award of this Contract).

(b) Warranty.

Except as otherwise disclosed and approved by HHSC prior to the Effective Date of the Contract, MCO warrants that, as of the Effective Date and to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to an organizational conflict of interest affecting this Contract. MCO affirms that it has neither given nor intends to give any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, at any time during the procurement process, in connection with the procurement process, or at any time after Contract Execution, except as allowed under relevant state and federal law.

(c) Continuing duty to disclose.

(1) MCO agrees that, if after the Effective Date, MCO discovers or is made aware of an organizational conflict of interest, MCO will immediately and fully disclose such interest in writing to the HHSC project manager. In addition, MCO must promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by MCO or by HHSC as a potential conflict. HHSC reserves the right to make a final determination.
regarding the existence of conflicts of interest, and MCO agrees to abide by HHSC’s decision.

(2) The disclosure will include a description of the action(s) that MCO has taken or proposes to take to avoid or mitigate such conflicts.

(d) Remedy.

If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the Contract under the terms found in Subsection 12.03(b)(9). If HHSC determines that MCO was aware of an organizational conflict of interest before the award of this Contract and did not disclose the conflict to HHSC, the nondisclosure will be considered a material breach of the Contract. Furthermore, the breach may be submitted to the Office of the Attorney General, Texas Ethics Commission, or appropriate state or federal law enforcement officials for further action.

(e) Flow-down obligation.

MCO must include the provisions of this Section in all Subcontracts for work to be performed similar to the service provided by MCO, and the terms “Contract,” “MCO,” and “project manager” modified appropriately to preserve HHSC’s rights.

Section 13.04 HHSC personnel recruitment prohibition.

MCO has not retained or promised to retain any person or company, or utilized or promised to utilize a consultant that participated in HHSC’s development of specific criteria of the RFP or who participated in the selection of the MCO for this Contract.

Unless authorized in writing by HHSC, MCO will not recruit or employ any HHSC professional or technical personnel who have worked on projects relating to the subject matter of this Contract, or who have had any influence on decisions affecting the subject matter of this Contract, for two years following the completion of this Contract.

Section 13.05 Anti-kickback provisions.

MCO certifies that it will comply with the Anti-Kickback Act of 1986 (41 U.S.C. § 51–58), 42 U.S.C. § 1320a-7(b), and Federal Acquisition Regulation Subpart 52.203-7, to the extent applicable.

Section 13.06 Debt or back taxes owed to State of Texas.

In accordance with Tex. Gov’t Code § 403.055, MCO agrees that any payments due to MCO under the Contract will be first applied toward any debt or back taxes MCO owes the State of Texas. MCO further agrees that payments will be so applied until those debts and back taxes are paid in full.

Section 13.07 Certification regarding status of license, certificate, or permit.

Article IX, Section 163 of the General Appropriations Act for the 1998/1999 state fiscal biennium prohibits an agency that receives an appropriation under either Article II or V of the General Appropriations Act from awarding a contract with the owner, operator, or administrator of a facility that has had a license, certificate, or permit revoked by another Article II or V agency. MCO certifies it is not ineligible for an award under this provision.

Section 13.08 Outstanding debts and judgments.

MCO certifies that it is not presently indebted to the State of Texas, and that MCO is not subject to an outstanding judgment in a suit by the State of Texas against MCO for collection of the balance. For purposes of this Section, an indebtedness is any amount of money that is due and owing to the State of Texas and is not currently under dispute. A false statement regarding MCO’s status will be treated as a material breach of this Contract and may be grounds for termination at the option of HHSC.

Article 14. Representations and Warranties

Section 14.01 Authorization.

(a) The execution, delivery, and performance of this Contract has been duly authorized by MCO and no additional approval, authorization, or consent of any governmental or regulatory agency is required in order for MCO to enter into this Contract and perform its obligations under this Contract.

(b) MCO has obtained all licenses, certifications, permits, and authorizations necessary to perform the Services under this Contract and currently is in good standing with all regulatory agencies that regulate any or all aspects of MCO’s performance of this Contract. MCO will maintain all required certifications, licenses, permits, and authorizations during the term of this Contract.

Section 14.02 Ability to perform.

MCO warrants that it has the financial resources to fund the capital expenditures required under the Contract without advances by HHSC or assignment of any payments by HHSC to a financing source.

Section 14.03 Minimum Net Worth.

The MCO has, and will maintain throughout the life of this Contract, minimum net worth to the greater of (a) $1,500,000; (b) an amount equal to the sum of $25 times the number of all enrollees including Members; or (c) an amount that complies with standards adopted by TDI. Minimum net worth means the excess total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with Tex. Ins. Code Chapter 843.

Section 14.04 Insurer solvency.

(a) The MCO must be and remain in full compliance with all applicable state and federal solvency requirements, including those set forth in 42
Subject: Attachment A – STAR Health Contract Terms and Conditions

Section 14.05 Workmanship and performance.

(a) All Services and Deliverables provided under this Contract will be provided in a manner consistent with the standards of quality and integrity as outlined in the Contract.

(b) All Services and Deliverables must meet or exceed the required levels of performance specified in or under this Contract.

(c) MCO will perform the Services and provide the Deliverables in a workmanlike manner, in accordance with best practices and high professional standards used in well-managed operations performing services similar to the services described in this Contract.

Section 14.06 Warranty of deliverables.

MCO warrants that Deliverables developed and delivered under this Contract will meet in all material respects the specifications described in the Contract during the period following its acceptance by HHSC, throughout the term of the Contract, including any terms subsequently negotiated by MCO and HHSC. MCO will promptly repair or replace any Deliverables not in compliance with this warranty at no charge to HHSC.

Section 14.07 Compliance with Contract.

MCO will not take any action substantially or materially inconsistent with any of the terms set forth in this Contract without the express written approval of HHSC.

Section 14.08 Technology Access.

All technological solutions offered by the MCO must comply with the requirements of Tex. Gov’t Code § 531.0162. This includes providing technological solutions that meet federal accessibility standards for persons with disabilities, as applicable.

Section 14.09 Electronic and Information Resources Accessibility Standards.

(a) Applicability.
The following Electronic and Information Resources (EIR) requirements apply to the Contract because the MCO performs services that include EIR that: (i) HHSC employees are required or permitted to access; or (ii) members of the public are required or permitted to access. This Section does not apply to incidental uses of EIR in the performance of a Contract, unless the Parties agree that the EIR will become property of the State of Texas or will be used by HHSC’s clients or recipients after completion of the Contract. Nothing in this section is intended to prescribe the use of particular designs or technologies or to prevent the use of alternative technologies, provided they result in substantially equivalent or greater access to and use of a Product.

(b) Definitions.

For purposes of this Section:
“Accessibility Standards” means the Electronic and Information Resources Accessibility Standards and the Web Site Accessibility Standards/Specifications.
“Electronic and Information Resources” means information resources, including information resources technologies, and any equipment or interconnected system of equipment that is used in the creation, conversion, duplication, or delivery of data or information. The term includes telephones and other telecommunications products, information kiosks, transaction machines, Internet websites, multimedia resources, and office equipment, including copy machines and fax machines.
“Electronic and Information Resources Accessibility Standards” means the accessibility...
standards for electronic and information resources contained in 1 Tex. Admin. Code Chapter 213. “Web Site Accessibility Standards/Specifications” means standards contained in 1 Tex. Admin. Code Chapter 206. “Product” means information resources technology that is, or is related to, EIR.

(c) Accessibility Requirements.
Under Tex. Gov’t Code Chapter 2054, Subchapter M, and implementing rules of the Texas Department of Information Resources, HHSC must procure Products that comply with the Accessibility Standards when those Products are available in the commercial marketplace or when those Products are developed in response to a procurement solicitation. Accordingly, MCO must provide electronic and information resources and associated Product documentation and technical support that comply with the Accessibility Standards.

(d) Evaluation, Testing, and Monitoring.
(1) HHSC may review, test, evaluate and monitor MCO's Products and associated documentation and technical support for compliance with the Accessibility Standards. Review, testing, evaluation and monitoring may be conducted before and after the award of a contract. Testing and monitoring may include user acceptance testing. Neither (1) the review, testing (including acceptance testing), evaluation or monitoring of any Product, nor (2) the absence of review, testing, evaluation or monitoring, will result in a waiver of the State's right to contest the MCO's assertion of compliance with the Accessibility Standards.

(2) MCO agrees to cooperate fully and provide HHSC and its representatives timely access to Products, records, and other items and information needed to conduct such review, evaluation, testing, and monitoring.

(e) Representations and Warranties.
(1) MCO represents and warrants that: (i) as of the Effective Date of the Contract, the Products and associated documentation and technical support comply with the Accessibility Standards as they exist at the time of entering the Contract, unless and to the extent the Parties otherwise expressly agree in writing; and (ii) if the Products will be in the custody of the State or an HHS Agency's client or recipient after the Contract expiration or termination, the Products will continue to comply with Accessibility Standards after the expiration or termination of the Contract Term, unless HHSC or its clients or recipients, as applicable, use the Products in a manner that renders it noncompliant.

(2) In the event MCO should have known, becomes aware, or is notified that the Product and associated documentation and technical support do not comply with the Accessibility Standards, MCO represents and warrants that it will, in a timely manner and at no cost to HHSC, perform all necessary steps to satisfy the Accessibility Standards, including remediation, replacement, and upgrading of the Product, or providing a suitable substitute.

(3) MCO acknowledges and agrees that these representations and warranties are essential inducements on which HHSC relies in awarding this Contract.

(4) MCO's representations and warranties under this subsection will survive the termination or expiration of the Contract and will remain in full force and effect throughout the useful life of the Product.

(f) Remedies.
(1) Under Tex. Gov’t Code § 2054.465, neither MCO nor any other person has cause of action against HHSC for a claim of a failure to comply with Tex. Gov’t Code Chapter 2054, Subchapter M, and rules of the Department of Information Resources.

(2) In the event of a breach of MCO's representations and warranties, MCO will be liable for direct, consequential, indirect, special, or liquidated damages and any other remedies to which HHSC may be entitled under this Contract and other applicable law. This remedy is cumulative of any other remedies to which HHSC may be entitled under this Contract and other applicable law.

Article 15. Intellectual Property

Section 15.01 Infringement and misappropriation.

(a) MCO warrants that all Deliverables provided by MCO will not infringe or misappropriate any right of, and will be free of any claim of, any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

(b) MCO will, at its expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC, its employees, officers, directors, contractors, and agents from and against any losses, liabilities, damages, penalties, costs, fees, including reasonable attorneys' fees and expenses, from any claim or action against HHSC that is based on a claim of breach of the warranty according to this section. HHSC will promptly notify MCO in writing of the claim, provide MCO a copy of all information received by HHSC with respect to the claim, and cooperate with MCO in defending or settling the claim. HHSC will not unreasonably withhold, delay, or condition approval of counsel selected by the MCO.

(c) In case the Deliverables, or any one or part of them, is held to constitute an infringement or misappropriation in an action, or the use is enjoined or restricted or if a proceeding appears to MCO to be likely to be brought, MCO will, at its own expense, either:

(1) Procure for HHSC the right to continue using the Deliverables; or

Page 60
Section 15.02 Exceptions.

MCO is not responsible for any claimed breaches of the warranties set forth in Section 15.01 to the extent caused by:

(a) Modifications made to the item in question by anyone other than MCO or its Subcontractors, or modifications made by HHSC or its contractors working at MCO’s direction or in accordance with the specifications; or

(b) The combination, operation, or use of the item with other items if MCO did not supply or approve for use with the item; or

(c) HHSC’s failure to use any new or corrected versions of the item made available by MCO.

Section 15.03 Ownership and Licenses

(a) Definitions.

For purposes of this Section, the following terms have the meanings set forth below:

(1) “Custom Software” means any software or modifications developed by the MCO; for HHSC; in connection with the Contract; and with funds received from HHSC. The term does not include MCO Proprietary Software or Third-Party Software.

(2) “MCO Proprietary Software” means: (i) software developed by the MCO prior to the Effective Date of the Contract, or (ii) software, modifications to software, or independent software developed by the MCO after the Effective Date of the Contract that is not developed for HHSC in connection with the Contract with funds received from HHSC.

(3) “Third-Party Software” means software that is: developed for general commercial use; available to the public; or not developed for HHSC. Third-Party Software includes without limitation: commercial off-the-shelf software; operating system software; and application software, tools, and utilities.

(4) “Foster Care Program Hardware” means hardware for which its total cost was paid for with funds received by HHSC and that was purchased by MCO in connection with the Contract.

(b) Deliverables.

The Parties agree that any Deliverable, including without limitation the Custom Software, will be the exclusive property of HHSC.

(c) Ownership rights.

(1) HHSC will own all right, title, and interest in and to its Confidential Information, Foster Care Program Hardware, and the Deliverables provided by the MCO, including the Custom Software and associated documentation. For purposes of this Section, the Deliverables will not include MCO Proprietary Software or Third-Party Software. MCO will take all necessary actions and transfer ownership of the Deliverables to HHSC, including the Custom Software and associated documentation prior to Contract termination.

(2) MCO will furnish these Deliverables, upon request of HHSC, in accordance with applicable state law. All Deliverables, in whole and in part, will be deemed works made for hire of HHSC for all purposes of copyright law, and copyright will belong solely to HHSC. To the extent that any Deliverable does not qualify as a work for hire under applicable law, and to the extent that the Deliverable includes materials subject to copyright, patent, trade secret, or other proprietary right protection, MCO agrees to assign, and hereby assigns, all right, title, and interest in and to Deliverables, including all copyrights, inventions, patents, trade secrets, and other proprietary rights (including renewals) to HHSC.

(3) MCO will, at the expense of HHSC, assist HHSC or its nominees to obtain copyrights, trademarks, or patents for all of these Deliverables in the United States and any other countries. MCO agrees not to assert any moral rights under applicable copyright law with regard to these Deliverables.

(d) License Rights

HHSC will have a royalty-free and non-exclusive license to access the MCO Proprietary Software and associated documentation during the term of the Contract. HHSC will also have ownership and unlimited rights to use, disclose, duplicate, or publish all information and data developed, derived, documented, or furnished by MCO under or resulting from the Contract. The data will include all results, technical information, and materials developed for or obtained by HHSC from MCO in the performance of the Services under this Contract, including all reports, surveys, plans, charts, recordings (video or sound), pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the Services performed as a result of the Contract.

(e) Proprietary Notices

MCO will reproduce and include HHSC’s copyright and other proprietary notices and product
identifications provided by MCO on the copies, in whole or in part, or on any form of the Deliverables.

(f) State and Federal Governments

In accordance with 45 C.F.R. § 95.617, all appropriate state and federal agencies will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use, for federal government purposes, all materials, the Custom Software and modifications of it, and associated documentation designed, developed, or installed with federal financial participation under the Contract, including those materials covered by copyright and all software source and object code, instructions, files, and documentation.

Article 16. Liability

Section 16.01 Property damage.

(a) MCO will protect HHSC’s real and personal property from damage arising from MCO’s, its agent’s, employees’ and Subcontractors’ performance of the Contract, and MCO will be responsible for any loss, destruction, or damage to HHSC’s property that results from or is caused by MCO’s, its agents’, employees’ or Subcontractors’ negligent or wrongful acts or omissions. Upon the loss of, destruction of, or damage to any property of HHSC, MCO will notify the HHSC Project Manager and, subject to direction from the Project Manager or her or his designee, will take all reasonable steps to protect that property from further damage.

(b) MCO agrees to observe and encourage its employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

(c) MCO will distribute a policy statement to all of its employees and agents that directs the employee or agent to promptly report to HHSC or to MCO any special defect or unsafe condition encountered while on HHSC premises. MCO will promptly report to HHSC any special defect or an unsafe condition it encounters or otherwise learns about.

Section 16.02 Risk of Loss.

During the period Deliverables are in transit and in possession of MCO, its carriers, or HHSC prior to being accepted by HHSC, MCO will bear the risk of loss or damage, unless the loss or damage is caused by the negligence or intentional misconduct of HHSC. After HHSC accepts a Deliverable, HHSC will bear the risk of loss or damage to the Deliverable, except loss or damage attributable to the negligence or intentional misconduct of MCO’s agents, employees, or Subcontractors.

Section 16.03 Limitation of HHSC’s Liability.

HHSC will not be liable for any incidental, indirect, special, or consequential damages under contract, tort, including negligence, or other legal theory. This will apply regardless of the cause of action and even if HHSC has been advised of the possibility of these damages.

HHSC’S liability to MCO under the contract will not exceed the total charges to be paid by HHSC to MCO under the contract, including change order prices agreed to by the parties or otherwise adjudicated.

MCO’s remedies are governed by the provisions in Article 12 (Remedies and Disputes).

Article 17. Insurance and Bonding

Section 17.01 Insurance Coverage.

(a) Statutory and General Coverage

MCO will maintain, at the MCO’s expense, the following insurance coverage

(1) Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles for bodily injury and property damage;

(2) Comprehensive General Liability Insurance of at least $1,000,000.00 per occurrence and $5,000,000.00 in the aggregate (including Bodily Injury coverage of $100,000.00 per each occurrence and Property Damage Coverage of $25,000.00 per occurrence); and

(3) If MCO’s current Comprehensive General Liability insurance coverage does not meet the above stated requirements, MCO will obtain Umbrella liability insurance to compensate for the difference in the coverage amounts. If Umbrella Liability Insurance is provided, it must follow the form of the primary coverage.

(b) Professional Liability Coverage.

(1) MCO must maintain, or cause its Network Providers to maintain, Professional Liability Insurance for each Network Provider of $100,000.00 per occurrence and $300,000.00 in the aggregate, or the limits required by the hospital at which the Network Provider has admitting privileges.

(2) MCO must maintain an Excess Professional Liability (Errors and Omissions) Insurance Policy for the greater of $3,000,000.00 or an amount (rounded to the nearest $100,000.00) that represents the number of Members enrolled in the MCO in the first month of the applicable State Fiscal Year multiplied by $150.00, not to exceed $10,000,000.00.

(c) General Requirements for All Insurance Coverage
(1) Except as provided in this subsection, all exceptions to the Contract’s insurance requirements must be approved in writing by HHSC. HHSC’s written approval is not required in the following situations:

(A) An MCO is not prohibited from requiring a Network Provider to obtain the insurance coverage described in Section 17.01 if the Network Provider qualifies as a state governmental unit or municipality under the Texas Tort Claims Act, and is required to comply with, and subject to the provisions of, the Texas Tort Claims Act.

(B) An MCO may waive the Professional Liability Insurance requirement described in Section 17.01(b)(1) for a Network Provider of Community-based Long Term Care Services. An MCO may not waive this requirement if the Network Provider provides other Covered Services in addition to Community-based Long Term Care Services, or if a Texas licensing entity requires the Network Provider to carry Professional Liability coverage. An MCO that waives the Professional Liability Insurance requirement for a Network Provider under this provision is not required to obtain coverage on behalf of the Network Provider.

(C) An MCO may waive the Professional Liability Insurance requirement described in Section 17.01(b)(1) for Network Providers of durable medical equipment. An MCO that waives the Professional Liability Insurance requirement for a Network Provider pursuant to this provision is not required to obtain such coverage on behalf of the Network Provider.

(2) The MCO or the Network Provider is responsible for any deductibles stated in the insurance policies.

(3) Insurance coverage must be issued by insurance companies authorized to conduct business in the State of Texas.

(4) With the exception of Professional Liability Insurance maintained by Network Providers, all insurance coverage must name HHSC as an additional insured. In addition, the Professional Liability Insurance maintained by Network Providers and Business Automobile Liability Insurance must name HHSC as a loss payee.

(5) Insurance coverage kept by the MCO must be maintained in full force at all times during the Term of the Contract, and until HHSC’s final acceptance of all Services and Deliverables. Failure to maintain insurance coverage will constitute a material breach of this Contract.

(6) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must have extended reporting periods of two years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.

(7) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must provide that prior written notice be given to HHSC at least 30 Days before coverage is reduced below minimum HHSC contractual requirements, canceled, or non-renewed. The MCO must submit a new coverage binder to HHSC to ensure no break in coverage.

(8) The Parties understand and agree that any insurance coverages and limits furnished by the MCO will in no way expand or limit the MCO’s liabilities and responsibilities specified within the Contract documents or by applicable law.

(9) The MCO understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by the MCO under the Contract.

(10) If the MCO, or its Network Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, the MCO or its Network Providers will be responsible for the acquisition and cost of such additional protection. This additional protection will not be an Allowable Expense under this Contract.

(11) MCO will require all insurers to waive their rights of subrogation against HHSC for claims arising from or relating to this Contract.

(d) Proof of Insurance Coverage

(1) Except as provided in Section 17.01(d)(2), the MCO must furnish the HHSC Project Manager original Certificates of Insurance evidencing the required insurance coverage on or before the Effective Date of the Contract. If insurance coverage is renewed during the Term of the Contract, the MCO must furnish the HHSC Project Manager renewal certificates of insurance, or such similar evidence, within five Business Days of renewal. The failure of HHSC to obtain this evidence from the MCO will not be deemed to be a waiver by HHSC and the MCO will remain under continuing obligation to maintain and provide proof of insurance coverage.

(2) The MCO is not required to furnish the HHSC Project Manager proof of Professional Liability Insurance maintained by Network Providers on or before the Effective Date of the Contract, but must provide that information upon HHSC’s request during the Term of the Contract.
Section 17.02 Performance Bond.

(a) Beginning on the Operational Start Date of the Contract, the MCO must obtain a performance bond with a one-year term. The performance bond must be renewable and renewal must occur no later than the first day of each subsequent State Fiscal Year. The performance bond must continue to be in effect for one year following the expiration of the final renewal period or the date the contract terminates. MCO must obtain and maintain the annual performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, securing MCO’s faithful performance of the terms of this Contract. The performance bond must comply with Tex. Insurance Code Chapter 843. At least one performance bond must be issued. The amount of the performance bond(s) should total $100,000.00 for the MCO Program covered under this Contract. Performance bonds must be issued by a surety licensed by TDI and specify cash payment as the sole remedy. MCO must deliver the initial performance bond to HHSC prior to the Operational Start Date of the Contract and each renewal prior to the first day of the State Fiscal Year.

(b) Prior performance bonds received for a specific SFY will be released upon completion of the audit of the 334-day FSR for the corresponding SFY.

Section 17.03 TDI Fidelity Bond.

The MCO will secure and maintain throughout the life of the Contract a fidelity bond in compliance with Tex. Insurance Code Chapter 843. The MCO must promptly provide HHSC with copies of the bond and any amendments or renewals.
## DOCUMENT HISTORY LOG

<table>
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<th>STATUS¹</th>
<th>DOCUMENT REVISION²</th>
<th>EFFECTIVE DATE</th>
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<td>Baseline</td>
<td>2.0</td>
<td>July 1, 2015</td>
<td>Initial version of Attachment B-1, RFP Sections 1 – 5, “Introduction; Procurement Strategy; General Instructions &amp; Requirements; Submission Requirements; and Evaluation Process &amp; Criteria” that includes all modifications negotiated by the Parties.</td>
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<td>Revision</td>
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<td>September 1, 2015</td>
<td>Contract amendment did not revise Attachment B-1, Sections 1 – 5, “Introduction; Procurement Strategy; General Instructions &amp; Requirements; Submission Requirements; and Evaluation Process &amp; Criteria.”</td>
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<td>March 1, 2016</td>
<td>All references to “abuse and neglect” are changed to “Abuse, Neglect, and Exploitation.”</td>
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<td>September 1, 2016</td>
<td>Section 1.8 is modified to remove the FFCHE program.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.4</td>
<td>March 1, 2017</td>
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<tr>
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<tr>
<td>Revision</td>
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<td>March 1, 2018</td>
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<td>September 1, 2018</td>
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<td>January 1, 2019</td>
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1 Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.
2 Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
3 Brief description of the changes to the document made in the revision.
Table of Contents

1    GENERAL INFORMATION ....................................................................................... 8
1.1.  Scope .................................................................................................................... 8
1.2.  Point-of-Contact ................................................................................................. 8
1.3.  Procurement Schedule ....................................................................................... 8
1.4.  Purpose ................................................................................................................ 9
1.5.  Mission Statement .............................................................................................. 9
1.6.  Mission Objectives ............................................................................................. 9
1.6.1. Network Adequacy and Access to Care ....................................................... 10
1.6.2. Behavioral Health Services ........................................................................... 10
1.6.3. Service Management and Service Coordination .......................................... 10
1.6.4. Medical Home ............................................................................................... 10
1.6.5. Timeliness of Initial Texas Health Steps Visit ............................................. 10
1.6.6. Health Passport ............................................................................................ 11
1.6.7. Timeliness of Claims Payments ...................................................................... 11
1.7.  STAR Health Overview .................................................................................... 11
1.7.1. Child Protective Services and Substitute Care in Texas .............................. 12
1.8.  Eligible Population ............................................................................................. 13
1.9.  Authorization ..................................................................................................... 13
1.10. Eligible Respondents ....................................................................................... 13
1.11. Contract Term .................................................................................................. 14
1.12. Development of Contracts ............................................................................... 14
2    PROCUREMENT STRATEGY AND APPROACH .............................................. 15
2.1.  Risk-Based Contract ......................................................................................... 15
2.2.  HHSC Model Management Strategy .................................................................. 16
2.3.  Performance Measures and Associated Remedies ........................................... 17
3    GENERAL INSTRUCTIONS AND REQUIREMENTS .................................... 18
3.1.  Strategic Elements ............................................................................................ 18
3.1.1. Contract Elements ........................................................................................ 18
3.1.2. HHSC’s Basic Philosophy: Contracting for Results ..................................... 18
3.2.  External Factors ................................................................................................ 18
3.3 Legal and Regulatory Constraints ............................................................... 18
3.3.1 Delegation of Authority ........................................................................ 18
3.3.2 Conflicts of Interest ............................................................................. 19
3.3.3 Former Employees of a State Agency ..................................................... 19
3.4 HHSC Amendments and Announcements Regarding this RFP ............... 20
3.5 RFP Cancellation/Partial Award/Non-Award ............................................. 20
3.6 Right to Reject Proposals or Portions of Proposals .................................... 20
3.7 Costs Incurred ......................................................................................... 20
3.8 Respondent Protest Procedures ................................................................. 20
3.9 Vendor Conference .................................................................................. 21
3.10 Questions and Comments ....................................................................... 21
3.11 Modification or Withdrawal of Proposal .................................................. 21
3.12 News Releases ....................................................................................... 22
3.13 Incomplete Proposals ............................................................................. 22
3.14 State Use of Ideas .................................................................................. 22
3.15 Property of HHSC ................................................................................ 22
3.16 Copyright Restriction ............................................................................. 22
3.17 Additional Information .......................................................................... 22
3.18 Multiple Proposals ............................................................................... 23
3.19 No Joint Proposals ............................................................................... 23
3.20 Use of Subcontractors .......................................................................... 23
3.21 Texas Public Information Act .................................................................. 23
3.22 Inducements ......................................................................................... 24
3.23 Definition of Terms ............................................................................... 24
4 Submission Requirements ........................................................................ 25
4.1 Part 1 - General Instructions ................................................................... 25
4.1.1 Economy of Presentation ...................................................................... 25
4.1.2 Number of Copies and Packaging ....................................................... 26
4.1.3 Due Date, Time, and Location ............................................................... 27
4.2 Part 2 - Business Proposal ....................................................................... 27
4.2.1 Section 1 – Executive Summary ......................................................... 27
4.2.2 Section 2 – Respondent Identification and Information ....................... 28
4.2.3 Section 3 - Corporate Background and Experience .................................................. 30
4.2.3.1 Organizational Chart .......................................................................................... 30
4.2.3.2 Résumés .......................................................................................................... 31
4.2.3.4 Financial Capacity ............................................................................................ 32
4.2.3.5 Financial Report of Parent Organization and Corporate Guarantee .......... 34
4.2.3.6 Bonding ............................................................................................................ 34
4.2.4 Section 4 – Material Subcontractor Information .................................................... 35
4.2.5 Section 5 – Historically Underutilized Business (HUB) Participation .................. 37
4.2.5.1 Introduction ....................................................................................................... 37
4.2.5.2 HHSC’s Administrative Rules ........................................................................... 37
4.2.5.3 HUB Participation Goal ..................................................................................... 37
4.2.5.4 Required HUB Subcontracting Plan ................................................................. 38
4.2.5.5 CPA Centralized Master Bidders List (CMBL) .................................................. 38
4.2.5.6 HUB Subcontracting Procedures – If a Respondent Intends to Subcontract ........ 39
4.2.5.7 HUB Subcontracting Procedures – If a Respondent Does Not Intend to Subcontract 41
4.2.5.8 Post-award HSP Requirements ......................................................................... 42
4.2.6 Section 6 – Certifications and Other Required Forms .......................................... 43
4.3 Part 3 – Programmatic Proposal ............................................................................. 43
4.3.1 Section 1 – Proposed Capacity ............................................................................ 45
4.3.2 Section 2 – Experience Providing Covered Services ........................................... 45
4.3.3 Section 3 – Value-added and Case-by-Case Added Services ............................. 46
4.3.3.1 Value-Added Services ...................................................................................... 46
4.3.3.2 Case-by-Case Added Services ......................................................................... 46
4.3.4 Section 4 – Access to Care ................................................................................. 47
4.3.4.1 Travel Distances ............................................................................................... 47
4.3.4.2 Assessing Access to Care ................................................................................ 47
4.3.5 Section 5 – Provider Network Provisions ............................................................. 48
4.3.5.1 Provider Network .............................................................................................. 49
4.3.5.2 Significant Traditional Providers (STPs) ........................................................... 50
4.3.5.3 Provider Network Capacity .................................................................50
4.3.5.4 Credentialing and Re-credentialing ....................................................50
4.3.5.5 Provider Training ...............................................................................51
4.3.5.6 Provider Hotline ...............................................................................52
4.3.5.7 Provider Incentives ..........................................................................53
4.3.5.8 Medical Advisory Committees (MACs) .................................................53
4.3.6 Section 6 – Member Services .................................................................53
4.3.6.1 Member Services Staffing .................................................................53
4.3.6.2 Member Hotline ...............................................................................54
4.3.6.3 Member Service Scenarios .................................................................55
4.3.6.4 Nurse Hotline ...................................................................................56
4.3.6.5 Nurse Hotline Scenarios .................................................................57
4.3.6.6 STAR Health Liaisons .......................................................................58
4.3.6.8 Cultural Competency .......................................................................59
4.3.6.9 Continuity of Care ............................................................................59
4.3.6.9 Objection to Providing Certain Services ............................................60
4.3.6.10 Member Complaint, Pre-Appeal and Appeal Processes ......................60
4.3.6.11 Marketing Activities and Prohibited Practices ..................................61
4.3.7 Section 7 – Quality Assessment and Performance Improvement ...............61
4.3.7.1 Clinical Initiatives .............................................................................61
4.3.7.2 Healthcare Effectiveness Data and Information Set (HEDIS) and Other Quality Data 62
4.3.7.3 Clinical Practice Guidelines ...............................................................62
4.3.7.4 Provider Profiling .............................................................................63
4.3.7.5 Network Management .....................................................................63
4.3.8 Section 8 – Utilization Management (UM) ..............................................64
4.3.9 Section 9 – Early Childhood Intervention (ECI) ......................................64
4.3.10 Section 10 – Health Passport ...............................................................64
4.3.11 Section 11 – Service Management and Service Coordination ...............65
4.3.12 Section 12 – Health Home ..................................................................66
4.3.13 Section 13 – Disease Management (DM) ..............................................67
4.3.14 Section 14 – Behavioral Health (BH) Services .................................................. 67
4.3.14.1 Behavioral Health (BH) Services Hotline ..................................................... 67
4.3.14.2 Behavioral Health (BH) Hotline Scenarios .................................................... 68
4.3.14.3 Health Provider Network Expertise ............................................................. 69
4.3.14.4 Coordination of Behavioral Health (BH) Care ............................................. 69
4.3.14.5 Behavioral Health (BH) Quality Management ............................................ 69
4.3.14.6 Utilization Management (UM) for Behavioral Health (BH) Services ............. 70
4.3.14.7 Behavioral Health (BH) Emergency Services .............................................. 70
4.3.14.8 Telemedicine .............................................................................................. 70
4.3.15 Section 15 – Pharmacy Services ..................................................................... 70
4.3.16 Section 16 – Management Information System (MIS) Requirements ............. 71
4.3.17 Section 17 – Fraud, Waste, and Abuse ............................................................ 72
4.3.18 Section 18 – Transition Plan .......................................................................... 72
5 EVALUATION PROCESS AND CRITERIA .................................................. 74
5.1 Evaluation of Proposals ...................................................................................... 74
5.2 Evaluation Criteria............................................................................................. 74
5.3 Initial Compliance Screening ............................................................................. 76
5.4 Competitive Field Determinations ...................................................................... 76
5.5 Oral Presentations and Site Visits ....................................................................... 76
5.6 Best and Final Offers ......................................................................................... 76
5.7 Discussions with Respondents .......................................................................... 76
1 GENERAL INFORMATION

1.1. Scope

The State of Texas, by and through the Health and Human Services Commission (HHSC), announces the release of request for proposal (RFP) # 529-15-0001 for STAR Health managed care services.

Public comments concerning the RFP are subject to public disclosure under the Public Information Act, Texas Government Code Chapter 552.

1.2. Point-of-Contact

The sole point-of-contact for inquiries concerning this RFP is the following.

Rick Blincoe, CTPM  
Procurement and Contract Services  
Health and Human Services Commission  
4405 N Lamar  
Austin, TX 78756  
Phone: (512) 206-5468  
richard.blincoe@hhsc.state.tx.us

Respondents must direct all communications relating to this RFP to the HHSC point-of-contact named above. All other communications between a Respondent and HHSC and the HHS agencies, their agents, employees, or contractors concerning this RFP are prohibited. In no instance is a Respondent to discuss cost information contained in a proposal with the HHSC point-of-contact or any other staff. Failure to comply with this requirement may result in HHSC’s disqualification of the proposal.

Only the HHSC point-of-contact can clarify issues and render any opinion regarding this RFP. No other individual HHSC employee or state employee is empowered to make binding statements regarding this RFP. No statements, clarifications, or opinions regarding this RFP are valid or binding except those issued in writing by the HHSC point-of-contact and posted on HHSC’s website at http://www.hhsc.state.tx.us/about_hhsc/BusOpp/BO_opportunities.asp.

1.3. Procurement Schedule

The anticipated schedule for this procurement is as follows. HHSC reserves the right to revise this schedule. Any revisions will be posted on the HHSC website at http://www.hhsc.state.tx.us/about_hhsc/BusOpp/BO_opportunities.asp.
### Procurement Schedule

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<td>February 6, 2014</td>
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<td>Draft RFP Respondent Comments Due</td>
<td>February 20, 2014</td>
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<td>RFP Release Date</td>
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<td>April 29, 2014  2:00 p.m. CDT</td>
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<td>Respondent Questions Due</td>
<td>May 9, 2014</td>
</tr>
<tr>
<td>Letters Claiming Mandatory Contract Status Due</td>
<td>May 9, 2014</td>
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<tr>
<td>HHSC Posts Responses to Respondent Questions</td>
<td>May 16, 2014</td>
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<tr>
<td>Proposals Due</td>
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<tr>
<td>Deadline for Proposal Withdrawal</td>
<td>June 13, 2014</td>
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<tr>
<td>Respondent Demonstrations/Oral Presentations (HHSC option)</td>
<td>To be Announced</td>
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<tr>
<td>Tentative Award Announcement</td>
<td>To be Announced</td>
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<tr>
<td>Anticipated Contract Effective Date</td>
<td>March 1, 2015</td>
</tr>
<tr>
<td>Operational Start Date</td>
<td>September 1, 2015</td>
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#### 1.4. Purpose

The purpose of this procurement is to contract with one Managed Care Organization (MCO) to manage a statewide STAR Health Program.

#### 1.5. Mission Statement

HHSC’s mission in this procurement is:
1. To ensure continuous delivery of integrated physical and Behavioral Health Services, centralize Service Coordination, and effectively manage healthcare data and information;
2. to ensure the STAR Health population is provided with a consistent source of healthcare through a Medical Home; and
3. to continue to improve health care outcomes for children in foster care through enhanced quality of services.

#### 1.6. Mission Objectives

To accomplish HHSC’s mission, HHSC will prioritize desired outcomes and benefits for the STAR Health population and will focus its monitoring efforts on the MCOs’ ability to provide satisfactory results for these mission objectives.
1.6.1. Network Adequacy and Access to Care

HHSC intends that all Members have timely access to quality care through a Provider Network designed to meet the needs of the STAR Health population. The MCO will be accountable for creating and maintaining a Network capable of delivering all Covered Services to Members throughout the State of Texas. The MCO must provide Members with access to qualified Network Providers within the travel distance and waiting time for appointment standards defined in this RFP. Refer to RFP Section 8.1.3.2, “Access to Network Providers,” for travel distance standards and RFP Section 8.1.3.1, “Waiting Times for Appointments,” for waiting time standards. HHSC will especially focus on Members’ access to dental and Behavioral Health Services.

1.6.2. Behavioral Health Services

The MCO must focus on access to, and delivery of, Behavioral Health Services. The MCO must provide Members with timely access to Medically Necessary Behavioral Health Services, such as mental health and substance abuse treatment and counseling, as well as timely and appropriate follow-up care. Contract requirements emphasize the importance of integration of care and formal, regular communication between Providers for Members who need assessment and evaluation for behavioral health concerns, or who are receiving both primary physical health and Behavioral Health Services. The Provider Network must include Providers experienced in treating victims of child Abuse, Neglect, and Exploitation, and Providers who specialize in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and other evidence-based treatments.

1.6.3. Service Management and Service Coordination

The MCO must ensure coordinated and integrated health care for Members through a Medical Home. Service Managers will assist Primary Care Providers (PCPs) in managing clinical services for Members with needs that require specialty care. The MCO will be responsive to inquiries and requests from the Department of Family and Protective Services (DFPS) Staff, Members, and Caregivers. The Service Coordinators will provide information to DFPS Staff, Members, and Caregivers, and assist these parties with accessing non-clinical services.

1.6.4. Medical Home

HHSC is committed to providing a consistent source of healthcare for the STAR Health population through a Medical Home. The MCO must develop and uphold the Medical Home model through the management and coordination of Healthcare Services.

1.6.5. Timeliness of Initial Texas Health Steps Visit

Except as provided below, the Network Providers must provide an initial Texas Health Steps medical checkup within 30 days of enrollment for all Members through the month of their 21st birthday. Network Providers must provide an initial Texas Health Steps dental checkup within 60 days of enrollment for Members who are between six months through 21 (until the end of the month of their 21st birthday). Network Providers must provide Members who are less than six months’ old
at the time of enrollment their initial Texas Health Steps dental checkup within 30 days of their turning six months’ old.

1.6.6. Health Passport

The MCO must develop and maintain an electronic Health Passport for Members to ensure that health information provided to DFPS Staff, DFPS residential contractors, Single Source Continuum Contractor (SSCC) staff, the court system, Court Appointed Special Advocate (CASA) staff, Network Providers, Members, and Medical Consenters is timely, portable, and readily accessible.

1.6.7. Timeliness of Claims Payments

A key element of an MCO’s success is the ability to ensure that Network Providers receive timely and fair payment for services rendered. MCOs must pay Clean Claims and appealed claims on a timely basis, as well as resolve Pended Claims in a timely manner. HHSC will require strict adherence to basic claims processing standards.

1.7. STAR Health Overview

Children and young adults in the STAR Health population often have significant healthcare needs. While they may have multiple and complex physical health, mental health, and developmental needs, they also have health needs similar to those of all children, requiring well-child health care, immunizations, and the treatment of acute childhood illnesses. Children and young adults in the STAR Health population may have health problems associated with poverty, such as low birth weight and malnutrition. They are also at risk for conditions associated with parental neglect, physical or sexual abuse, parental substance abuse or mental illness, and the separation and loss associated with out-of-home care.¹

In 2005, the Texas Legislature addressed the special healthcare needs of the STAR Health population in Senate Bill 6². HHSC designed a comprehensive, cost-effective medical services delivery model to meet the STAR Health population’s physical and behavioral health needs as required.³ On April 1, 2008, HHSC launched the STAR Health program as the first comprehensive health and medical network for children and young adults who are, or were formerly, in the state’s foster care system. The goal is to give each of these children and young adults Healthcare Services that are coordinated, comprehensive, easy to find, and uninterrupted when the child moves.

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

² Senate Bill 6, 79th Legislature, Regular Session, 2005.
³ Section 1.65 of Senate Bill 6, codified in Texas Family Code, Chapter 266, effective September 1, 2005
1.7.1. Child Protective Services and Substitute Care in Texas

Through its Child Protective Services (CPS) Program, DFPS provides child welfare services to the state’s children and families. CPS is responsible for conducting civil investigations of reported child Abuse, Neglect, and Exploitation; protecting children from Abuse, Neglect, and Exploitation; promoting the safety, integrity, and stability of families; and providing permanent placements for children who cannot safely remain with their own families.4 State law requires anyone who suspects a child is being abused or neglected to report his or her concerns to the DFPS abuse hotline (1-800-252-5400).

When CPS can reasonably assure child safety, CPS provides in-home services to help stabilize the family and reduce the risk of future abuse or neglect. When it is not safe for children to live with their own families, CPS petitions the court to remove the children from their homes. CPS may temporarily place a child with relatives, a verified substitute family, an emergency shelter, a specialized group home, a residential treatment center, or other licensed residential child-care facilities. CPS is required to provide all medical, dental, and therapeutic services needed by the child.5

After CPS removes children from their home and places the children in the state’s custody, 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.6

In 2011, the Texas Legislature addressed the redesign of the Child Protective Services and foster care systems in Senate Bill 2187. DFPS, along with various child welfare stakeholders, developed a redesigned foster care system that would address existing problems and improve permanency outcomes for children and youth. The foundation of this redesigned foster care system rests primarily upon eight quality indicators:

1. First and foremost, children are safe in their placements.
2. Children are placed in their home communities.
3. Children are appropriately served in the least restrictive environment that supports minimal moves for the child.
4. Connections to family and others important to the child are maintained.
5. Children are placed with siblings.
6. Services respect the child’s culture.
7. To be fully prepared for successful adulthood, children and youth are provided opportunities, experiences, and activities similar to those experienced by their non-foster care peers.
8. Children and youth are provided opportunities to participate in decisions that impact their lives.

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7 Senate Bill 218, 82nd Legislature, Regular Session, 2011.
DFPS is in the process of transitioning to this redesigned system. (For the most up-to-date information, see http://www.dfps.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/redesign.asp.) DFPS is contracting 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.

1.8. Eligible Population

The following groups ("the Eligible Population" or the "STAR Health population") will be eligible to enroll in STAR Health: (1) children and young adults in DFPS conservatorship, (2) young adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement, and (3) young adults aged 18 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 due to ineligibility for the FFCC program.

1.9. Authorization

The Texas Legislature has designated HHSC as the single state agency to administer the Medicaid and managed care models in the State of Texas. HHSC has authority to contract with an MCO to carry out the duties and functions of the STAR Health Program under Title XIX of the Social Security Act; Texas Health and Safety Code § 12.011 and § 12.021; Texas Family Code Chapter 266; and Texas Government Code Chapter 533. Contracts awarded under this RFP are subject to all necessary federal and state approvals, including Centers for Medicare and Medicaid Services’ (CMS) approval.

1.10. Eligible Respondents

Except as provided in this document, eligible Respondents include insurers that are licensed by the Texas Department of Insurance (TDI) as MCOs in accordance with Chapter 843 of the Texas Insurance Code, a certified Approved Non-Profit Health Corporation (ANHC) formed in compliance with Chapter 844 of the Texas Insurance Code, and Exclusive Provider Organizations (EPO) with TDI-approved Exclusive Provider Benefit Plans (EPP).

Throughout this RFP, the term MCO includes HMOs, ANHCs, and EPOs. A Respondent that has submitted its application for licensure as an HMO, for certification as an ANHC, or for approval of an EPP prior to the Proposal due date is also eligible to respond to this RFP; however, the Respondent must receive TDI approval no later than 60 days after HHSC executes the Contract (see RFP Section 1.3, "Procurement Schedule"). Failure to receive the required approval within 60 days after HHSC executes the Contract will result in the cancellation of the award.

Failure to timely submit proof of TDI licensure, certification, or approval will result in HHSC’s termination of the Contract. The MCO will be at risk for all costs incurred by HHSC or its
authorized representatives through the date of termination, as well as all costs HHSC incurs to replace the MCO.

For more information on the reasons for HHSC’s disqualification of Respondents, see RFP Section 3.3.2, “Conflicts of Interest,” and Section 3.3.3, “Former Employees of a State Agency.”

1.11. Contract Term

The Contract will begin on the Contract’s Effective Date and will continue through August 31, 2018 (Initial Contract Period). HHSC may, at its option, extend the Contract for an additional period or periods, not to exceed a total of eight operational years. All reserved Contract extensions beyond the Initial Contract Period will be subject to good faith negotiation between the parties.

As discussed in other sections of the RFP, the MCO must begin serving Members on the Operational Start Date, which HHSC anticipates will be September 1, 2015.

1.12. Development of Contracts

For reference only, HHSC has included a template of a STAR Health Managed Care Contract in the Procurement Library. The Managed Care Contract identifies an MCO’s awarded MCO Program and identifies all documents that will become part of the agreement, including RFP Attachment A, “STAR Health Contract Terms.”
2 PROCUREMENT STRATEGY AND APPROACH

HHSC seeks to contract with one MCO to provide statewide coordinated services to the STAR Health population.

HHSC conducts this procurement as a competitive negotiation in accordance with HHSC administrative rules 1 Tex. Admin. Code Ch. 391.

Tex. Gov't Code § 2155.144 obligates HHSC to purchase goods and services on the basis of best value. HHSC rules define “best value” as the optimum combination of economy and quality that is the result of fair, efficient, and practical procurement decision-making and that achieves health and human services procurement objectives (see 1 Tex. Admin. Code § 391.31). As stated in 1 Tex. Admin. Code § 391.121, HHSC may consider any of the following factors in determining best value:

1. Any installation costs;
2. The delivery terms;
3. The quality and reliability of the vendor’s goods or services;
4. The extent to which the goods or services meet the agency's needs;
5. Indicators of probable vendor performance under the contract such as past vendor performance, the vendor's financial resources and ability to perform, the vendor's experience and responsibility, and the vendor's ability to provide reliable maintenance agreements;
6. The impact on the ability of the agency to comply with laws and rules relating to historically underutilized businesses or relating to the procurement of goods and services from persons with disabilities;
7. The total long-term cost to the agency of acquiring the vendor’s goods or services;
8. The cost of any employee training associated with the acquisition;
9. The effect of an acquisition on agency productivity;
10. The acquisition price;
11. The extent to which the goods or services meet the needs of the client(s) for whom the goods or services are being purchased; and
12. Any other factor relevant to determining the best value for the agency in the context of a particular acquisition that is sufficiently described in a solicitation instrument.

HHSC will evaluate proposals using the criteria developed from these best value factors as set forth in RFP Section 5, “Evaluation Process and Criteria.”

2.1 Risk-Based Contract

In making the award of the Contract, HHSC will rely on the MCO’s assurances of the following.

1. The MCO is an established HMO, ANHC, or EPO that arranges for the delivery of Healthcare Services, and will be fully authorized by TDI to conduct business in the Service Area no later than 60 days after the Contract’s Effective Date.
2. The MCO and the MCO’s Administrative Services Subcontractors have the skills, qualifications, expertise, financial resources, and experience necessary to provide the Services and Deliverables described in this RFP, the Respondent’s Proposal, and the Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities.

3. The MCO has thoroughly reviewed, analyzed, and understood this RFP, has timely raised all questions or objections to this RFP, and has had the opportunity to review and fully understand HHSC’s current program and operating environment for the activities that are the subject of the Contract and the needs and requirements of HHSC during the Contract term.

4. The MCO has had the opportunity to review and understands HHSC’s stated objectives in entering into the Contract and, based on this review and understanding, the MCO currently has the capability to perform in accordance with the terms of the Contract.

5. The MCO is at risk for expenses that may be necessary or incurred in order to deliver contractually required services and deliverables, even if these expenses are in excess of the Capitation Payments received.

2.2 HHSC Model Management Strategy

HHSC has identified performance measures and objectives that it expects the MCO to address during the term of the Contract (see RFP Section 1.6, “Mission Objectives,” and RFP Section 8, “Operations Phase Requirements.”)

HHSC will use two “Performance Indicator Dashboards” (one for administrative and financial measures and another for quality measures). The two Performance Indicator Dashboards are included in the Uniform Managed Care Manual (UMCM) Chapter 10.1.3, “STAR Health Performance Indicator Dashboard for Administrative and Financial Measures,” and Chapter 10.1.8, “STAR Health Performance Indicator Dashboard for Quality Measures.” The Performance Indicator Dashboards are not all-inclusive sets of performance measures; HHSC will measure other aspects of MCO performance as well. Rather, the Performance Indicator Dashboards assemble performance indicators that assess many of the most important dimensions of MCO performance, and include measures that, when publicly shared, will also serve to incentivize MCO excellence.

HHSC will seek to accelerate improvement efforts in areas of high priority, including those identified in RFP Section 1.6, “Mission Objectives.” As described in RFP Section 8.1.1, “Performance Evaluation,” HHSC’s method for accelerating improvement is to establish with the MCO a series of performance improvement projects. The MCO will be committed to making its best efforts to achieve the established projects. HHSC may establish some or all of the performance improvement projects. HHSC and the MCO will negotiate any remaining projects. These projects will be highly specified and measurable. The projects will reflect areas that present significant opportunities for performance improvement. Once finalized and approved by HHSC, the projects will become part of the MCO’s plan for its Quality Assurance and Performance Improvement (QAPI) Program, as defined in RFP Section 8.1.7, “Quality Assessment and Performance Improvement,” and will be incorporated by reference into the Contract.
HHSC recognizes the importance of applying a variety of financial and non-financial incentives and disincentives for demonstrated MCO performance. It is HHSC’s objective to recognize and reward both excellence in MCO performance and improvement in performance, within existing state and federal financial constraints. It is likely that HHSC will modify this approach over time based on several variables, including accumulated experience by HHSC and the MCO, changes in the status of state finances, and changes in MCO performance levels. RFP Section 6.3, “Performance Incentives and Disincentives,” describes the incentive and disincentive approach in additional detail.

HHSC anticipates that incentives and disincentives will be linked to some of the measures in the Performance Indicator Dashboards, as found in the UMCM Chapters 10.1.3 and 10.1.8. HHSC may use MCO performance relative to the performance improvement projects (PIPs) to identify and reward excellence and improvement by the MCO in subsequent years.

Finally, HHSC plans to improve methods for sharing policy information with the MCO through HHSC-sponsored work groups and other initiatives.

2.3 Performance Measures and Associated Remedies

The MCO must provide all services and deliverables under the Contract at an acceptable quality level and in a manner consistent with acceptable industry standard, custom, and practice. Failure to do so may result in HHSC’s assessment of contractual remedies, including liquidated damages, as set forth in Attachment B-3, “Deliverables/Liquidated Damages Matrix.”
3 GENERAL INSTRUCTIONS AND REQUIREMENTS

3.1 Strategic Elements

3.1.1 Contract Elements

The term “Contract” means the contract awarded as a result of this RFP and all attachments. At a minimum, the following documents will be incorporated into the contract: this RFP and all attachments; any modifications, addendum, or amendments issued in conjunction with this RFP; HHSC’s STAR Health Contract Terms; and the successful Respondent’s proposal. Respondents are responsible for reviewing all parts of the Contract, including the STAR Health Contract Terms, and noting any exceptions, reservations, and limitations on the Respondent Information and Disclosures form.

3.1.2 HHSC’s Basic Philosophy: Contracting for Results

HHSC’s fundamental commitment is to contract for results. A successful result is defined as the generation of defined, measurable, and beneficial outcomes that support HHSC’s Missions and Objectives and satisfy the Contract requirements. This RFP describes what is required of the MCO in terms of performance measures and outcomes, and places the responsibility for meeting objectives on the MCO.

3.2 External Factors

External factors such as budgetary and resource constraints could affect the project. The Contract resulting from this procurement is subject to the availability of state and federal funds. As of the issuance of this RFP, HHSC anticipates that funds are available to fulfill the RFP requirements. However, if funds become unavailable, HHSC reserves the right to withdraw this RFP or terminate the resulting contract without penalty.

3.3 Legal and Regulatory Constraints

3.3.1 Delegation of Authority

State and federal laws generally limit HHSC’s ability to delegate certain decisions and functions to a vendor, including: (1) policy-making authority and (2) final decision-making authority on the acceptance or rejection of contracted services.
3.3.2 Conflicts of Interest

A conflict of interest is a set of facts or circumstances in which either a Respondent or anyone acting on its behalf in connection with this procurement has past, present, or currently planned personal, professional, or financial interests or obligations that, in HHSC’s determination, would actually or apparently conflict or interfere with the Respondent’s contractual obligations to HHSC. A conflict of interest would include circumstances in which a party’s personal, professional, or financial interests or obligations may directly or indirectly:

1. Make it difficult or impossible to fulfill its contractual obligations to HHSC in a manner that is consistent with the best interests of the State of Texas;
2. Impair, diminish, or interfere with that party’s ability to render impartial or objective assistance or advice to HHSC; or
3. Provide the party with an unfair competitive advantage in future HHSC procurements.

Neither the Respondent nor any other person or entity acting on its behalf, including subcontractors, employees, agents, and representatives, may have a conflict of interest with respect to this procurement. Before submitting a proposal, Respondents should carefully review RFP Attachment A, “STAR Health Contract Terms,” for additional information concerning conflicts of interest.

A Respondent must certify that it does not have personal or business interests that present a conflict of interest with respect to this RFP and resulting contract (see the Required Certifications form). Additionally, if applicable, the Respondent must disclose all potential conflicts of interest. The Respondent must describe the measures it will take to ensure that there will be no actual conflict of interest and that it will maintain fairness, independence, and objectivity (see the Respondent Information and Disclosures form). HHSC will determine to what extent, if any, a potential conflict of interest can be mitigated and managed during the term of the Contract. Failure to identify potential conflicts of interest may result in HHSC’s disqualification of a proposal or termination of the Contract.

3.3.3 Former Employees of a State Agency

Respondents must comply with state and federal laws and regulations relating to the hiring of former state employees, such as Texas Government Code § 572.054, Texas Government Code § 669.003, and 45 C.F.R. § 74.43. “Revolving door” provisions generally restrict former agency heads from communicating with or appearing before the agency on certain matters for 2 years after leaving the agency, or from contracting with the agency 4 years after leaving the agency. These “revolving door” provisions also restrict some former employees from representing clients on or receiving compensation for services rendered on behalf of any person regarding matters that the employee participated in during state service or matters that were in the employees’ official responsibility.

As a result of these and similar laws and regulations, a Respondent must certify that it has complied with all applicable laws and regulations regarding all former state employees (see the Required Certifications Forms). Furthermore, a Respondent must disclose any relevant past
state employment of the Respondent’s or its subcontractors’ employees and agents in the Respondent Information and Disclosure form.

3.4 HHSC Amendments and Announcements Regarding this RFP

HHSC will post all official communication regarding this RFP on its website, including the notice of tentative award. HHSC reserves the right to revise the RFP at any time. HHSC will issue any changes, clarifications, amendments, addendum, or written responses to Respondents’ questions on HHSC’s website. Respondents should check the website frequently for notice of matters affecting the RFP. To access the website, go to the “HHSC Contract Opportunities” page and enter a search for this procurement. Also, Respondents can find announcements regarding this RFP on the ESBD website at: http://esbd.cpa.state.tx.us/.

3.5 RFP Cancellation/Partial Award/Non-Award

HHSC reserves the right to cancel this RFP, to make a partial award, or to make no award if it determines that action is in the best interest of the State of Texas.

3.6 Right to Reject Proposals or Portions of Proposals

HHSC may, in its discretion, reject any proposal or portion of the proposal.

3.7 Costs Incurred

Respondents understand that issuance of this RFP in no way constitutes a commitment by HHSC to award a contract or to pay any costs incurred by a Respondent in the preparation of a response to this RFP. HHSC is not liable for any costs incurred by a Respondent prior to issuance of or entering into a formal agreement, contract, or purchase order. Costs of developing proposals, preparing for or participating in oral presentations and site visits, or any other similar expenses incurred by a Respondent are entirely the Respondent’s responsibility, and HHSC will not reimburse the Respondent in any manner.

3.8 Respondent Protest Procedures

3.9 Vendor Conference

HHSC will hold a vendor conference according to the time and date in RFP Section 1.3, “Procurement Schedule,” in HHSC Building 2, Hearing Room 164, located at 909 West 45th Street, Austin, Texas, 78751. Vendor conference attendance is strongly recommended, but is not required.

Respondents may e-mail questions for the conference to the HHSC Point-of-Contact (see RFP Section 1.2, “Point-of-Contact”) no earlier than five days before the conference. HHSC will also give Respondents the opportunity to submit written questions at the conference. All questions should refer to the appropriate RFP page and section number. HHSC will attempt to respond to questions at the vendor conference, but responses are not official until posted in final form on the HHSC website. HHSC reserves the right to amend answers prior to the proposal submission deadline.

3.10 Questions and Comments

All questions and comments regarding this RFP should be sent to the HHSC Point-of-Contact (see RFP Section 1.2). Questions should reference the appropriate RFP page and section number, and must be submitted by the deadline set forth in RFP Section 1.3, “Procurement Schedule.” HHSC will not respond to questions received after the deadline. HHSC’s responses to Respondent questions will be posted to the HHSC website. HHSC reserves the right to amend answers prior to the proposal submission deadline.

Respondents must notify HHSC of any ambiguity, conflict, discrepancy, exclusionary specification, omission, or other error in the RFP by the deadline for submitting questions and comments. If a Respondent fails to notify HHSC of these issues, it will submit a proposal at its own risk, and if awarded a contract: (1) will have waived any claim of error or ambiguity in the RFP or resulting contract, (2) must not contest HHSC’s interpretation of such provision(s), and (3) is not entitled to additional compensation, relief, or time by reason of the asserted ambiguity, error, or its later correction.

3.11 Modification or Withdrawal of Proposal

Prior to the proposal submission deadline set forth in RFP Section 1.3, “Procurement Schedule,” a Respondent may: (1) withdraw its proposal by submitting a written request to the HHSC Point-of-Contact, or (2) modify its proposal by submitting a written amendment to the HHSC Point-of-Contact. HHSC may request proposal modifications at any time.

HHSC reserves the right to waive minor informalities in a proposal and award a contract that is in the best interest of the State of Texas. A “minor informality” is an omission or error that, in HHSC’s determination, if waived or modified when evaluating proposals, would not give a Respondent an unfair advantage over other Respondents or result in a material change in the proposal or RFP requirements. When HHSC determines that a proposal contains a minor informality, it may, at its discretion, provide the Respondent with the opportunity to correct the minor informality.
3.12 News Releases

Prior to tentative award, a Respondent may not issue a press release or provide any information for public consumption regarding its participation in the procurement. After tentative award, a Respondent must receive prior written approval from HHSC before issuing a press release or providing information for public consumption regarding its participation in the procurement. Requests should be directed to the HHSC Point-of-Contact identified in RFP Section 1.2.

Section 3.12 does not preclude business communications necessary for a Respondent to develop a proposal, or required reporting to shareholders or governmental authorities.

3.13 Incomplete Proposals

HHSC may reject without further consideration a proposal that does not include a complete, comprehensive, or total solution as requested by this RFP.

3.14 State Use of Ideas

HHSC reserves the right to use any and all ideas and information presented in a proposal. A Respondent may not object to HHSC’s use of this information.

3.15 Property of HHSC

Except as otherwise provided in this RFP or the resulting Contract, all products produced by a Respondent, including without limitations the proposal, all plans, designs, software, and other contract deliverables, become the sole property of HHSC. See RFP Attachment A, Article 15, “Intellectual Property,” for additional information concerning intellectual property rights.

3.16 Copyright Restriction

HHSC will not consider any proposal that is copyrighted by the Respondent, in whole or part.

3.17 Additional Information

By submitting a proposal, the Respondent grants HHSC the right to obtain information from any lawful source, whether identified in Respondent’s proposal or not, regarding the Respondent’s and its
directors’, officers’, and employees’: (1) past business history, practices, and conduct, (2) ability to supply the goods and services, and (3) ability to comply with Contract requirements. By submitting a proposal, a Respondent generally releases from liability and waives all claims against any party providing HHSC information about the Respondent. HHSC may take this information into consideration in evaluating proposals.

3.18 Multiple Proposals

A Respondent may only submit one proposal as a prime contractor. If a Respondent submits more than one proposal, HHSC may reject one or more of the submissions. This requirement does not limit a subcontractor’s ability to collaborate with one or more Respondents submitting proposals.

A Respondent may not entice or require a subcontractor to enter into an exclusive subcontract for the purpose of this procurement. Any subcontract entered into by a Respondent with a third party to meet a requirement of this RFP must not include any provision that would prevent or bar that subcontractor from entering into a comparable contractual relationship with another Respondent submitting a proposal under this procurement. This prohibition against exclusive subcontracts does not apply to professional services that solely pertain to development of the proposal, including gathering of competitive intelligence.

3.19 No Joint Proposals

HHSC will not consider joint or collaborative proposals that require it to contract with more than one Respondent.

3.20 Use of Subcontractors

Subcontractors providing services under the Contract must meet the same requirements and level of experience as required of the Respondent. No subcontract under the Contract must relieve the Respondent of the responsibility for ensuring the requested services are provided. Respondents planning to subcontract all or a portion of the work to be performed must identify the proposed subcontractors and describe the subcontracted functions in their proposals.

3.21 Texas Public Information Act

Proposals will be subject to the Texas Public Information Act (the Act), located in Chapter 552 of the Texas Government Code, and may be disclosed to the public upon request. By submitting a proposal, the Respondent acknowledges that all information and ideas presented in the proposal are public information and subject to disclosure under the Act, with the limited exception of Social Security Numbers and certain non-public financial reports or information submitted in response to RFP Sections.

If the Respondent asserts that financial reports or information provided in response to RFP Sections 4.2.3.3 and 4.2.3.4 contain trade secret or other confidential information as specified under the provisions of the Act, the Respondent must clearly mark that information in boldface type and include the words “confidential” or “trade secret” at the top of each page the Respondent claims is confidential or trade secret. Furthermore, the Respondent must identify by specific page numbers the financial reports or information, and provide an explanation of why the reports or information are excepted from public disclosure under the provisions of the Act, on the Respondent Information and Disclosures form.

HHSC will process any request from a member of the public in accordance with the procedures outlined in the Act. Respondents should consult the Texas Attorney General’s website (www.oag.state.tx.us) for information concerning the Act’s application to applications and potential exceptions to disclosure.

3.22 Inducements

HHSC submits this RFP setting forth certain information regarding the objectives of the Contract and HHSC’s desire to mitigate risk throughout the life of the Contract by use of expert MCO services.

Therefore, HHSC will consider all representations contained in a Respondent’s proposal, oral or written presentations, correspondence, discussions, and negotiations as representations of the Respondent’s expertise. HHSC accepts these representations as inducements to contract.

3.23 Definition of Terms

Defined terms have the meaning described in RFP Attachment A, “STAR Health Contract Terms”), unless the context clearly indicates otherwise. Defined terms are capitalized throughout this RFP.
4 Submission Requirements

To be considered for award, the Respondent must address all applicable RFP specifications to HHSC’s satisfaction. If requested by HHSC, the Respondent must provide HHSC with information necessary to validate any statements made in its Proposal. This includes granting permission or access for HHSC to verify information with third parties, whether identified by the Respondent or HHSC. If any requested information is not provided within the timeframe allotted, HHSC may reject the Proposal.

Respondents must prepare and submit proposals in accordance with the provisions of this section. Proposals received that do not follow these instructions may be evaluated as non-responsive and may not be considered for award.

If a Respondent believes that parts of a Proposal are excepted from required public disclosure under the Texas Public Information Act, the Respondent must specify those parts and the exception(s) that it believes apply, with specific detailed reasons. See RFP Section 3.21 "Texas Public Information Act" for more information.

4.1 Part 1 - General Instructions

A Proposal must include the following two components:

1. Business Proposal; and

Respondents must submit all Proposal information on 8½" x 11", white bond paper, three-hole punched, and placed in sturdy three-ring binders. Text must be no smaller than 11-point font, single-spaced. Figures may not incorporate text smaller than 8-point font. All pages must have one-inch margins and page numbering must be sequential per section. Where practical, pages should be double-sided. Respondents must clearly label each binder with the title of this RFP, the Respondent’s legal name, and the title of the document contained in the binder, e.g., Business Proposal or Programmatic Proposal.

Proposals must be organized and numbered in a manner that facilitates reference to this RFP and its requirements. Respondents must respond to each item in the order it appears in the RFP. The Respondent’s response must include headings and numbering to match the corresponding section of the RFP. Respondents may place attachments in a separate section, if the attachments are not included in any page limits specified in the RFP.

4.1.1 Economy of Presentation

HHSC does not want unnecessarily elaborate Proposals beyond those sufficient to provide a complete and effective response to this RFP and they may be construed as an indication of the Respondent’s lack of ability to provide efficient work products.
The Respondent must adhere to page limits where specified. Page limits are listed in parentheses at the end of the title of the section to which the page limit applies. A three-page limit, for example, means that the response should not be in excess of three one-sided pages that meet the size, font, and margin requirements specified in the General Instructions in RFP Section 4.1.

In other cases, additional pages may be provided based on certain aspects of the Respondent's Proposal or organization, such as the number of organizational charts submitted reflecting arrangements with Material Subcontractors, or the number of Key Contract Personnel included in the Proposal.

If the Respondent chooses to repeat the RFP question in its Proposal, the question text will be included in the page limit.

In responding to questions in RFP Section 4.2, “Business Proposal,” and Section 4.3, “Programmatic Proposal,” for which the Respondent includes information about a Material Subcontractor or Corrective Action Plan, up to one page may be used to describe each Material Subcontractor arrangement, and up to one page may be used to describe each Corrective Action Plan. These pages are outside of the page limit instructions for the specific submission requirement.

HHSC reserves the right not to review information provided in excess of the page limits. Respondents need not feel compelled to submit unnecessary text in order to reach the page limits.

Attachments required by the RFP, such as certain policies and procedures, are not counted in calculating the Respondent’s page limits. Respondents must not submit information or attachments not explicitly requested in the RFP. Elaborate artwork, expensive paper and bindings, and expensive visual or other presentation aids are neither necessary nor desired.

4.1.2 Number of Copies and Packaging

Respondents must submit one hardbound original and eight hardbound copies of the Proposal. The original must be clearly labeled “Original” on the outside of the binder. In addition to the hardbound original and copies, Respondents must submit 22 electronic copies of each Proposal component on portable media, such as flash drives or compact discs. The Respondent must clearly label the exterior of the shipping package with proposal number 529-15-0001. At the Respondent’s option, it may produce only electronic copies of certain attachments and appendices. This exception applies to attachments and appendices that exceed 10 pages, such as Geo-Access tables, Significant Traditional Provider (STP) files, Texas Department of Insurance (TDI) filings, and other financial documents. The exception does not apply to the attachments referenced in RFP Section 4.2, “Part 2 - Business Proposal,” Section 4.2.5, “Section 5 - HUB Subcontracting Plan,” or Section 4.2.6, “Section 6 - Certifications and Other Required Forms,” which must be included in both the hardbound and electronic copies of the Proposal. If the Respondent produces only an electronic copy of an attachment or appendix, the hardbound Proposals should refer the reader to the electronic Proposal for the required information.
For the electronic copies, the Proposal, attachments, financial documents, signed forms, pamphlets, and all other documents included in the proposal hardcopy must be submitted on CDs or flash drives compatible with Microsoft Office 2010 files. Portable Document Files (PDF) should be prepared in a format that is text searchable. **HHSC will not accept Proposals by facsimile or e-mail.**

### 4.1.3 Due Date, Time, and Location

Submit all copies of the Proposal to HHSC’s Procurement and Contracting Services (PCS) no later than **2:00 p.m. Central Time (CT)** according to the timeline in **RFP Section 1.3, “Procurement Schedule.”** All submissions will be date and time stamped when received by PCS. The clock in the PCS office is the official timepiece for determining compliance with the deadlines in this procurement. HHSC reserves the right to reject late submissions. It is the Respondent’s responsibility to appropriately mark and deliver the Proposal to HHSC’s sole point-of-contact by the specified date and time. The sole point-of-contact for inquiries concerning this RFP is:

Rick Blincoe, CTPM  
Procurement and Contracting Services  
Health and Human Services Commission  
4405 North Lamar Blvd  
Austin, Texas 78756-3422  
Phone: (512) 206-5468  
Fax: (512) 206-5552  
Richard.Blincoe@hhsc.state.tx.us

### 4.2 Part 2 - Business Proposal

The Business Proposal must include the following:

- **Section 1 – Executive Summary**  
- **Section 2 – Respondent Identification and Information**  
- **Section 3 – Corporate Background and Experience**  
- **Section 4 – Material Subcontractor Information**  
- **Section 5 – HUB Subcontracting Plan**  
- **Section 6 – Certifications and Other Required Forms**

#### 4.2.1 Section 1 – Executive Summary

(2 pages)

In this section, condense and highlight the content of the Business Proposal to provide HHSC with a broad understanding of the respondent's approach to meeting the RFP’s business requirements. The
summary must demonstrate an understanding of HHSC’s goals and objectives for this procurement. The summary of experience should address projects similar in scope and complexities to the project described in the RFP, and describe the Respondent’s experience serving the STAR Health population or similar populations.

4.2.2 Section 2 – Respondent Identification and Information

(no page limit)

Submit the following information:

1. **Respondent identification and basic information.**
   a. The Respondent’s legal name, trade name, d.b.a, acronym, and any other name under which the Respondent does business.
   b. The physical address, mailing address, and telephone number of the Respondent’s headquarters office.

2. **TDI Authority.** A copy of the MCO’s licensure, certification, or approval to operate as an MCO, ANHC, or EPO. If the Respondent has not received TDI approval, then submit a copy of the application filed with TDI. In accordance with **RFP Section 7.3.10**, “TDI Licensure, Certification, or Approval,” the Respondent must receive TDI approval no later than 60 days after HHSC executes the Contract.

3. **Authorized Counties.** For an HMO, ANHC, or EPO, use the “TDI Certificate of Authority” chart provided in the **RFP Procurement Library** to indicate whether the Respondent is currently certified by TDI as an HMO, ANHC, or EPO in all counties in the state. For each county listed in Column C, the Respondent must document that it applied to TDI for approval prior to the submission of a Proposal for this RFP. The Respondent must indicate the date that it applied for TDI approval and the status of its application to get TDI approval in the relevant counties in this section of its submission to HHSC.

4. **Texas Comptroller Certificate.** A current Certificate of Good Standing issued by the Texas Comptroller of Public Accounts, or an explanation for why this form is not applicable to the Respondent.

5. **Respondent Legal Status and Ownership.**
   a. The type of ownership of the Respondent by its ultimate parent:
      i. wholly-owned subsidiary of a publicly-traded corporation;
      ii. wholly-owned subsidiary of a private (closely-held) stock corporation;
      iii. subsidiary or component of a non-profit foundation;
      iv. subsidiary or component of a governmental entity such as a County Hospital District;
      v. independently-owned member of an alliance or cooperative network;
      vi. joint venture (describe ultimate owners);
      vii. stand-alone privately-owned corporation (no parents or subsidiaries); or
      viii. other (describe).
   b. The legal status of the Respondent and its parent (any/all that may apply):
i. Respondent is a corporation, partnership, sole proprietor, or other (describe);
ii. Respondent is for-profit, or non-profit;
iii. the Respondent’s ultimate parent is for-profit, or non-profit; or
iv. the Respondent’s ultimate parent is privately-owned, listed on a stock exchange, a component of government, or other (describe).

c. The legal name of the Respondent’s ultimate parent (e.g., the name of a publicly-traded corporation, or a County Hospital District).

d. The name and address of any other sponsoring corporation, or others (excluding the Respondent’s parent) who provide financial support to the Respondent, and the type of support (e.g., guarantees, letters of credit). Indicate if there are maximum limits of the additional financial support.

6. Hospital District/Non-Profit Corporation. RFP Section 5, “Evaluation Process and Criteria,” requires Respondents who believe they qualify for mandatory STAR Health contracts under Texas Government Code § 533.004 to submit a detailed, written notice to HHSC no later than May 9, 2014. Please indicate whether the Respondent provided this notice to HHSC in the manner described in RFP Section 5.

7. The name and address of any health professional that has at least a 5% financial interest in the Respondent, and the type of financial interest.

8. The full names and titles of the Respondent’s officers and directors.

9. The state in which the Respondent is incorporated and the state in which the Respondent is licensed to do business as an MCO. The Respondent must also indicate the state where it is commercially domiciled, if outside Texas.

10. The Respondent’s federal taxpayer identification number.

11. If any change of ownership of the Respondent’s company or its parent is anticipated during the 12 months following the Proposal due date, the Respondent must describe the circumstances of the change and indicate when the change is likely to occur.

12. Whether the Respondent or its parent (including other managed care subsidiaries of the parent) had a managed care contract terminated or not renewed for any reason within the past 5 years. In this instance, the Respondent must describe the issues and the parties involved, and provide the address and telephone number of the principal terminating party. The Respondent must also describe any corrective action taken to prevent any future occurrence of the problems that may have led to the termination or non-renewal.

13. Whether the Respondent has ever sought, or is currently seeking, accreditation status from an organization as allowed by the Texas Department of Insurance (such as the National Committee for Quality Assurance (NCQA)), and if it has or is, indicate:
   a. its current accreditation status;
   b. if accredited, its accreditation term effective dates; and
   c. if not accredited, a statement describing whether and when accreditation status was ever denied the Contractor.

14. The website address (URL) for the homepage of any website operated, owned, or controlled by the Respondent, including any that the Respondent may have contracted to be run by another
entity. If the Respondent has a parent, then also provide the same for the parent, and any parent of the parent. If none exists, provide a clear and definitive statement to that effect.

4.2.3 Section 3 - Corporate Background and Experience

(no page limit)

1. Provide the following information on all publicly-funded managed care contracts (if the Respondent does not have publicly-funded managed care contracts, it may include information on privately-funded managed care contracts). Include information for all current contracts, as well as work performed in the past 3 years:
   a. client name and address;
   b. name, telephone, and e-mail address of the person HHSC could contact as a reference that can speak to the Respondent’s performance;
   c. contract size: average monthly covered lives and annual revenues;
   d. whether payments under the contract were capitated or non-capitated;
   e. contract start date and duration;
   f. whether work was performed as a prime contractor or Subcontractor; and
   g. a general and brief description of the scope of services provided by the Respondent; including the covered population and services (e.g., Medicaid, state-funded program).

2. With respect to the Respondent and its parent (and including other managed care subsidiaries of the parent), briefly describe any regulatory actions, sanctions, or fines imposed by any federal or Texas regulatory entity, or a regulatory entity in another state, within the last three years. Include a description of any letters of deficiencies, corrective actions, findings of non-compliance, or sanctions. Please indicate which of these actions or fines, if any, were related to the Medicaid program. HHSC may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the Respondent.

3. If the Respondent had a contract terminated or not renewed for nonperformance or poor performance within the past five years, the Respondent must describe the issues, the parties involved, and provide the address and telephone number of the principal terminating party. The Respondent must also describe any corrective action taken to prevent any future occurrence of the problem leading to the termination.

Respondents should not include letters of support or endorsement from any individual, organization, agency, interest group, or other identified entity in this section or other parts of the Proposal.

When evaluating proposals, HHSC may consider a current or past contractor's performance under an agreement with an HHS agency in Texas, including any corrective actions or damages imposed by HHSC or another HHS agency.

4.2.3.1 Organizational Chart

(1 page narrative for each organizational chart, excluding organizational chart itself)

Respondents should submit the following:
1. An organizational chart (Chart A), showing the corporate structure and lines of responsibility and authority in the administration of the Respondent's business as a health plan.

2. An organizational chart (Chart B) showing the Texas organizational structure, including staffing and functions performed within the state. Specifically show the organizational structure if the Respondent proposes to maintain offices in more than one city in Texas. If Chart A represents the entire organizational structure, label the submission as Charts A and B.

3. An organizational chart (Chart C) that illustrates how administration of services to Members is integrated into the overall administrative structure of the Respondent’s business as an MCO. Specifically show the organizational structure if the Respondent proposes to maintain offices in more than one city in Texas.

4. An organizational chart (Chart D) showing the Management Information System (MIS) staff organizational structure, including staffing and functions performed in Texas and, if applicable, outside of Texas. Specifically show the organizational structure if the Respondent proposes to maintain offices in more than one city in Texas.

5. An organizational chart (Chart E) showing the Respondent’s committee structure and committee lines of accountability. Indicate which committee(s) will participate in establishing treatment guidelines and criteria for delivery of Covered Services to Members.

6. If the Respondent is proposing to use a Material Subcontractor, the Respondent must include an organizational chart demonstrating how the Material Subcontractors will be managed within the Respondent’s Texas organizational structure, including the primary individuals at the Respondent’s organization and at each Material Subcontractor organization responsible for overseeing the key functional areas under each Material Subcontract. This information may be included in Chart B, or in a separate organizational chart (Chart F).

7. A brief narrative explaining the organizational charts submitted, and highlighting the key functional responsibilities and reporting requirements of each organizational unit relating to the Respondent’s proposed management of the STAR Health Program. With regard to any proposed Material Subcontractors managing BH Services, dental services, vision services, or pharmacy services, indicate whether (and if so, how and where) the Respondent and any proposed Material Subcontractor will co-locate their offices.

8. The MCO, HHSC, and DFPS will meet twice monthly for the first three months following any transition regarding the management of the STAR Health Program, and monthly thereafter. Describe how the MCO will integrate these meetings into its overall Program planning and coordination efforts with HHSC and DFPS, and how it will address Program modifications that arise as a result of these meetings.

4.2.3.2 Résumés

(1 page per Key Personnel, excluding résumés)

Identify and describe the respondent’s and its Subcontractor’s proposed labor skill set, years of experience, and provide résumés of all proposed key personnel. Résumés must demonstrate experience germane to the position proposed. Résumés should include work on projects cited under the respondent’s corporate experience, and the specific functions performed on these projects. Each résumé should include at least three references from recent projects, if the projects were performed for unaffiliated parties. References may not be the Respondent’s or Subcontractor’s employees.

For each of the Key MCO Personnel listed below, submit (a) a job description and qualifications; (b) a resume of each individual expected to hold the position, if the person has already been identified by the
Respondent; and (c) indicate the portion of each person’s time the Respondent anticipates will be dedicated to STAR Health:

1. Executive Director
2. Medical Director
3. Member Services Manager
4. Behavioral Health (BH) Services Manager
5. Dental Services Manager
6. Vision Services Manager
7. Pharmacy Benefits Services Manager
8. MIS Manager
9. Health Passport Manager
10. Claims Processing Manager
11. Provider Network Development and Management Manager
12. Benefit Administration and Utilization Review Manager
13. Service Management Manager
14. Service Coordination Manager
15. Quality Improvement Manager
16. STAR Health Liaison Manager
17. Financial Functions Manager
18. Reporting Manager

4.2.3.3 Service Managers and Service Coordinators. Please refer to RFP Section 8.1.13.2, “Access to Care and Service Management,” for a description of Service Manager responsibilities and RFP Section 8.1.14, “Service Coordination,” for a description of Service Coordinator responsibilities. In addition to the Service management manager and Service Coordination Manager, please submit the following for each individual Service manager and Service Coordinator:

1. A job description and qualifications; and
2. the résumé of each individual expected to hold the position, if the Respondent has identified them.

4.2.3.4 Financial Capacity

(no page limit)

Submit the following financial documents to demonstrate the Respondent’s financial solvency, and its capacity to comply with RFP Section 6, “Premium Payment, Incentives, and Disincentives,” and RFP Section 8, “Operations Phase Requirements,” and RFP Attachment A, “STAR Health Contract Terms”:

1. Audited Financial Statements covering the two most recent years of the Respondent’s financial results. These statements must include the independent auditor’s report (audit opinion letter to the Board or shareholders), the notes to the financial statements, any written description of legal issues or contingencies, and any management discussion or analysis.

Make sure that the name and address of the firm that audits the Respondent is shown. State the date of the most-recent audit, and whether the Respondent is audited annually or otherwise. State definitively if there has, or has not, been any of the following:
Section 5 – Evaluation Process and Criteria

RFP No. 529-15-0001

a. a “going concern” statement was issued by any auditor in the last three years and if so, include the relevant audit report and opinion letter;
b. a qualified opinion was issued by any auditor in the last three years and if so, include the relevant audit report and opinion letter;
c. a change of audit firms in the last three years; and
d. any significant delay (two months or more) in completing the current audit.

2. The most recent quarterly and annual financial statements filed with the TDI, and if the Respondent is domiciled in another state, the financial statements filed with the state insurance department in its state of domicile. The annual financial statement must include all schedules, attachments, supplements, management discussion, analysis, and actuarial opinions.

3. The most recent financial examination report issued by TDI and by any state insurance department in states where the Respondent operates a Medicaid or comparable managed care product. If any submitted financial examination report is 2 or more years old, or if Respondent has never had a financial examination report issued, submit the anticipated approximate date of the next issuance of a TDI or state department of insurance financial examination report.

4. The most recent Form B Registration Statement disclosure filed by Respondent with TDI, and any similar form filed with any state insurance department in other states where the Respondent operates a Medicaid or comparable managed care product. If Respondent is exempt from the TDI Form B filing requirement, demonstrate this and explain the nature of the exemption.

5. Other related documents, as applicable:
   a. SEC Form 10-K and 10-Q. If Respondent is a publicly-traded (stock-exchange-listed) corporation, then submit the most recent United States Securities and Exchange Commission (SEC) Form 10-K Annual Report, and the most-recent 10-Q Quarterly report.
   b. IRS Form 990. If the Respondent is a non-profit entity, then submit the most recent annual Internal Revenue Service (IRS) Form 990 filing, complete with all attachments or schedules. If Respondent is a non-profit entity that is exempt from the IRS 990 filing requirement, demonstrate this and explain the nature of the exemption.
   c. Non-Profit Entities. If the Respondent is a non-profit entity that is a component or subsidiary of a County Hospital District, or otherwise an entity of a government, then submit the most recent annual financial statements as prepared under the relevant rules or statutes governing annual financial reporting and disclosure for Respondent, including all attachments, schedules, and supplements.
   d. Bond or debt rating analysis. If Respondent has been, in the last three years, the subject of any bond rating analysis, ratings affirmation, write-up, or related report, such as by AM Best, Fitch Ratings, Moody’s, Standard & Poor, submit the most-recent detailed report from each rating entity that has produced a report.
   e. Annual Report. If Respondent produces any written “annual report” or similar item that is in addition to the above-referenced documents, submit the most recent version. This might be a yearly report or letter to shareholders, the community, regulators, lenders, customers, employees, the Respondent’s owner, or other constituents.
   f. Press Releases. If the Respondent has issued any press releases in the 12 months prior to the submission due date, and the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or
losses, penalties/fines/sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, provide a copy of each press release. HHSC does not wish to receive other types of press releases that are primarily promotional in nature.

With respect to items 5(a) through 5(e), Respondent must also submit a schedule that shows for each of the five categories: whether there is any applicable filing or report; the name(s) of the entity that does the filing or report; and the regular or estimated filing/distribution date(s).

At a minimum, the financial statements and reports submitted must include:
1. balance sheet;
2. statement of income and expense;
3. statement of cash flows;
4. statement of changes in financial position (capital & surplus; equity);
5. independent auditor's letter of opinion;
6. description of organization and operation, including ownership, markets served, type of entity, number of locations and employees, and, dollar amount and type of any Respondent business outside of that with HHSC; and
7. disclosure of any material contingencies, and any current, recent past, or known potential material litigation, regulatory proceedings, legal matters, or similar issues.

The Respondent must include key non-financial metrics and descriptions, such as facilities, number of covered lives, area of geographic coverage, years in business, material changes in business situation, key risks, and prospective issues.

**4.2.3.5 Financial Report of Parent Organization and Corporate Guarantee**

(no page limit)

If another corporation or entity either substantially or wholly owns the Respondent, submit the most recent detailed financial reports (as required in Section 4.2.3.4) for the parent organization. If there are one or more intermediate owners between the Respondent and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

The Respondent must also include a statement that the parent organization will unconditionally guarantee performance by the Respondent of each and every obligation, warranty, covenant, term, and condition of the Contract. This guarantee is not required for Respondents owned by political subdivisions of the State (e.g., hospital districts).

If HHSC determines that an entity does not have sufficient financial resources to guarantee the Respondent’s performance, HHSC may require the Respondent to obtain another acceptable financial instrument or resource, or to obtain an acceptable guarantee from another entity with sufficient financial resources to guarantee performance.

**4.2.3.6 Bonding**

(no page limit)
The Respondent must submit a statement that, if selected as a Contractor, the Respondent agrees to:

1. secure and maintain throughout the life of the Contract, fidelity bonds required by the TDI in compliance with Tex. Ins. Code § 843.402; and

4.2.4 Section 4 – Material Subcontractor Information

(no page limit)

See RFP Attachment A, “STAR Health Contract Terms,” for contractual definitions of Material Subcontractor and Affiliate. Organize this information by Material Subcontractor, and list them in descending order of estimated annual payments. For each Material Subcontractor, the MCO must provide:

1. The Material Subcontractor’s legal name, trade name, acronym, d.b.a., and any other name under which the Material Subcontractor does business.
2. The Respondent’s estimated annual payments to the Material Subcontractor, by MCO program.
3. The physical address, mailing address, and telephone number of the Material Subcontractor’s headquarters office, and the name of its Chief Executive Officer.
4. Whether the Material Subcontractor is an Affiliate of the Respondent or an unrelated third party.
5. If the Material Subcontractor is an Affiliate, then provide:
   a. the name of the Material Subcontractor’s parent organization, and the Material Subcontractor’s relationship to the Respondent;
   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 Respondent would procure under the proposed Subcontract;
   c. a description of the proposed method of pricing under the Subcontract;
   d. indicate if the Respondent presently procures, or has ever procured, similar services from a non-Affiliate;
   e. the number of employees (staff and management) who are dedicated full-time to the Affiliate’s business;
   f. whether the Affiliate’s office facilities are completely separate from the Respondent and the Respondent’s parent. If not, identify the approximate number of square feet of office space that are dedicated solely to the Affiliate’s business;
g. attach 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 are they legally employed by a different legal entity (such as a parent corporation). The employee’s W-2 form identifies the name of the corporation and is indicative of the actual employer.

6. A description of each Material Subcontractor’s corporate background and experience, including its estimated annual revenues from unaffiliated parties, number of employees, location(s), and identification of three major clients.

7. A signed letter of commitment from each Material Subcontractor that states the Material Subcontractor’s willingness to enter into a Subcontractor agreement with the Respondent, and a statement of work for subcontracted activities. Respondents must provide Letters of Commitment on the Material Subcontractor’s official company letterhead, signed by an official with the authority to bind the company for the subcontracted work. The Letter of Commitment must state, if applicable, the company’s certified HUB status.

8. The business entity structure of the Material Subcontractor and the Affiliate. [For example, wholly-owned subsidiary of a publicly-traded corporation; wholly-owned subsidiary of a private (closely-held) stock corporation; subsidiary or component of a non-profit foundation; subsidiary or component of a governmental entity such as a County Hospital District; independently-owned member of an alliance or cooperative network; joint venture (describe owners)] Indicate the name of the ultimate owner (e.g., the name of a publicly-traded corporation or a County Hospital District).

9. Indicate status (all that may apply): sole proprietor, partnership, corporation, for-profit, non-profit, privately owned, or listed on a stock exchange. If a Subsidiary or Affiliate, name of the direct and ultimate parent organization.

10. The name and address of any sponsoring corporation or others who provide financial support to the Material Subcontractor and the type of support, e.g., guarantees, letters of credit. Indicate if there are maximum limits of the additional financial support.

11. The name and address of any health professional that has at least a 5% financial interest in the Material Subcontractor and the type of financial interest.

12. The state in which the Material Subcontractor is incorporated, commercially domiciled, and the states in which the organization is licensed to do business.

13. The Material Subcontractor’s federal taxpayer identification number.

14. Whether the Material Subcontractor had a managed care contract terminated or not renewed for any reason within the past five years. If so, the Respondent must describe the issues, the parties involved, and provide the address and telephone number of the principal terminating party. The Respondent must also describe any corrective action taken to prevent any future occurrence of the problem that may have led to the termination.

15. Whether the Material Subcontractor has ever sought, or is currently seeking, accreditation status from an organization as allowed by the Texas Department of Insurance (such as NCQA), and if it has or is, indicate:

a. its current accreditation or certification status;
b. if accredited or certified, its accreditation or certification term effective dates; and
c. if not accredited, a statement describing whether and when accreditation status was ever denied the Material Subcontractor.

16. The URL for the homepage of any website operated, owned, or controlled by the Material Subcontractor, including any websites run by another entity on the Material Subcontractor’s behalf. If the Material Subcontractor has a parent, then also provide the same for the parent organization, and any parent of the parent organization. If none exist, provide a clear and definitive statement to this effect.

4.2.5 Section 5 – Historically Underutilized Business (HUB) Participation

(no page limit)

In accordance with Texas Government Code § 2162.252, a proposal that does not contain a HUB Subcontracting Plan (HSP) is non-responsive and will be rejected without further evaluation. In addition, if HHSC determines that the HSP was not developed in good faith, it will reject the proposal for failing to comply with material RFP specifications.

4.2.5.1 Introduction

HHSC is committed to promoting full and equal business opportunities for businesses in state contracting in accordance with the goals specified in the State of Texas Disparity Study. HHSC encourages the use of HUB through race, ethnic and gender-neutral means. HHSC has adopted administrative rules relating to HUBs, and a Policy on the Utilization of HUBs, which is located on HHSC’s website.

Pursuant to Texas Government Code § 2161.181 and § 2161.182, and HHSC’s HUB policy and rules, HHSC is required to make a good faith effort to increase HUB participation in its contracts. HHSC may accomplish the goal of increased HUB participation by contracting directly with HUBs or indirectly through subcontracting opportunities.

4.2.5.2 HHSC’s Administrative Rules

HHSC has adopted the Comptroller of Public Accounts’ (CPA) HUB rules as its own. HHSC’s rules are located in 15 Tex. Admin. Code Ch. 392, Subchapter J of the Texas Administrative Code, and the CPA rules are located in 34 Tex. Admin. Code Ch. 20, Subchapter B. If there are any discrepancies between HHSC’s administrative rules and this RFP, the rules will take priority.

4.2.5.3 HUB Participation Goal

The CPA has established statewide annual HUB utilization goals for different categories of contracts in 34 Tex. Admin. Code § 20.13 of the HUB Rules. In order to meet or exceed the statewide annual HUB utilization goals, HHSC encourages outreach to certified HUBs. Contractors must make a good faith effort to include certified HUBs in the procurement process.
This contract is classified as an “All Other Services” contract under the CPA rule, and therefore, has a statewide annual HUB utilization goal of **24.6%** per fiscal year. This goal applies to MCO Administrative Services, as defined below.

### 4.2.5.4 Required HUB Subcontracting Plan

In accordance with Government Code, Chapter 2161, Subchapter F, each state agency that considers entering into a contract with an expected value of $100,000 or more over the life of the contract (including any renewals) shall, before the agency solicits bids, proposals, offers, or other applicable expressions of interest, determine whether subcontracting opportunities are probable under the contract.

In accordance with 34 Tex. Admin. Code § 20.14(a)(1)(C) of the HUB Rule, state agencies may determine that subcontracting is probable for only a subset of the work expected to be performed or the funds to be expended under the contract. If an agency determines that subcontracting is probable on only a portion of a contract, it must document its reasons in writing for the procurement file.

HHSC has determined that subcontracting opportunities are probable for this RFP for MCO Administrative Services. MCO Administrative Services are those services or functions other than the direct delivery of medical Covered Services necessary to manage the delivery of and payment for these services. MCO Administrative Services include Network, utilization, clinical or quality management, service authorization, claims processing, MIS operation, and reporting. The Respondent must submit an HSP (see the RFP Procurement Library) with its proposal for these MCO Administrative Services. The HSP is required whether a Respondent intends to subcontract or not.

HSP requirements will not apply to subcontracts with Network Providers (providers who contract directly with the MCO to deliver medical Covered Services to STAR Health Members). A Respondent therefore should not include Network Providers’ participation in its HSP submissions.

In the HSP, a Respondent must indicate whether it is a Texas-certified HUB. Being a certified HUB does not exempt a respondent from completing the HSP requirement.

HHSC will review the documentation submitted by the respondent to determine if a good faith effort has been made in accordance with solicitation and HSP requirements. During the good faith effort evaluation, HHSC may, at its discretion, allow revisions necessary to clarify and enhance information submitted in the original HSP.

If HHSC determines that the respondent’s HSP was not developed in good faith, the HSP will be considered non-responsive and will be rejected as a material failure to comply with advertised specifications. The reasons for rejection will be recorded in the procurement file.

### 4.2.5.5 CPA Centralized Master Bidders List (CMBL)

Respondents may search for HUB subcontractors in the CPA’s Centralized Master Bidders List (CMBL) HUB Directory, which is located on the CPA’s website at http://www2.cpa.state.tx.us/cmbl/cmblhub.html. For this procurement, HHSC has identified the following class and item codes for potential subcontracting opportunities.
NIGP Class/Item Code:
1. 948-07: Administration Services, Health;
2. 958-56: Healthcare Management Services (Including Managed Care Services); and
3. 915-49: High Volume, Telephone Call Answering Services (See 915-05 for Low Volume Services)

Respondents are not required to use, nor limited to using, the class and item codes identified above, and may identify other areas for subcontracting.

HHSC does not endorse, recommend, or attest to the capabilities of any company or individual listed on the CPA’s CMBL. The list of certified HUBs is subject to change, so Respondents are encouraged to refer to the CMBL often to find the most current listing of HUBs.

4.2.5.6 HUB Subcontracting Procedures – If a Respondent Intends to Subcontract

An HSP must demonstrate that the Respondent made a good faith effort to comply with HHSC’s HUB policies and procedures. The following subparts outline the items that HHSC will review in determining whether an HSP meets the good faith effort standard. A Respondent that intends to subcontract must complete the HSP to document its good faith efforts.

4.2.5.6.1 Identify Subcontracting Areas and Divide Them into Reasonable Lots

A Respondent should first identify each area of the contract MCO Administrative Service work it intends to subcontract. Then, to maximize HUB participation, it should divide the contract MCO Administrative Service work into reasonable lots or portions, to the extent consistent with prudent industry practices.

4.2.5.6.2 Notify Potential HUB Subcontractors

The HSP must demonstrate that the respondent made a good faith effort to subcontract with HUBs. The Respondent’s good faith efforts will be shown through utilization of all methods in conformance with the development and submission of the HSP and by complying with the following steps:

1. Divide the contract work into reasonable lots or portions to the extent consistent with prudent industry practices. The Respondent must determine which portions of work, including goods and services, will be subcontracted.
2. Use the appropriate method(s) to demonstrate good faith effort. The Respondent can use method(s) 1, 2, 3, or 4:

   Method 1: Respondent Intends to Subcontract with only HUBs:

   The Respondent must identify in the HSP the HUBs that will be utilized and submit written documentation that confirms 100% of all available subcontracting opportunities will be performed by one or more HUBs; or,

   Method 2: Respondent Intends to Subcontract with HUB Protégé(s):
The Respondent must identify in the HSP the HUB protégé(s) that will be utilized and should:

1. Include a fully executed copy of the Mentor Protégé Agreement, which must be registered with the CPA prior to submission to HHSC; and
2. Identify areas of the HSP that will be performed by the protégé.

HHSC will accept a Mentor Protégé Agreement that has been entered into by a respondent (mentor) and a certified HUB (protégé) in accordance with Texas Government Code § 2161.065. When a Respondent proposes to subcontract with a protégé(s), it does not need to provide notice to three HUB vendors for that subcontracted area.

Participation in the Mentor Protégé Program, along with the submission of a protégé as a subcontractor in an HSP, constitutes a good faith effort for the particular area subcontracted to the protégé; or,

**Method 3: Respondent Intends to Subcontract with HUBs and Non-HUBs (Meet or Exceed the Goal):**

The Respondent must identify in the HSP and submit written documentation that one or more HUB subcontractors will be utilized; and that the aggregate expected percentage of subcontracts with HUBs will meet or exceed the goal specified in this solicitation. When utilizing this method, only HUB subcontractors with existing contracts with the Respondent for five years or less may be used to comply with the good faith effort requirements.

When the aggregate expected percentage of subcontracts with HUBs meets or exceeds the goal specified in this solicitation, respondents may also use non-HUB subcontractors; or,

**Method 4: Respondent Intends to Subcontract with HUBs and Non-HUBs (Does Not Meet or Exceed the Goal):**

The Respondent must identify in the HSP and submit documentation regarding both of the following requirements:

1. written notification to minority or women trade organizations or development centers to assist in identifying potential HUBs of the subcontracting opportunities the respondent intends to subcontract.

Respondents must give minority or women trade organizations or development centers at least seven working days prior to submission of the Respondent’s response for dissemination of the subcontracting opportunities to their members. A list of minority and women trade organizations is located on HHSC’s website under the Minority and Women Organization link.

2. written notification to at least three HUB businesses of the subcontracting opportunities that the respondent intends to subcontract. The written notice must be sent to potential HUB subcontractors prior to submitting proposals and must include:
Section 5 – Evaluation Process and Criteria

RFP No. 529-15-0001

4.2.5.6.3 Written Justification of the Selection Process

HHSC will make a determination if a good faith effort was made by the respondent in the development of the required HSP. One or more of the methods identified in the previous sections may be applicable to the respondent’s good faith efforts in developing and submission of the HSP. HHSC may require the respondent to submit additional documentation explaining how the respondent made a good faith effort in accordance with the solicitation.

A Respondent must provide written justification of its selection process if it chooses a non-HUB subcontractor. The justification should demonstrate that the respondent negotiated in good faith with qualified HUB bidders, and did not reject qualified HUBs who were the best value responsive bidders.

4.2.5.7 HUB Subcontracting Procedures – If a Respondent Does Not Intend to Subcontract

If the Respondent plans to complete all contract MCO Administrative Service requirements with its own equipment, supplies, materials, or employees, it is still required to complete an HSP.

The Respondent must complete the “Self Performance Justification” portion of the HSP, and attest that it does not intend to subcontract for any administrative goods or services, including the class and item codes identified in RFP Section 4.2.5.5, “CPA Centralized Master Bidders List.” In addition, the Respondent must identify the sections of the proposal that describe how it will complete the Scope of Work using its own resources or provide a statement explaining how it will complete the Scope of Work using its own resources. The Respondent must agree to comply with the following if requested by HHSC:

1. Provide evidence of sufficient respondent staffing to meet the RFP requirements;
2. provide monthly payroll records showing the respondent staff fully dedicated to the contract;
3. allow HHSC to conduct an on-site review of company headquarters or work site where services are to be performed; and
4. provide documentation proving employment of qualified personnel holding the necessary licenses and certificates required to perform the Scope of Work.

4.2.5.8 Post-award HSP Requirements

The HSP will be reviewed and evaluated prior to contract award and, if accepted, the finalized HSP will become part of the contract with the successful respondent(s).

After contract award, HHSC will coordinate a post-award meeting with the successful Respondents to discuss HSP reporting requirements. The MCO must maintain business records documenting compliance with the HSP, and must submit monthly reports to HHSC by completing the HUB “Prime Contractor Progress Assessment Report.” This monthly report is required as a condition for payment and tells the agency the identity and the amount paid to all subcontractors.

As a condition of award the Contractor is required to send notification to all selected subcontractors as identified in the accepted/approved HSP. In addition, a copy of the notification must be provided to the agency’s Contract Manager or HUB program Office within 10 days of the contract award.

During the term of the contract, if the parties in the contract amend the contract to include a change to the scope of work or add additional funding, HHSC will evaluate to determine the probability of additional subcontracting opportunities. When applicable, the Contractor must submit an HSP change request for HHSC review. The requirements for an HSP change request will be covered in the post-award meeting.

UMCM-Chapter 5.4.4, “HUB Reports,” outlines the procedures for changing the HSP, as well as the HSP compliance and reporting requirements. When making a change to an HSP, the Contractor will obtain prior written approval from HHSC before making any changes to the HSP. Proposed changes must comply with the HUB program good faith effort requirements relating to the development and submission of the HSP.

If the MCO decides to subcontract any part of the contract after the award, it must follow the good faith effort procedures outlined in RFP Section 4.2.5.6, “HUB Subcontracting Procedures,” (e.g., divide work into reasonable lots, notify at least three vendors per subcontracted area, provide written justification of the selection process, or participate in the Mentor Protégé Program).

For this reason, HHSC encourages Respondents to identify, as part of their HSP, multiple subcontractors who are able to perform the work in each area the Respondent plans to subcontract. Selecting additional subcontractors may help the selected MCO make changes to its original HSP, when needed, and will allow HHSC to approve any necessary changes expeditiously.

Failure to meet the HSP and post-award requirements will constitute a breach of contract, and will be subject to remedial actions. HHSC may also report noncompliance to the CPA in accordance with the provisions of the Vendor Performance and Debarment Program (see 34 Tex. Admin. Code § 20.108 and 34 Tex. Admin. Code § 20.105).
4.2.6 Section 6 – Certifications and Other Required Forms

Respondents must submit the following required forms with their proposals:

1. Child Support Certification;
2. Debarment, Suspension, Ineligibility, and Voluntary Exclusion of Covered Contracts;
3. Federal Lobbying Certification;
4. Nondisclosure Statement;
5. Required Certifications; and
6. Respondent Information and Disclosures.

The required forms are located on HHSC’s website, under the “Business Opportunities” link. HHSC encourages Respondents to carefully review all of these forms and submit questions regarding their completion prior to the deadline for submitting questions (see RFP Section 1.3, “Procurement Schedule”).

Respondents should note that the “Respondent Information and Disclosures” form asks Respondents to provide information on certain litigation matters. In addition to the information required on this form, Respondents must provide all of the information described in UMCM Chapter 5.8, “Report of Legal and Other Proceedings and Related Events.” Respondents may include this supplemental information on the “Respondent Information and Disclosures” form, or under a separate submission.

4.3 Part 3 – Programmatic Proposal

Respondents must provide a detailed description of the proposed programmatic solution, which must support all business activities and requirements described in the RFP. The Programmatic Proposal must reflect a clear understanding of the nature of the work undertaken.

Respondents should carefully read the submission requirement instructions for specific questions in this section. For each applicable programmatic submission requirement, the Respondent must indicate, in addition to the information requested in each subsection, the following information if applicable to the Respondent and it’s Proposal:

Material Subcontractor: If the Respondent plans to provide the service or perform the function through a Material Subcontractor, the Respondent must detail the services or function to be subcontracted, and how the Respondent and the Material Subcontractor will coordinate the service or function. Describe the specific management tools and strategies the Respondent will use to provide oversight of the Material Subcontractor’s performance. Respondents should describe any prior working relationships with the Material Subcontractor.

Action Plan: This requirement applies to any Respondent who is not currently (1) providing services or performing functions relating to a specific RFP submission, or (2) meeting the Operations Phase Requirements in RFP Section 8 relating to a specific submission requirement for the STAR Health Program. In the Action Plan, the Respondent must, for each submission requirement describe:
1. the services, functions, or requirements the Respondent is not currently performing;
2. its current comparable experience and abilities, if any; and
3. how the Respondent must meet the STAR Health Contract responsibilities, including assigned staffing and resources for completing the services, functions, or requirements and a timeline for completing each.

In responding to questions for which the Respondent includes information about a Material Subcontractor or Action Plans, up to one page may be used to describe each Material Subcontractor arrangement and up to one page may be used to describe each Action Plan. These pages are outside of the page limit instructions for the specific submission requirement.

HHSC understands that some Respondents may not have current experience providing managed care services to STAR Health Program members in Texas. In responding to questions relating to experience, Respondents should clearly indicate if their experience is in Texas, and if their experience is with STAR Health or other comparable populations.

The Programmatic Proposal must include a detailed description of the following Program components, at a minimum:

- Section 1 – Proposed Capacity
- Section 2 – Experience Providing Covered Services
- Section 3 – Value-added and Case-by-Case Added Services
- Section 4 – Access to Care
- Section 5 – Provider Network Provisions
- Section 6 – Member Services
- Section 7 – Quality Assessment and Performance Improvement (QAPI)
- Section 8 – Utilization Management (UM)
- Section 9 – Early Childhood Intervention (ECI)
- Section 10 – Health Passport
- Section 11 – Service Management and Service Coordination
- Section 12 – Health Home
- Section 13 – Disease Management (DM)
- Section 14 – Behavioral Health (BH) Services
- Section 15 – Pharmacy Services
- Section 16 – Management Information Systems (MIS) Requirements
- Section 17 – Fraud, Waste, and Abuse
- Section 18 – Transition Plan
4.3.1 Section 1 – Proposed Capacity

(3 pages, excluding tables)

The Respondent must:

1. complete the MCO program Proposed Capacity table found in the RFP Procurement Library, which must include an estimate of the number of HHSC MCO Members the Respondent has the capacity to serve on the Operational Start Date;

2. describe the calculations and assumptions used to arrive at these capacity projections. In developing these projections, the Respondent should consider the capacity of its Network, including its PCP Network, its BH Services Network, its specialty care Network, and its Pharmacy Network. Respondents should specify:
   a. the anticipated STAR Health Program enrollment;
   b. the expected utilization of services, taking into consideration the characteristics and healthcare needs of specific populations represented in the STAR Health Program;
   c. the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the Covered Services;
   d. the numbers of Network Providers and providers with signed contracts, LOAs, or LOIs who are not accepting new patients, by MCO program;
   e. the geographic location of providers and HHSC MCO members, considering travel time, the means of transportation ordinarily used by HHSC MCO members, and whether the location provides physical access for members with disabilities; and
   f. generally describe anticipated capacity changes, if any, over the Initial Contract Period; and
   g. generally describe methods that the MCO will use to ensure access to all Covered Services upon potential population growth due to changes in law.

4.3.2 Section 2 – Experience Providing Covered Services

(3 pages)

Covered Services are described in RFP Section 8.1.2, “Covered Services,” and Section 11, “Covered Services.”

The Respondent must briefly describe the Respondent’s experience providing services equivalent or comparable to STAR Health Covered Services described in RFP Section 11:

1. Indicate which STAR Health Covered Service(s) (in whole or in part) the Respondent does not have experience providing on a capitated basis or does not have experience providing to a comparable
population.

2. Briefly describe the Respondent’s proposal for providing Covered Services, including any plans for expansions of its Provider Network prior to a Readiness Review. If the Respondent proposes to use a Material Subcontractor to provide BH Services, the Respondent must describe its relationship with the Material Subcontractor, as required by RFP Section 4.3, “Part 3—Programmatic Proposal.”

3. Describe the Respondent’s experience in providing Service Management or Service Coordination to the STAR Health population or a comparable population. Respondent should specifically describe the processes and procedures used to coordinate non-capitated services and community resources. If the Respondent does not have experience coordinating these services, indicate how the Respondent intends to meet this requirement.

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4.3.3 Section 3 – Value-added and Case-by-Case Added Services

4.3.3.1 Value-Added Services

(1 page per Value-added Service)

Respondents may propose to offer Value-added Services as described in RFP Section 8.1.2.1, “Value-added Services.” If offered, the Respondent will not receive additional compensation for Value-added Services, and may not report the costs of Value-added Services as allowable medical or administrative costs.

For each MCO program and Value-added Service proposed, the Respondent must:

1. define and describe the Value-added Service;
2. identify the category or group of Members eligible to receive the proposed Value-added Services if it is a type of service that is not appropriate for all Members;
3. note any limitations or restrictions that apply to the Value-added Services;
4. if the Value-added Service is not a Healthcare Service or benefit, specify which staff will determine whether a Member is eligible to receive the Value-added Service;
5. identify the types of Providers or other person(s) responsible for providing the Value-added Service, including any limitations on Provider or other person’s capacity if applicable;
6. describe how the Respondent will identify the Value-added Service in administrative data (Encounter Data), or will otherwise document the delivery of the Value-added Service;
7. propose how and when Providers and Members will be notified about the availability of any Value-added Service;
8. describe how a Member may obtain or access the Value-added Service; and
9. include a statement that the Respondent will provide any Value-added Service(s) that are approved by HHSC for at least 12 months after the Operational Start Date of the Contract.

4.3.3.2 Case-by-Case Added Services

(1 page per Service)

Respondents must briefly describe any Case-by-Case Added Services, which the Respondent proposes could, based upon Medical Necessity criteria, be cost-effective and have the potential for the
improved health status of Members in the STAR Health population or a comparable population. Describe an example in which a service might be proposed to the Member, or the Member’s Medical Consenter, in lieu of the typical scope of services.

4.3.4 Section 4 – Access to Care

Access to Care standards are described in RFP Section 8.1.3, “Access to Care.”

4.3.4.1 Travel Distances

(no page limit, should only submit applicable tables)

Submit tables created using UMCM Chapter 5.14.4, “STAR Health Geo-Mapping Report,” UMCM Chapter 5.14.5, “STAR Health and Medicaid Dental Geo-Mapping Report,” and maps created using Geo-Access, or a comparable software program, to demonstrate the geographic adequacy of the Respondent’s proposed Provider Network compared to the projected population statewide. For purposes of Geo Mapping, the distribution method will be to place all members at the center of the zip code.

Providers in the demonstrated Provider Network must have an executed contract with the Respondent, a letter of intent (LOI), or a letter of agreement (LOA) indicating the provider intends to contract with the Respondent if HHSC awards the Respondent an MCO Contract. Respondents do not need to submit the signed contracts, LOIs, or LOAs with the Proposal, but HHSC may request to review these documents during its evaluation of the Proposal. Providers who have not signed a Network Provider contract or LOI/LOAs may not be included in the Respondent’s Network for purposes of responding to this RFP submission requirement.

Respondents should submit one set of the above tables and maps.

4.3.4.2 Assessing Access to Care

(5 pages)

1. Identify the processes by which the Respondent must measure and regularly verify:
   a. Network compliance, including pharmacy, regarding travel distance access in RFP Section 8.1.3.2, “Access to Network Providers;”
   b. Provider compliance regarding appointment access standards in RFP Section 8.1.3.1, “Waiting Times for Appointments;” and
   c. PCP compliance with after-hours coverage standards in RFP Section 8.1.4.2, “Primary Care Providers and the Medical Home.”

2. Describe the steps the Respondent has taken in the past when it identified a deficiency in its compliance with plan or state travel distance access standards. The description should include how the Respondent will address deficiencies in the Network related to:
   a. the lack of an age-appropriate PCP with an Open Panel within the required travel distance;
   b. the lack of inpatient BH Services within the required travel distance;
c. the lack of outpatient BH Services from Providers, including child psychiatrists, within the required travel distance;
d. the lack of a specialist within the travel distance of a Member’s residence;
e. for female Members that may have experienced sexual abuse and female Members of childbearing age, the lack of an OB/GYN within the travel distance of the Member’s residence; and
f. the lack of a Network pharmacy within the travel distance of the Member’s residence.

3. Describe the steps the Respondent has taken in the past when it identified a deficiency in its compliance with a Provider that:
   a. was not meeting plan or state appointment access standards, and
   b. a PCP that was not in compliance with the plan or state after-hours coverage requirements.

If the Respondent has not taken the steps listed in 2 and 3 above with regularity, describe how it proposes to take those steps in the future.

4. Describe the processes the Respondent will implement to accommodate additional Members and to ensure the access standards are met if actual enrollment exceeds projected enrollment.

5. Describe how the Respondent will provide training to ensure the Providers understand and respond to the STAR Health population’s special healthcare needs.

6. Describe how the Respondent plans to provide BH Emergency Services, including emergency screening services, Emergency Services and short-term crisis stabilization services, and how the Respondent will address a Provider not meeting the Respondent’s or state’s appointment standards.

4.3.5 Section 5 – Provider Network Provisions

Provider Network requirements are primarily described in RFP Section 8.1.4, “Provider Network.” In addition, the STP requirements applicable to Medicaid MCOs are described in RFP Section 8.1.29, “Medicaid Significant Traditional Providers (STPs).” Respondents should review these RFP requirements when developing their responses to questions in this section.

The Respondent must provide a narrative overview in its proposal of the Respondent’s Network. This narrative must include a description of the deficiencies in the Respondent’s proposed Provider Network and a description of how the Respondent’s Network addresses the BH needs and other special needs of the STAR Health population.

The Respondent must provide a Provider Network Development Plan in its proposal that details how the Respondent will address any Provider Network deficiencies before the Operational Start Date. The Respondent should describe the items below as part of the Provider Network Development Plan:

1. Timeframes for addressing deficiencies;
2. types of providers that the Respondent will recruit, including STPs;
3. how the Respondent will recruit the providers, including STPs;
4. who will be responsible for recruiting the providers; and
5. how the Respondent will determine that the Provider Network is complete.

After the Contract Effective Date, the MCO must provide updates to the Provider Network Development Plan on a fixed schedule as determined by HHSC.

### 4.3.5.1 Provider Network

(1 page, excluding Provider listing and tables)

Network Providers must have an executed contract with the Respondent, a (LOI, or a LOA indicating the Provider intends to contract with the Respondent should HHSC award the Respondent a contract for the applicable MCO program. Network Providers must be licensed in the State of Texas to provide the contracted Covered Services. As described in **RFP Section 8.1.4**, “Provider Network,” Network Providers must be credentialed by selected Respondents prior to serving Members. Sample LOI/LOA agreements and sample Network Providers tables can be found in the **RFP Procurement Library**.

1. The Respondent must submit a complete list of proposed Network Providers for each of the following Acute Care provider types that would be responsible for providing Covered Services. The list must indicate for each provider type, the name, address, and NPI (and TPIN, if applicable) of the Providers with signed contracts, LOIs, or LOAs. The Respondent must include in an Excel file at least the two nearest Providers meeting each of the following provider type descriptions. The Respondent must also include in the Excel file all Providers in the designated provider type within the Service Area. The listing must include separate lists of each provider type of Acute Care Services in the order listed below:

   a. Acute Care Hospitals, inpatient, and outpatient services;
   b. Hospitals providing Level 1 trauma care;
   c. Hospitals providing Level 2 trauma care;
   d. Hospitals designated as transplant centers;
   e. Hospitals designated as Children’s Hospitals by the CMS;
   f. other Hospitals with specialized pediatric services;
   g. Psychiatric Hospitals providing mental health services, inpatient and outpatient;
   h. other facilities or clinics providing outpatient BH services;
   i. Hospitals providing substance abuse services, inpatient and outpatient; and
   j. other facilities or clinics providing outpatient substance abuse services.

2. Identify the types of Providers the Respondent allows as PCPs for adults, PCPs for children, and outpatient BH Service Providers. The Respondent should identify its contractual requirements for these provider types and any exceptions. For example, Respondent should note under what circumstances, if any, an internist is allowed to be a PCP for children, a family practitioner is allowed to be an OB/GYN, or a certified nurse midwife practicing under a physician that qualifies as a PCP is allowed to be a PCP.
4.3.5.2 Significant Traditional Providers (STPs)

(No page limit for STP tables, 1 page for narrative)

The STP requirements applicable to Medicaid MCOs are described in RFP Section 8.1.29. HHSC-designated Medicaid STPs can be found in the RFP Procurement Library. For each STP provider type, the Respondent must complete the “STP Network Percentage Table” charts provided in the RFP Procurement Library. The total number of STPs can be found in the RFP Procurement Library by type of STP.

Respondent may provide a one-page narrative to explain STP status.

4.3.5.3 Provider Network Capacity

(3 pages)

HHSC has targeted improved Network capacity and improved Member access to Covered Services as a priority for the Initial Contract Period.

1. Indicate which, if any, Covered Services are not available from a qualified Provider in the Respondent’s proposed Network in the Service Area and how the Respondent proposes to provide the Covered Services to Members in the Service Area; and

2. Briefly describe how deficiencies will be addressed when the Provider Network is unable to provide a Member with appropriate access to Covered Services due to lack of a qualified, Network Providers within the travel distance of the Member’s residence specified in RFP Section 8.1.3.2, “Access to Network Providers.” The description should include how the Respondent will address deficiencies in the Network related to:

   a. the lack of an age-appropriate PCP with an Open-Panel within the required travel distance of the Member’s residence;
   b. the lack of inpatient and outpatient BH Services, including child psychiatrists, within the required travel distance;
   c. the lack of a cardiologist within the travel distance of the Member’s residence;
   d. the lack of an OB/GYN within the travel distance of the Member’s residence; and
   e. the lack of a Network pharmacy within the travel distance of the Member’s residence.

4.3.5.4 Credentialing and Re-credentialing

(5 pages)

Provider credentialing and re-credentialing requirements are described in RFP Section 8.1.4.4, “Provider Credentialing and Re-credentialing.” For all of the following submission requirements, instead of attaching copies of the Respondent’s credentialing/re-credentialing policies and procedures, the Respondent should provide a brief summary of its policies and procedures.
1. Describe the Respondent’s minimum credentialing and licensure requirements and procedures for each type of Provider listed in RFP Section 8.1.4, “Provider Network,” and demonstrate how the Respondent ensures, or proposes to ensure, that the minimum credentialing requirements are met by any Provider rendering Covered Services. The description must demonstrate compliance with RFP Section 8.1.4.4, “Provider Credentialing and Re-credentialing.” If the Respondent uses a Material Subcontractor for any portion of its Provider Network and delegates responsibility for that Network to the Material Subcontractor, the Respondent must describe how it will ensure that the Material Subcontractor’s Providers meet minimum credentialing requirements.

2. Describe the re-credentialing process, including any credentialing activities that occur between formal re-credentialing cycles for Providers.

3. Describe how the DFPS background check process is integrated into the Respondent’s credentialing process.

4. Describe how the Respondent will capture and assess the following information:
   a. Member Pre-Appeals, Complaints and Appeals
   b. Results from quality reviews and Provider quality profiling
   c. UR information
   d. Information from licensing and accreditation agencies.

5. A Respondent currently operating in Texas must separately report the following information. A Respondent not currently operating in Texas must separately report the same information for a managed care program it operates in another state similar to the STAR Health Program:
   a. the percentage of providers in its Texas network re-credentialed in the past three years, for the following provider types: Primary Care Provider specialty care physician, and masters-level outpatient BH providers; and
   b. the number and percentage of providers in its Texas network who were subjected to the regularly scheduled re-credentialing process over the past 24 months that were denied continued network status.
   c. the number and percentage of providers in its Texas network who were subjected to a DFPS background check and were denied network status due to the associated findings.

### 4.3.5.5 Provider Training

Provider training requirements are described in RFP Section 8.1.4.6, “Provider Relations Including Manual, Materials and Training.”

1. Provide a brief description of the proposed Provider training programs. The description should include:
   a. the types of programs to be offered, including the modality of training;
   b. what topics will be covered (such as billing, complaints and appeals, service coordination);
   c. how the Respondent will specifically train Providers on issues such as the special needs of the STAR Health population and accessing local community resources relevant to the STAR Health population;
   d. which Providers will be invited to attend;
   e. how the Respondent proposes to maximize Provider participation, including how the Respondent proposes to use Internet and televideo capabilities to provide training;
f. how Provider training programs will be evaluated;
g. the frequency of Provider training;
h. how the Respondent will facilitate training programs for Providers to receive continuing education credits; and
i. how the Respondent will specifically train Providers to be attuned to the need for increased sensitivity and respect for confidentiality in dealing with the STAR Health population.

2. Briefly describe two examples of recent Provider training programs conducted by the Respondent that may be relevant to the STAR Health Program. These examples must include:
   a. a description of the training program;
   b. a summary of distributed materials (the actual materials are not to be submitted);
   c. number and type of attendees; and
   d. results of any evaluations from the training.

A Respondent currently participating in any of HHSC’s Medicaid MCO programs must submit the above Provider training examples for each MCO program.

A Respondent not currently participating in one or more of HHSC’s Medicaid MCO programs must submit the above provider training examples for a similar managed care program. If the Respondent referenced a non-HHSC managed care program in another submission requirement, the Respondent must submit its provider education information in this submission requirement.

4.3.5.6 Provider Hotline

(3 pages; excluding hotline telephone reports)

Describe the proposed Provider Hotline function and how the Respondent would meet the requirements of RFP Section 8.1.4.8, “Provider Hotline.” The description must include:

1. normal hours of operation of the hotline;
2. staffing for the hotline;
3. training for the hotline staff on Covered Services and STAR Health Program requirements;
4. the routing of calls among hotline staff to ensure timely and appropriate response to provider inquiries;
5. responsibilities of hotline staff, if any, in addition to responding to Provider Hotline calls (e.g., responding to non-Network provider calls or Member Hotline calls);
6. after-hours procedures and available services;
7. Provider Hotline telephone reports for the most recent four quarters with data that show:
   a. monthly trends for call volume,
   b. the monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and
   c. the monthly trends for the abandonment rate.
8. whether the Provider Hotline has the capability to administer automated surveys to callers at the end of calls.
A Respondent currently participating in any of HHSC’s Medicaid MCO programs must submit the information in **RFP Section 4.3.5.6(7)** for each Provider Hotline operated, and identify any proposed changes to Provider Hotline functions that would occur under the STAR Health Program.

A Respondent not currently participating in any of HHSC’s Medicaid MCO programs must submit the information in **RFP Section 4.3.5.6(7)** for a similar managed care program that it operates. If a Respondent referenced a non-HHSC managed care program in another submission requirement, the Respondent must submit its Provider Hotline telephone report for the same managed care program.

### 4.3.5.7 Provider Incentives

(2 pages)

Provide a high-level description of the processes the Respondent will put in place to meet the requirements as described in **RFP Section 8.1.4.11**, “Provider Incentives.”

The Respondent must submit a proposal for a pilot “gain sharing” program. The program should focus on collaborating with Network physicians and Hospitals in order to allow them to share a portion of the Respondent’s savings resulting from reducing inappropriate utilization of services, including inappropriate admissions and readmissions. The proposal should include mechanisms for the Respondent to provide incentive payments to Hospitals and physicians for quality care. The proposal should include quality metrics required for incentives, recruitment strategies of providers, and a proposed structure for payment.

### 4.3.5.8 Medical Advisory Committees (MACs)

(2 pages)

For the STAR Health Program, the Respondent must:

1. Describe the role of the MAC in establishing and monitoring clinical policies and procedures, and in developing and updating clinical practice guidelines.
2. Describe how the Respondent will encourage and provide an opportunity for its Providers to have access to peer-to-peer consultation and to consult with the MCO’s physical health staff and BH staff.
3. The Respondent must describe the process for implementing and maintaining the MAC, including the selection of participants and how the Respondent will ensure participation.

### 4.3.6 Section 6 – Member Services

#### 4.3.6.1 Member Services Staffing

(7 pages; excluding organizational charts)

The MCO must maintain a Member Services Department to assist Members, Caregivers, Medical Consenters, Single Source Continuum Contractor (SSCC) staff, and DFPS Staff in obtaining Covered Services for Members as described in RFP **Section 8.1.5**, “Member Services.”
1. Provide an organizational chart of the Member Services Department, showing the placement of Member Services within the Respondent’s organization and showing the key staff within the Member Services Department.

2. Explain the functions of the Member Services staff, including brief job descriptions and qualifications.

3. Describe the training the Respondent will provide to Members, Caregivers, SSCC staff, and DFPS staff on topics such as navigating the healthcare system and accessing local community resources.

4. Describe the curriculum for training the MCO will provide to the MCO’s Member Services representatives. The description should include training schedules and how the trainings will prepare Member Services representatives to assist Members, Caregivers, Medical Consenters, SSCC staff, and DFPS Staff with:

   a. access to Covered Services, including the medical consent process, access to Texas Health Steps (THSteps) medical checkups and BH Services;
   b. understanding STAR Health requirements;
   c. coordinating clinical assessments, access to court-ordered services, and special evaluations to facilitate Member facility admissions (such as psychosocial or psychological evaluations, psychometric testing, and neuropsychological evaluations) as necessary to meet the Member’s needs and facility licensing and admission requirements;
   d. sharing of information between the MCO and other parties such as DFPS and Caregivers responsible for ensuring the Member’s safety;
   e. understanding and being prepared to address Members’ cultural needs;
   f. providing assistance to Members with limited English proficiency, including developing Member Materials and providing language assistance to Members speaking languages of Major Population Groups making up 10 percent or more of the population; and
   g. educating Members, DFPS staff, SSCC staff, and Caregivers about Non-capitated Services and providing referrals for these services.

5. Identify the turnover rate for Member Services staff in the past two years. A Respondent operating any HHSC Medicaid MCO program must provide the staff turnover rate of these programs. A Respondent not currently operating an HHSC Medicaid MCO program must provide its Member Services staff turnover rate for a comparable managed care program and identify the managed care program.

6. Identify the number of Member Services staff Respondent intends to dedicate to the Service Coordination function and describe their professional backgrounds.

7. Identify the percentage of Member Services staff who will be physically located in the Service Area.

4.3.6.2 Member Hotline

(3 pages; excluding hotline telephone reports)

The Member Hotline requirements are described in RFP Section 8.1.5.6, “Nurse and Member Hotline Requirements.”

Describe the proposed Member Hotline function, including:
1. normal hours of operation;
2. number of Member Hotline staff dedicated to the STAR Health Program, expressed in the number of full time employees (FTEs) per 1000 Members who are available 8:00 a.m. to 5:00 p.m., local time in all areas of the state, Monday through Friday, excluding state-approved holidays;
3. routing of calls among Member Hotline staff to ensure timely and accurate response to Member inquiries;
4. responsibilities of Member Hotline staff, if any, in addition to responding to STAR Health Member Hotline calls, (e.g., responding to non-STAR Health Member calls or Provider Hotline or BH Hotline calls);
5. after-hours procedures and available services, including those provided to non-English speaking Members and Members who are deaf or hard-of-hearing;
6. the number and percentage of FTE Member Hotline staff who are bilingual in English and Spanish;
7. the number and percentage of FTE Member Hotline staff who are multi-lingual for any additional language, by language spoken;
8. the number and percentage of FTE Member Hotline staff dedicated to the Service Coordination function;
9. Member Hotline telephone reports for the most recent four quarters with data that show:
   a. the monthly trends for call volume;
   b. monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and
   c. monthly trends for the abandonment rate; and
10. whether the Member Hotline has the capability to administer automated telephonic surveys to callers at the end of calls.

A Respondent currently participating in any of HHSC’s Medicaid MCO programs must submit the information in items 1 through 10 above for each Member Hotline operated, and identify any proposed changes to hotline functions for the STAR Health Program.

If the Respondent is not currently participating in any of HHSC’s Medicaid MCO programs, it should describe its experience and proposed approach in establishing and maintaining an accessible call center for members that is comparable to the Member Hotline described in RFP Section 8.1.5.6, “Nurse and Member Hotline Requirements.” The description must include the information listed in items 1 to 10 above.

Finally, if a Respondent is proposing to use a single point of access, i.e., toll-free number, for multiple hotlines (e.g., Member Services, BH, Nurse Hotline, and Provider Hotline), the Respondent shall note in its proposal the differences, if any, in its staffing for each of these Hotlines, and shall describe how calls to the Hotline(s) are triaged.

4.3.6.3 Member Service Scenarios

(8 pages)

Describe the procedures a Member Services representative will follow to deal with the following situations:

1. A Member, Caregiver, Medical Consenter, or DFPS caseworker has received a bill for payment of Covered Services from a Network Provider or Out-of-Network provider;
2. a Member, Caregiver or Medical Consenter is unable to reach her PCP after normal business hours;
3. a Member, Caregiver or Medical Consenter is having difficulty scheduling an appointment for preventive care with her PCP;
4. a Member, Caregiver, Medical Consenter, or DFPS caseworker requests assistance as the Member became ill while traveling outside of the state;
5. a Member, Caregiver or Medical Consenter has a request for a specific medication that the pharmacy is unable to provide;
6. a Member or Caregiver does not speak English;
7. a Caregiver or Medical Consenter calls after hours asking for assistance in managing the Member's BH crisis;
8. a Caregiver or Medical Consenter calls to complain that the Member’s Substitute Care status was discussed in a loud voice in the waiting room of the PCP’s office;
9. a Provider who has been ordered by the Court to provide an assessment of the Member calls with questions regarding the assessment;
10. a DFPS caseworker calls asking for the results of a Member’s medical assessment;
11. a Member’s PCP calls to report a suspicion that he/she is treating an adolescent with a substance abuse problem;
12. a Caregiver, Medical Consenter, or DFPS caseworker believes the Member is not receiving needed home and community-based services;
13. a Caregiver or a Member with a hearing impairment or another communicative disorder calls the Member Hotline and needs assistance; and
14. a Caregiver, Medical Consenter, or DFPS caseworker calls requesting that a Member be enrolled in Service Management; and
15. a Caregiver or a Medical Consenter calls to request Personal Care Services for a Member with complex needs.

4.3.6.4 Nurse Hotline

(3 pages; excluding hotline telephone reports)

The Nurse Hotline requirements are described in RFP Section 8.1.5.6, "Nurse and Member Hotline Requirements."

Describe the proposed Nurse Hotline function and how its purpose differs from the Member Hotline, including:

1. normal hours of operation;
2. number of nurses dedicated to the STAR Health Program Nurse Hotline, expressed in the number of FTEs per 1000 Members who are available 8:00 a.m. to 5:00 p.m., local time in all areas of the state, Monday through Friday, excluding state-approved holidays;
3. routing of calls to Nurse Hotline nurses, to ensure timely and accurate response to Member inquiries;
4. responsibilities of Nurse Hotline staff, if any, in addition to responding to STAR Health Nurse Hotline calls, (e.g., responding to non-STaR Health Member calls or Provider Hotline or BH Hotline calls );
5. after-hours procedures and available services, including those provided to non-English speaking Members and Members who are deaf or hard-of-hearing;
6. the number and percentage of FTE Nurse Hotline staff who are bilingual in English and Spanish;
7. the number and percentage of FTE Nurse Hotline staff who are multi-lingual for any additional language, by language spoken;
8. Nurse Hotline telephone reports for the most recent four quarters with data that show:
   a. the monthly trends for call volume;
   b. monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and
   c. monthly trends for the abandonment rate; and
9. whether the Nurse Hotline has the capability to administer automated telephonic surveys to callers at the end of calls.

A Respondent currently participating in any of HHSC’s MCO programs must submit the information in items 1 through 9 above for each Nurse Hotline operated, and identify any proposed changes to hotline functions for the STAR Health Program.

If the Respondent is not currently participating in any of HHSC’s MCO programs, it should describe its experience and proposed approach in establishing and maintaining an accessible call center for members that is comparable to the Nurse Hotline described in RFP Section 8.1.5.6, “Nurse and Member Hotline Requirements.” The description must include the information listed in items 1 to 9 above.

Finally, if a Respondent is proposing to use a single point of access, i.e., toll-free number, for multiple hotlines, e.g., Member Services, BH, Nurse Hotline, and Provider Hotline, the Respondent must note in its proposal the differences, if any, in its staffing for each of these Hotlines, and must describe how calls to the Hotline(s) are triaged.

4.3.6.5 Nurse Hotline Scenarios

(5 pages)

Describe the procedures a Nurse Hotline representative will follow to deal with the following situations:

1. a Member, Caregiver, or Medical Consenter calls requesting advice regarding a missed medication dose;
2. a Member, Caregiver, or Medical Consenter is unable to reach her PCP after normal business hours;
3. a Member, Caregiver, Medical Consenter, or DFPS caseworker is having difficulty filling a needed prescription after hours;
4. a Member, Caregiver, or Medical Consenter calls requesting an evaluation of whether or not to go to an Emergency Room for immediate care;
5. a Caregiver or Medical Consenter calls after hours asking for assistance in managing the Member’s BH crisis;
6. a Member, Caregiver, or Medical Consenter calls requesting a referral to a BH provider experienced in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT);
7. a DFPS caseworker calls asking for the results of a Member’s medical assessment;
8. a Caregiver or Medical Consenter calls to report a suspicion that the Member has returned to the home under the influence of drugs or alcohol;
9. a Caregiver or Medical Consenter calls to request a new wheelchair for a Member that was placed in their home today with badly damaged equipment from the biological home; and
10. a Caregiver, Medical Consenter, or DFPS caseworker calls requesting enrollment of the Member into a DM program.

4.3.6.6 STAR Health Liaisons

(5 pages)

The STAR Health Liaison requirements are described in RFP Attachment A, Section 4.05, “STAR Health Liaisons,” and Section 8.1.11, “Coordination with the Department of Family and Protective Services.”

For the STAR Health Program, the Respondent must:

1. Explain the functions of the STAR Health Liaisons, including brief job descriptions and qualifications.
2. State the assumptions the Respondent used in determining the number of STAR Health Liaisons that are needed.
3. Identify the number of STAR Health Liaisons who will be physically located in the Service Area they represent.
4. Describe the training curriculum the Respondent will provide to its STAR Health Liaison staff. The description should include training schedules and how the training will prepare Liaisons to:
   a. understand STAR Health requirements;
   b. coordinate with DFPS staff to resolve escalated issues related to STAR Health or the individual healthcare of a Member;
   c. understand and address Members’ cultural needs; and
   d. identify and assist DFPS staff with training needs related to STAR Health or the Member’s healthcare.

4.3.6.7 Member Education

(8 pages)

Member education requirements are described in RFP Section 8.1.5.7, “Member Education.”

1. Provide a brief description of the proposed Member education materials that will be used to educate Medical Consenters, Members, DFPS staff, Caregivers, guardians ad litem, judges, and attorneys ad litem. The description should include:
   a. the types of materials to be offered, including the modality of training;
   b. what topics will be covered (such as the role of the PCP, referrals for services using Network Providers, Value-Added Services, complaints and appeals, Service Coordination and Service Management, and Health Passport);
c. how the Respondent will specifically educate Members, Caregivers, and Medical Consenters on issues such as the value of screening, preventative care, and other Medical Home services;
d. how the Respondent proposes to increase Member and Medical Consenter attendance, including any proposed use of Internet and televideo capabilities to provide training; and
e. the frequency of Provider training.

2. Briefly describe two examples of recent Member education initiatives conducted by the Respondent that may be relevant to the STAR Health Program. These examples must include:
   a. a description of the education initiative;
   b. a summary of distributed materials (do not submit the actual materials);
   c. number and type of attendees; and
   d. results of any evaluations from the training.

A Respondent currently participating in any of HHSC’s MCO programs must submit the above Member education examples for each MCO Program.

A Respondent not currently participating in one or more of HHSC’s Medicaid MCO programs must submit the above Member education examples for a similar managed care program. If the Respondent referenced a non-HHSC managed care program in another submission requirement, the Respondent must submit its Member education information in this submission requirement.

4.3.6.8 Cultural Competency

(3 pages)

Provide a high-level description of the processes the Respondent will put in place to meet the requirements of the cultural competency requirements as described in RFP Section 8.1.5.8, "Cultural Competency Plan."

1. Describe how the Respondent will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.
2. Describe how the Respondent will develop intervention strategies and work with Network Providers to avoid disparities in the delivery of medical services to diverse populations.

4.3.6.9 Continuity of Care

(3 pages)

Continuity of Care transition requirements for certain new Members with Out-of-Network providers are in RFP Section 8.1.27, “Continuity of Care and Out-of-Network (OON) Providers.”

1. Describe how the Respondent will ensure continuity of prior authorized services whenever a Member transfers from the Fee-for-Service program to the STAR Health Program or from a Medicaid or CHIP MCO to the STAR Health Program. Also, describe how the Respondent will share information with the Fee-for-Service program or another Medicaid or CHIP MCO when the Member
transfers out of the STAR Health Program. The Respondent’s description should include how the MCO will authorize the Member’s OON providers to finish the treatment plan authorized by the Fee-for-Service program or another Medicaid or CHIP MCO.

2. Describe the proposed Continuity of Care Transition Plan for serving new Members whose current PCP, OB/GYN, specialty care providers, including BH providers, are not participants in the Respondent’s Provider Network.

3. Describe the MCO’s Provider recruitment process and timeframes (especially for recruiting STP providers) for outreaching to and enrolling OON providers serving new Members.

4.3.6.9 Objection to Providing Certain Services

(1 page)

In accordance with 42 C.F.R. § 438.102, the Respondent may file an objection to provide, reimburse for, or provide coverage of, counseling or referral service for a Covered Service based on moral or religious grounds, as described in RFP Section 8.1.28.7, “Objection to Provide Certain Services.” HHSC reserves the right to make downward adjustments to Capitation Rates for any Respondent that objects to providing certain services based on moral or religious grounds.

Respondent should indicate objections, if any, to providing a Covered Service based on moral or religious grounds. Identify the specific services to which it objects and describe the basis for its objection on moral or religious grounds.

4.3.6.10 Member Complaint, Pre-Appeal and Appeal Processes

(5 pages, excluding flowchart)

Medicaid Member Complaint, Pre-Appeal, and Appeal Processes are described in RFP Section 8.1.33, “Member Complaint and Appeal System.” A Respondent’s submission should reflect how it intends to meet the applicable Member Complaint, Pre-Appeal, and Appeal requirements. A Respondent should not submit detailed Complaint and Appeal policies and procedures as an attachment.

The Respondent must:

1. describe the process the Respondent will put in place for the review of Member Complaints and Appeals, including which staff would be involved;
2. provide a flowchart that depicts the process the Respondent will employ, from the receipt of a request through each phase of the review to notification of disposition, including providing notice of access to HHSC Fair Hearings;
3. document the MCO’s average time for resolution over the past 12 months for Member Complaints and Appeals (excluding expedited appeals), from date of receipt to date of notification of disposition;
4. describe the number and job descriptions of member advocates, how Members are informed of the availability of member advocates, and how Members access Advocates;
5. describe the Pre-Appeals process the Respondent will develop, implement, and maintain to facilitate resolution of Caregiver, Medical Consenter, SSCC staff, DFPS Staff or Member requests for the Respondent to reconsider the denial or limited authorization of a requested
service, including the type or level of service and the denial, in whole or in part, of payment for service. Describe how the MCO will work to reach timely compromise and resolution, and reduce the number of formal Appeals; and
6. describe the training, tools, and processes the Respondent will use to ensure that Member Advocates who do not reside in the same geographical area as the Member they are assisting is located are knowledgeable about key Network Providers in the geographic area where the Member resides; and describe how Respondent will help Members access Covered Services in a convenient manner, close to home when feasible and link Members to non-Covered Services.

4.3.6.11 Marketing Activities and Prohibited Practices

(no page limit)

If the Respondent has been sanctioned or placed under corrective action for prohibited Marketing practices related to managed care products by CMS, Texas, or by another state:
1. describe the basis for each sanction or corrective action, and;
2. explain how the Respondent would ensure that it would not engage in any Marketing practices prohibited by CMS or HHSC, including practices prohibited by UMCM Chapter 4.3, “Uniform Managed Care Marketing Policy and Procedures.”

A Respondent should report whether it has been sanctioned or been placed under corrective action by the federal government, Texas, or any other state in the past three years as part of its Business Specifications submission.

4.3.7 Section 7 – Quality Assessment and Performance Improvement

The Quality Assessment and Performance Improvement (QAPI) requirements of the RFP are described in RFP Section 8.1.7, “Quality Assessment and Performance Improvement (QAPI).”

4.3.7.1 Clinical Initiatives

(3 pages, excluding QAPI plan)

1. Describe data-driven clinical initiatives that the Respondent initiated within the past 24 months that have yielded improvement in clinical care for a managed care population comparable to the STAR Health population.
2. Document two statistically significant improvements generated by the Respondent’s clinical initiatives.
3. Describe two new or ongoing clinical initiatives that the Respondent proposes to pursue in the first year of the Contract. Document why each topic warrants Quality Improvement investment, and describe the Respondent’s measurable goals for the initiative.
4. For Respondents that already participate in an HHSC MCO program, provide a copy of the most recent QAPI Plan. For Respondents that do not participate in an HHSC MCO program, provide a copy of a 2013 quality assessment plan that the Respondent developed for a Medicaid population, or if a Respondent did not operate a Medicaid managed care plan in 2013, the most recent quality
assessment plan for a program operated by the Respondent and serving a population comparable to the STAR Health population.

4.3.7.2 Healthcare Effectiveness Data and Information Set (HEDIS) and Other Quality Data

(3 pages)

HHSC's External Quality Review Organization (EQRO) will perform HEDIS and Consumer Assessment of Health Plans Survey (CAHPS) calculations required by HHSC for MCO management. The following questions are designed to solicit information on a Respondent’s proposed approach to generating its own clinical indicator information to identify and address opportunities for improvement, as well as the Respondent’s approach to acting on clinical indicator data reported by HHSC’s EQRO.

The Respondent must:

1. identify the MCO-level HEDIS and any other statistical clinical indicator measures the Respondent will generate to identify MCO opportunities for clinical quality improvement;
2. document examples of statistical clinical indicator measures previously generated by the Respondent within the last two years for the STAR Health population or a managed care population comparable to the STAR Health population;
3. describe efforts that the Respondent has made to assess member satisfaction within the last two years for the STAR Health population or a managed care population comparable to the STAR Health population; and
4. describe management interventions implemented within the last two years based on member satisfaction measurement findings for the STAR Health population or a managed care population comparable to the STAR Health population, and whether these interventions resulted in measurable improvements in later member satisfaction findings.

4.3.7.3 Clinical Practice Guidelines

(5 pages)

There is significant evidence that medical professionals are often slow to adopt evidence-based clinical practice guidelines.

1. Describe four clinical guidelines (two related to non-preventive acute or chronic medical conditions and two related to BH conditions) that are relevant to the STAR Health population and that the Respondent believes are currently not being adhered to at a satisfactory level.
2. Describe what steps the Respondent will take to increase compliance with the clinical guidelines noted in its response to number 1.
3. Provide a general description of the Respondent’s process for developing and updating clinical guidelines, and for disseminating them to participating Providers.
4. Discuss how the Respondent will monitor Provider compliance with the requirement to conduct a thorough health history, assessment, mental status exam, and physical exam before prescribing psychotropic medication, as stated in Psychotropic Medication Utilization Parameters for Foster Children found at: http://www.dfps.state.tx.us/documents/Child_Protection/pdf/TxFosterCareParameters-September2013.pdf
5. Describe how the Respondent will use Evidence-based Practices (EBPs) or promising practices that dictate different approaches to BH treatment based on the classification of the Member’s disorder.

4.3.7.4 Provider Profiling

(3 pages, excluding sample profile reports)

1. Describe the Respondent’s practice of profiling the quality of care delivered by Network PCPs, and any other Acute Care Providers (e.g., high volume specialists, Hospitals) including the methodology for determining which and how many Providers will be profiled.
2. Submit sample quality profile reports used by the Respondent, or proposed for future use (identify which). Describe any new quality measures that will be included in these reports that are relevant to the STAR Health population.
3. Describe the rationale for selecting the performance measures presented in the sample profile reports.
4. Describe the proposed frequency with which the Respondent will distribute the reports to Network Providers, and identify which Providers will receive the profile reports.
5. Describe the explicit steps the Respondent will take with each profiled Provider following the production of each profile report, including a description of how the Respondent will motivate and facilitate improvement in the performance of each profiled Provider.

4.3.7.5 Network Management

(7 pages)

Describe how the Respondent will actively work with Network Providers to ensure accountability and improvement in the quality of care provided by the Providers. The description should include:

1. how the Respondent will train its Providers specific to the management and treatment of the STAR Health population;
2. the process and timeline the Respondent proposes for periodically assessing Provider progress on its implementation of strategies to attain improvement goals;
3. how the Respondent will reward Providers who demonstrate continued excellence or significant performance improvement over time, through non-financial or financial means, including pay-for-performance;
4. how the Respondent will share “best practice” methods or programs with Providers of similar programs in its Network, specifically, best practices related to the treatment of the STAR Health population;
5. how the Respondent will take action with Providers who demonstrate continued unacceptable performance and performance that does not improve over time;
6. the extent to which the Respondent currently operates a Network management program consistent with HHSC requirements in RFP Section 8.1.7.9, “Network Management,” and measurable results it has achieved from those Network management efforts; and
7. how the Respondent will document internally the certifications or special skills possessed by BH Providers, such as TF-CBT, Child Parent Psychotherapy, or other EBPs or promising practices, and increase the numbers of such Providers in the Network.
4.3.8 Section 8 – Utilization Management (UM)

(4 pages)

UM requirements are described generally in RFP Section 8.1.8, “Utilization Management (UM),” and specifically for BH Services in RFP Section 8.1.17, “Behavioral Health (BH) Services and Network.” A Respondent’s response to this submission requirement should address UM for all Covered Services, including BH Services unless otherwise indicated.

1. Describe the UM guidelines the Respondent plans to employ, including whether and how the guidelines comply with the standards in RFP Sections 8.1.8 and 8.1.17.
2. If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.
3. Describe how the UM guidelines will generally be applied to authorize or retrospectively review services for the spectrum of Covered Services, including BH Services.

4.3.9 Section 9 – Early Childhood Intervention (ECI)

(3 pages)

ECI Services are described in RFP Section 8.1.9, “Early Childhood Intervention (ECI).”

1. Describe the Respondent’s experience with, and general approach to, providing ECI services, including how the Respondent will identify these individuals.
2. Describe procedures and protocols for using the Individual Family Service Plan (IFSP) information to develop a Member Care Plan and authorize services.
3. Describe procedures and protocols for developing and including the interdisciplinary team in the assessment and care planning process.
4. Describe the process by which the Respondent will provide the IFSP and other necessary information to the PCP.

4.3.10 Section 10 – Health Passport

(9 pages)

Data requirements for the Health Passport are described in RFP Section 8.1.12, “Health Passport.” The Respondent can propose additional system functionality or data elements that enhance the productivity of the Health Passport. The Respondent must describe:

1. the Respondent’s experience working with healthcare data and any prior affiliations with local, state, or federal government agencies;
2. the Respondent’s experience with electronic medical records systems;
3. the platform on which the system will reside and describe the software(s) that will be used to maintain and operate the Health Passport;

4. in detail, how the proposed software or system will integrate with the Respondent’s claims database and pharmacy database to ensure that the required Health Passport data for each Member is updated in an accurate and timely manner;

5. the method by which the Respondent will ensure that all applicable state and federal laws protecting patient confidentiality are followed, to include HIPAA, 45 C.F.R. §§ 164.302.318; 164.500.534, HITECH Act, Chapter 390 of the Texas Administrative Code, and current Enterprise Information Security Standards and Guidelines (EISSG).

6. the frequency of the data refresh and the impact that the refresh strategy will have on system availability;

7. how the Respondent will accomplish termination of access to the Health Passport for users who leave the Provider Network or cease employment with DFPS;

8. the method by which the Respondent will train users to utilize the Health Passport and specify the types of training materials the Respondent will provide;

9. how the Respondent will identify security breaches in the Health Passport system, the processes the Respondent will employ to address any breaches, and the process by which the Respondent will notify HHSC in the event of a security breach; and

10. statistical measures related to the Health Passport that the Respondent proposes to report to HHSC to evaluate access, utilization, and compliance with the Health Passport and assist HHCS in identifying issues for improvement.

4.3.11 Section 11 – Service Management and Service Coordination

(15 pages, excluding assessment/triage tools)

Service Management and Service Coordination requirements are described in RFP Sections 8.1.13.2, “Access to Care and Service Management,” and 8.1.14, “Service Coordination.” Services for Members with Special Healthcare Needs (MSHCN) are described in RFP Section 8.1.13.

For the STAR Health Program, the Respondent must:

1. Describe the qualifications for MCO Service Managers and Service Coordinators, including experience, expertise, and responsibilities. Include descriptions of Service Management and Service Coordination activities, including staff expertise working with the PCP or PCP Team, SSCC staff, DFPS Staff, the Medical Consenter, and the Member (or similar parties in a comparable program) as appropriate.

2. Describe the Respondent’s experience with providing Service Management and Service Coordination services for the STAR Health population, or comparable population, including those with a Disability such as a developmental or Intellectual Disability, and chronic or complex medical and BH conditions, including mental health/chemical dependency co-occurring conditions.

3. Describe the process for initially and periodically assessing Members’ needs for services.

4. Describe how the Respondent will arrange to include clinical information and options for Medically Necessary Covered Services in the Member’s Healthcare Service Plan (HCSP), and
share this information with the PCP or PCP Team, SSCC staff, DFPS Staff, the Medical Consenter, and the Member, as appropriate.

5. Describe how the Service Manager will evaluate and report Members’ clinical progress and adherence to the HCSP and include this information in the Health Passport after discussing with the PCP or PCP Team.

6. Describe how the Respondent will use Encounter Data and other means to identify MSHCN who have not been identified by the Medical Consenter or through the screening process.

7. Submit the proposed assessment/triage tools the Respondent will use to identify MSHCN for the purposes of enrolling them in Service Management, Service Coordination, or DM programs.

8. Describe how the MCO Service Coordinator and Service Manager will assist the Member to have direct access to a specialist as appropriate for the Member’s condition and access to non-primary care physician specialists as PCPs, as required in RFP Section 8.1.13, “Services for Members with Special Healthcare Needs (MSHCN).”

9. Provide a description of the appropriate staffing ratio of Service Managers and Service Coordinators to Members and the Respondent’s target ratio of Service Managers and Service Coordinators to Members.

10. Describe in detail the training provided to Service Managers and Service Coordinators, both initially and ongoing, to ensure they are knowledgeable about the STAR Health population, and their responsibilities. Include information regarding who trains and his or her credentials, topics covered, frequency of training, and how a determination is made regarding the effectiveness of the training.

11. Describe the MCO’s plan for tracking Service Management and Service Coordination provided to its Members, including numbers and types of contact, timeliness of contacts, and the qualifications of individuals making the contact.

12. Describe how the Respondent’s Service Management and Service Coordination teams will engage young adults in Target Population categories 2, 3, and 4 in accessing needed healthcare Services and maintaining their health and well-being.

4.3.12 Section 12 – Health Home

(3 pages)

Health Home requirements are described in RFP Section 8.1.15, “Health Home Services.”

1. Describe the Respondent’s experience in implementing health home services programs for populations comparable to the STAR Health Program.

2. Identify any measurable results in terms of clinical outcomes and program savings that have resulted from the Respondent’s health home services initiatives, and briefly describe the analyses used to identify these outcomes and savings.

3. Identify the process by which the Respondent proposes to provide Members with health home services. Describe how the Respondent will identify Members in need of health home services program, the proposed outreach approach, and the health home services program components for Members of different risk levels.

4. Describe the process by which the Respondent will ensure continuity of care with the Member’s previous health home services program(s), if any.
4.3.13 Section 13 – Disease Management (DM)

(5 pages)

Disease Management is described in RFP Section 8.1.16, “Disease Management (DM).”

1. Describe the Respondent’s current DM programs and the Respondent’s experience in implementing DM programs for the STAR Health population or populations comparable to the STAR Health population, including both physical and BH programs.

2. Identify any measurable results in terms of clinical outcomes and program savings that have resulted from the Respondent’s DM initiatives, and briefly describe the analyses used to identify the outcomes and savings.

3. Describe the DM programs the Respondent proposes for the STAR Health population and the rationale for proposing these programs.

4. Identify the process by which the Respondent proposes to provide Members with DM. Describe how the Respondent will identify Members in need of the DM program, the proposed outreach approach, and the DM program components.

5. Describe how the Respondent proposes to gain Member and Caregiver or Medical Consenter involvement in the DM program’s strategies.

6. Describe the process by which the Respondent will ensure continuity of care with the Member’s previous DM program(s), if any.

7. Identify how information on DM programs will be made available to Members and Providers.

4.3.14 Section 14 – Behavioral Health (BH) Services

The BH Services and Network requirements are described in RFP Section 8.1.17, “Behavioral Health (BH) Services and Network.”

4.3.14.1 Behavioral Health (BH) Services Hotline

(3 pages; excluding telephone reports)

The BH Services Hotline requirements are described in RFP Section 8.1.17.3, “Behavioral Health (BH) Hotline and Emergency Services.” Describe the proposed BH Services Hotline function, including:

1. verification that it is, or will be, staffed 24 hours per day, 365 days per year;

2. staffing of BH Services Hotline staff, including clinical credentials;

3. routing of calls among BH Services Hotline staff to ensure timely and accurate response to inquiries from DFPS Staff, Medical Consenters, Caregivers, and Members, as appropriate.

4. the curriculum for training to be provided to BH Services Hotline representatives, including when the training will be conducted and how the training will address:
   a. Covered Services;
   b. STAR Health Program requirements;
c. Cultural Competency; and
d. providing assistance to Members and Medical Consenters with limited English proficiency.

5. responsibilities of BH Services Hotline staff, if any, in addition to responding to STAR Health Member Hotline calls, (e.g., responding to non-STaR Health member calls or STAR Health Provider Hotline or Member Hotline calls);

6. the number and percentage of FTE BH Services Hotline staff who are bilingual in English and Spanish;

7. the number and percentage of FTE BH Services Hotline staff who are multi-lingual for any additional language, by language spoken;

8. BH Services telephone reports for the most recent four quarters with data that show the monthly trends for call volume, monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and monthly trends for the abandonment rate; and

9. whether the BH Services Hotline has the capability to administer automated surveys to callers at the end of calls.

A Respondent currently participating in any of HHSC’s MCO programs must submit the information above for each BH Services Hotline that it operates, and should provide the monthly call volume by MCO program. The Respondent should also indicate any changes it proposes to its BH Services Hotline.

If the Respondent is not currently participating any of HHSC’s MCO programs, the Respondent must describe its experience and proposed approach in establishing and maintaining an accessible call center for Members that is comparable to the BH Services Hotline described in RFP Section 8.1.17.3. The description must include the information listed in items 1 to 9 above.

4.3.14.2 Behavioral Health (BH) Hotline Scenarios

Describe the procedures a BH Hotline representative will follow to deal with the following situations:

1. a Member, Caregiver, or Medical Consenter is having difficulty scheduling an appointment for medication management with his psychiatrist;
2. a Member, Caregiver, or Medical Consenter has a request for a specific medication that the pharmacy is unable to provide;
3. a Member or Caregiver does not speak English;
4. a Caregiver or Medical Consenter calls after hours asking for assistance in managing the Member’s BH crisis;
5. a Caregiver, Medical Consenter, or DFPS caseworker calls to inquire about the Member entering an inpatient facility;
6. a Provider who has been ordered by the Court to provide an assessment of the Member calls with questions regarding the assessment;
7. a DFPS caseworker calls asking for a Member’s initial assessment and monthly summaries not present in the Health Passport;
8. a Member’s PCP calls to inquire about enrollment for the Member in a substance abuse program;
9. a Caregiver, Medical Consenter, or DFPS caseworker calls requesting that a Member receive Mental Health Rehabilitation services; and
10. A Caregiver, Medical Consenter, or DFPS caseworker calls regarding a Member discharged from a facility (e.g., correctional, inpatient psychiatric, or emergency) without appropriate medications.

**4.3.14.3 Health Provider Network Expertise**

(no page limit)

1. Identify BH Service Providers with expertise in providing linguistically appropriate and culturally competent services to children and adolescents with the following treatment needs:
   a. BH including substance abuse, mental health, and dual diagnosis of mental health and substance abuse;
   b. Lesbian, Gay, Bi-Sexual, Transgender (LGBT) related issues;
   c. eating disorders;
   d. physical and sexual abuse;
   e. sex offender treatment;
   f. significant trauma;
   g. intellectual or developmental disabilities; and
   h. fetal alcohol syndrome or related disorders.

2. Indicate the criteria the Respondent will use to determine that the BH Providers have the requisite expertise.

**4.3.14.4 Coordination of Behavioral Health (BH) Care**

(2 pages)

Coordination requirements between the BH Service Provider and the PCP are described in RFP Section 8.1.17.4, “Coordination between the BH Provider and the PCP.”

1. Describe the Respondent’s approach to coordinating BH Service delivery with Acute Care Services delivered by a Member’s PCP, and vice versa.
2. Describe or propose innovative programs and identify Network Providers contracted to serve special populations through integrated medical/BH Service delivery models. Describe the program model services, treatment approach, special considerations, and expected outcomes for the special populations.
3. Describe the process by which the Respondent will ensure the delivery of outpatient BH Services within seven days of inpatient discharge for BH Services.

**4.3.14.5 Behavioral Health (BH) Quality Management**

(2 pages)

1. Identify the areas Respondent believes to be the greatest opportunities for clinical quality improvement in BH in the STAR Health Program and provide supporting information.
2. Discuss the approaches the Respondent will pursue to realize an opportunity.
3. Describe how the Respondent proposes to integrate BH into its quality assessment program, as described in **RFP Section 8.1.7.5, “Behavioral Health (BH) Services Integration into QAPI Program.”**

### 4.3.14.6 Utilization Management (UM) for Behavioral Health (BH) Services

(2 pages)

1. Identify the source of the Respondent’s BH Services UM guidelines and include a copy of internally developed BH Services UM guidelines, if any.
2. Describe how the UM guidelines, whether internally or externally developed, will generally be applied to authorize or retrospectively review inpatient, residential, and outpatient BH Services.
3. Discuss any special issues in applying the BH Services UM guidelines for:
   a. substance abuse services;
   b. Inpatient BH Services provided to children.

### 4.3.14.7 Behavioral Health (BH) Emergency Services

(2 pages)

Describe the Respondent’s experience with, and plans for, providing BH Emergency Services, including, emergency screening services, Emergency Services, and short-term crisis stabilization to the STAR Health population or to a comparable population.

### 4.3.14.8 Telemedicine

The Respondent must describe the Respondent’s telemedicine capabilities, how the Respondent will recruit providers with telemedicine capabilities, and how the Respondent will structure its Provider Network to use telemedicine to connect providers throughout Texas. The Respondent must describe how it will meet the telemedicine requirements in **RFP Sections 8.1.3.4, “Telemedicine Access,” and 8.1.17.1, “Behavioral Health (BH) Provider Network.”**

### 4.3.15 Section 15 – Pharmacy Services

(8 pages)

The Pharmacy Services requirements are described in **RFP Section 8.1.20**, “Pharmacy Services.” For all of the following submission requirements, instead of attaching copies of the Respondent’s policies and procedures, the Respondent should describe its policies and procedures, including:

1. the processes it will use to manage the pharmacy benefit when HHSC requires the MCO to implement the Medicaid formulary and preferred drug lists (PDLs);
2. the policies and procedures for how mail-order pharmacies will be available to Members;
3. the rationale for requiring prior authorizations, identify the types of drugs that normally require prior authorization, and describe the policies and procedures for the prior authorization process;
4. how rebates will be negotiated (if HHSC determines that the MCO will perform this service), identified, and reported;
5. the policies and procedures for drug utilization reviews, including ensuring prospective reviews take place at the dispensing pharmacy's point of sale (POS); and
6. the policies and procedures for targeted interventions for Network Providers over-utilizing certain drugs.

4.3.16 Section 16 – Management Information System (MIS) Requirements

(10 pages –excluding system diagrams, compliance plan, and process flowcharts.)

The Respondent must:

1. Describe the MIS the Respondent will implement, including how the MIS will comply with HIPAA as amended or modified. The response must address the requirements of RFP Section 8.1.24, “Management Information Systems (MIS) Requirements.” At a minimum, the description should address:
   a. hardware and system architecture specifications;
   b. data and process flows for all key business processes in RFP Section 8.1.24.3, “System-wide Functions;” and
   c. attest to the availability of the data elements required to produce required management reports.

2. If claims processing and payment functions are outsourced, provide the above information for the Material Subcontractor.

3. Describe how the Respondent would ensure accuracy, timeliness, and completeness of Encounter Data submissions.

4. Describe the Respondent’s ability and experience in performing coordination of benefits, as well as the Respondent’s ability and experience related to Third Party Recovery (TPR).

5. Describe the Respondent’s ability and experience in allowing providers to submit claims electronically and its ability and experience in processing electronic claims payments to providers:
   a. If currently receiving claims electronically, generally describe the type and volume of provider claims received electronically in the previous year versus paper claims for each claim type.
   b. If currently making claims payments to providers electronically, generally describe the type and volume of provider claims processed electronically.

6. Describe the Respondent’s experience and capability to comply with the Internet website requirements of RFP Section 8.1.5.5, “Internet Website,” and briefly describe any additional website capabilities that the Respondent proposes to offer to Providers, DFPS Staff, Medical Consenters, Caregivers, and Member, as appropriate.

7. Provide acknowledgment and verification that the Respondent’s proposed systems are 5010 compliant by submitting a copy of the 5010 compliance plan.

8. Describe the Respondent’s capability to pay providers via direct deposit and its experience in doing so, including the percentage, number, and types of providers paid via direct deposit in the most recent 12-month period for which the Respondent has those statistics. If the Respondent operates in Texas, the Respondent must provide this information related to its experience in
Texas. If the Respondent does not currently operate in Texas, the Respondent must provide this information for a state in which the Respondent currently operates a managed care program similar to the STAR Health Program.

4.3.17 Section 17 – Fraud, Waste, and Abuse

(3 pages)

The Fraud, Waste, and Abuse requirements are described in RFP Section 8.1.25, “Fraud, Waste, and Abuse.” The Respondent must describe how they will implement a Fraud, Waste, and Abuse Plan that will comply with state and federal law and this RFP, including the requirements of Texas Government Code § 531.113. The Respondent must:

1. Include detail about what parts of the organization and which key staff will have responsibilities in implementing and carrying out the Fraud, Waste, and Abuse Program.
2. Identify the officer or director of the Respondent organization who will have overall responsibility and authority for carrying out the Fraud, Waste, and Abuse Program provisions.

4.3.18 Section 18 – Transition Plan

(4 pages)

The Transition Plan Requirements are described in RFP Section 7, “Transition Phase Requirements.”

1. Briefly describe the Respondent’s experience establishing and maintaining electronic interfaces with other contractors responsible for portions of Medicaid operations. A Respondent with experience participating in one or more HHSC MCO programs must clearly note its experience in establishing and maintaining these interfaces in Texas. A Respondent without experience establishing and maintaining electronic interfaces with other contractors responsible for Medicaid operations must note its experience in establishing and maintaining similar electronic interfaces with contractors for similar operations.
2. Respondent must answer either (a) or (b) as it applies to Respondent.
   a. A Respondent that is proposing to participate in STAR Health for the first time must briefly describe its Transition Plan, including major activities related to the System Readiness Review and the Operational Readiness Review, including Network development, internal system testing, and proposed schedule to comply with the anticipated Operational Start Date and other requirements described in RFP Section 7. The Respondent must clearly indicate in which Texas counties it currently does not operate as an MCO and any differences in its transition approach by county.
   b. A Respondent that is currently a contractor for the STAR Health Program must briefly describe its Transition Plan, including major activities related to the System Readiness Review and the Operational Readiness Review, such as Network Development, internal system testing, and schedule to comply with the anticipated Operational Start Date and other requirements described in RFP Section 7.
5 EVALUATION PROCESS AND CRITERIA

5.1 Evaluation of Proposals

HHSC will use a formal evaluation process to select the successful Respondent. HHSC will consider capabilities or advantages that are clearly described in the proposal, which may be confirmed by oral presentations, site visits, demonstrations, and references contacted by HHSC. HHSC reserves the right to contact individuals, entities, or organizations that have had dealings with the Respondent or proposed staff, whether or not identified in the proposal.

HHSC will more favorably evaluate proposals that offer no or few exceptions, reservations, or limitations to the terms of the RFP, including RFP Attachment A, “STAR Health Contract Terms.”

5.2 Evaluation Criteria

HHSC will evaluate each proposal using the following criteria, in descending order of priority, developed from the best value factors listed in RFP Section 2, “Procurement Strategy and Approach.”

<table>
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<th>Evaluation Criteria</th>
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<tr>
<td>1</td>
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<tr>
<td>The extent to which the goods and services meets HHSC’s needs and the needs of the Members for whom the goods and services are being purchased, including:</td>
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<tr>
<td>1. The extent to which the proposal addresses HHSC’s priority objectives for the initial Contract Period, as defined in RFP Section 1.6, “Mission Objectives;”</td>
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<tr>
<td>2. The extent to which the Respondent accepts without reservation or exception the RFP’s terms, including Attachment A, “STAR Health Contract Terms;”</td>
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<tr>
<td>3. The extent to which the proposal exhibits expertise in providing services to populations comparable to STAR Health Members and ability to comply with the requirements of this RFP—particularly the requirements outlined in RFP Section 8, “Operations Phase Requirements;”</td>
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<td>4. The quality and reliability of the goods and services, including the ability to retain and maintain providers in Respondent’s Network and to respond timely and adequately to Member Complaints; and</td>
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<td>5. The degree to which the proposal demonstrates program innovation, adaptability, and exceptional customer service.</td>
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<tr>
<td>Indicators of probable vendor performance, including</td>
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<tr>
<td>1. Respondent’s past performance in Texas or comparable experience in other states;</td>
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<tr>
<td>2. Current financial solvency and the ability to remain financially solvent during the Initial Contract Period;</td>
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</tbody>
</table>
3. Capacity for Respondent’s organizational structure to support operations;
4. Ability to obtain and maintain TDI approval to operate and a status of Good Standing with the Comptroller; and
5. The qualifications and experience of Respondent’s key personnel to achieve program goals.

Effect of the acquisition on agency productivity, including:
1. The level of effort and resources required by HHSC to monitor the Respondent’s performance under the Contract; and
2. The level of effort required by HHSC to maintain a good working relationship with Respondent.

Delivery Terms, including:
1. The Respondent’s ability to complete transition phase requirements in RFP Section 7, “Transition Phase Requirements,” and to fully implement services by the Operational Start Date;
2. The Respondent’s ability to maintain full service operations throughout the Initial Contract Period; and
3. The Respondent’s ability to comply with turnover requirements in RFP Section 9, “Turnover Requirements,” upon termination of the Contract.

If all other considerations are equal, HHSC will give preference to:
1. Proposals that include substantial participation by Network providers who are Significant Traditional Providers (STPs). HHSC defines “substantial participation” as proposals that include at least 50 percent of the STPs in a Service Area. The Respondent must either have a Network Provider agreement in place with the STP, or a Letter of Intent/Letter of Agreement to participate in the Network. A listing of STPs for the new Service Areas can be found in the Procurement Library.

2. Proposals that ensure continuity of coverage for Medicaid Members for at least three months beyond the period of Medicaid eligibility. For purposes of this provision, HHSC defines “continuity of coverage” as providing the full set of Covered Services.

Respondents who are licensed as health maintenance organizations under Texas Insurance Code Chapter 843 and believe they meet the requirements for mandatory contracting under Texas Government Code § 533.004 must provide written notice to HHSC’s Point-of-Contact no later than May 9, 2014. The notice must provide a clear description of why the Respondent believes it is entitled to a mandatory contract under the Texas Government Code and the basis for that belief. The notice must include an in-depth analysis of how the Respondent meets the exact requirements of Texas Government Code § 533.004.
5.3 Initial Compliance Screening

HHSC will perform an initial screening of all proposals received. Unsigned proposals and proposals that do not include all required forms and sections are subject to rejection without further evaluation. In accordance with RFP Section 3.11, “Modification or Withdrawal of Proposal,” HHSC reserves the right to waive minor informalities in a proposal and award contracts that are in the best interest of the State of Texas.

5.4 Competitive Field Determinations

HHSC may determine that certain proposals are within the field of competition for admission to discussions. The field of competition consists of the proposals that receive the highest or most satisfactory ratings. HHSC may, in the interest of administrative efficiency, place reasonable limits on the number of proposals admitted to the field of competition.

5.5 Oral Presentations and Site Visits

HHSC may, at its sole discretion, request oral presentations, site visits, or demonstrations from one or more Respondents admitted to the field of competition. HHSC will notify selected Respondents of the time and location for these activities, and may supply agendas or topics for discussion. HHSC reserves the right to ask additional questions during oral presentations, site visits, or demonstrations to clarify the scope and content of the written proposal. The Respondent’s oral presentation, site visit, or demonstration must substantially represent material included in the written proposal and should not introduce new concepts or offers unless specifically requested by HHSC.

5.6 Best and Final Offers

Respondents will not submit cost proposals for this RFP. HHSC will establish the Capitation Rates for each Program and Service Area in accordance with the methodology described in RFP Attachment A, Article 10, “Terms of Payment.” HHSC may, but is not required to, permit Respondents to prepare one or more revised offers. For this reason, Respondents are encouraged to treat their original proposals, and any revised offers requested by HHSC, as best and final offers of services.

5.7 Discussions with Respondents

HHSC may, but is not required to, conduct discussions with all, some, or none of the Respondents admitted to the field of competition for the purpose of obtaining the best value for the State of Texas. It may conduct discussions for the purpose of:

1. obtaining clarification of proposal ambiguities;
2. requesting modifications to a proposal; or
3. obtaining a best and final offer.

HHSC may make an award prior to the completion of discussions with all Respondents admitted to the field of competition if HHSC determines that the award represents best value to the State of Texas.
# DOCUMENT HISTORY LOG

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<td>All references to Frew v. Traylor are changed to Frew v. Smith.</td>
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<td>September 1, 2020</td>
<td>Global Change to correct the references to UMCM</td>
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1 Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.
2 Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
3 Brief description of the changes to the document made in the revision.
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<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Capitation Rate Payments</td>
<td>4</td>
</tr>
<tr>
<td>6.2</td>
<td>Performance Incentives and Disincentives</td>
<td>4</td>
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</tr>
<tr>
<td>6.4</td>
<td>Remedies and Liquidated Damages</td>
<td>4</td>
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<td>6.5</td>
<td>Additional Incentives and Disincentives</td>
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6 PREMIUM PAYMENT, INCENTIVES, AND DISINCENTIVES

This section describes Capitation Rate payments and performance incentives and disincentives related to HHSC’s value-based purchasing approach.

6.1 Capitation Rate Payments

Refer to Attachment A, Article 10, “Terms of Payment,” and UMCM Chapter 6 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.

6.2 Performance Incentives and Disincentives

Performance incentives and disincentives are subject to change by HHSC over the course of the Contract Period.

HHSC will refine the methodologies required to implement these strategies after collaboration with the MCO through a new incentives workgroup that HHSC will establish.

MCO is prohibited from passing down financial disincentives or sanctions imposed on the MCO to healthcare providers, except on an individual basis and related to the individual provider’s inadequate performance.

6.2.1 Performance Profiling

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

6.3 Frew Incentives and Disincentives

This Contract includes a system of incentives and disincentives required by the Frew v. Smith “Corrective Action Order: Managed Care” that apply to the MCO. The incentives and disincentives and corresponding methodology are set forth in the UMCM Chapter 12.

6.4 Remedies and Liquidated Damages

All areas of responsibility and all requirements of the MCO in the Contract will be subject to performance evaluation by HHSC. Any and all responsibilities or requirements not fulfilled may have remedies, and HHSC may assess damages, including liquidated damages. Refer to

6.5 Additional Incentives and Disincentives

HHSC will evaluate all performance-based incentive and disincentive methodologies in consultation with the MCO. HHSC may then modify the methodologies as needed, or develop additional methodologies as funds become available, or as mandated by court decree, statute, or rule in an effort to motivate, recognize, and reward the MCO for performance.
## DOCUMENT HISTORY LOG

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<th>EFFECTIVE DATE</th>
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<td>Global Change to correct the references to UMCM</td>
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¹ Baseline: Initial version of the document. Revision: Updated versions of the document.

² Document Revision: The version number of the document.

³ Description: Details of the changes made in each revision.
### Section 7 has been modified to clarify MCO requirements and expectations when terminating, merging, or acquiring a new business.

Section 7.1 has been modified to clarify MCO requirements and expectations when terminating, merging, or acquiring a new business.

Section 7.2 has been modified to clarify MCO requirements and expectations when terminating, merging, or acquiring a new business.

Section 7.2.1 has been modified to clarify MCO requirements and expectations when terminating, merging, or acquiring a new business.

Section 7.2.2 is modified to clarify language to include expectations required of contracted MCO’s should they terminate, merge, or acquire new business.

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1 Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.

2 Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>TRANSITION PHASE REQUIREMENTS</td>
<td>4</td>
</tr>
<tr>
<td>7.1</td>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>7.2</td>
<td>Transition Phase Schedule and Tasks</td>
<td>4</td>
</tr>
<tr>
<td>7.2.1</td>
<td>Transition Phase and Planning</td>
<td>5</td>
</tr>
<tr>
<td>7.2.2</td>
<td>Administration and Key MCO Personnel</td>
<td>5</td>
</tr>
<tr>
<td>7.2.2.1</td>
<td>Material Subcontractors</td>
<td>6</td>
</tr>
<tr>
<td>7.2.3</td>
<td>Organizational and Financial Readiness Review</td>
<td>6</td>
</tr>
<tr>
<td>7.2.4</td>
<td>System Testing and Transfer of Data</td>
<td>6</td>
</tr>
<tr>
<td>7.2.5</td>
<td>System Readiness Review</td>
<td>7</td>
</tr>
<tr>
<td>7.2.6</td>
<td>Demonstration and Assessment of System Readiness</td>
<td>7</td>
</tr>
<tr>
<td>7.2.7</td>
<td>Operations Readiness</td>
<td>8</td>
</tr>
<tr>
<td>7.2.8</td>
<td>Assurance of System and Operational Readiness</td>
<td>10</td>
</tr>
<tr>
<td>7.2.9</td>
<td>Health Passport Readiness</td>
<td>10</td>
</tr>
<tr>
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<td>TDI Licensure, Certification, or Approval</td>
<td>11</td>
</tr>
<tr>
<td>7.2.11</td>
<td>Post-Transition</td>
<td>11</td>
</tr>
</tbody>
</table>
7 TRANSITION PHASE REQUIREMENTS

7.1 Introduction

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

The Transition Phase includes a timeline for Readiness Review, which must be completed to HHSC’s satisfaction prior to the MCO’s Operational Start Date for each Service Area. Readiness Review includes but is not limited to the following areas, which are further explained in this Article 7:

• Administration of Key MCO Personnel
• Organizational Readiness Review
• Financial Readiness Review
• System Testing and Transfer of Data
• System Readiness Review
• Demonstration and Assessment of System Readiness
• Operations Readiness
• Assurance of System and Operational Readiness

Upon the identification by the MCO or HHSC of any deficiencies during or as a result of Readiness Review, MCO will correct the deficiencies within 10 Days of identification and written notification to the Parties or provide a Corrective Action Plan or risk mitigation plan as directed by HHSC if the deficiency requires more than 10 Days to correct.

HHSC may, at its discretion, postpone the MCO’s Operational Start Date, or assess contractual remedies including termination of the Contract, if the MCO fails to timely correct all Readiness Review deficiencies within a reasonable cure period determined by HHSC.

If for any reason, an MCO does not fully meet the Readiness Review prior to the Operational Start Date, and HHSC has not approved a delay in the Operational Start Date or approved a delay in the MCO’s compliance with the applicable Readiness Review requirement, then HHSC will impose remedies including actual or liquidated damages.

7.2 Transition Phase Schedule and Tasks

The MCO has overall responsibility for the timely and successful completion of each of the Transition Phase tasks. The MCO is responsible for clearly specifying and requesting information needed from HHSC, other HHSC contractors, and Providers in a manner that does not delay the schedule or work to be performed.
7.2.1 Transition Phase and Planning

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

1. define 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 Contract Deliverables.

The MCO must update the Transition Plan provided with its Proposal no later than 30 Days after the Effective Date, then provide monthly implementation progress reports through the sixth month of MCO Program operations. In the case of the assignment and assumption of a Contract due to termination, expiration, merger or acquisition, the incoming or transitioning MCO must provide a Transition Plan no later than 30 Days after the MCO notifies HHSC, or upon notification from HHSC of the termination, expiration, merger, or acquisition. The exiting MCO must comply with the requirements as described in Attachment B-1, Section 9, Turnover Requirements.

The Transition Plan must include:

(1) specific staffing patterns by function for all operations, including enrollment, information systems, member services, quality improvement, claims management, case management, and provider and recipient training;
(2) specific time frames for demonstrating preparedness for implementation before the Operational Start Date; and
(3) Other elements identified by HHSC.

7.2.2 Administration and Key MCO Personnel

No later than the Effective Date, the MCO must designate and identify Key MCO Personnel that meet the requirements in Attachment A “STAR Health Contract Terms.” The MCO will supply HHSC with the current resume of each Key MCO Personnel. The MCO must also provide HHSC with any organizational information that has changed since the MCO’s Proposal, such as job descriptions and organizational charts, if applicable. For Service Coordinators and Service Managers, the MCO must also provide information on the anticipated maximum caseload per Service Coordinator and Service Manager (i.e., number of Members per Service Coordinator and number of Members per Service Manager). For the STAR Health Liaisons, provide information on the anticipated number of needed staff to fulfill contract requirements. If the MCO is using a Material Subcontractor, the MCO must also provide the organizational chart for the Material Subcontractor.

In the case of assignment and assumption of a Contract, the incoming or transitioning MCO must provide HHSC with the Key MCO Personnel who will facilitate ongoing activities and requirements described in the Transition Plan. The MCO will also provide HHSC with the Material Subcontractor’s functions and responsibilities as identified in UMCM Chapter 5.21.
7.2.2.1 Material Subcontractors

The MCO or its designee will conduct, routine monitoring, of each Material Subcontractor that is also a delegated entity or a third-party administrator, in accordance with its assessed risk process, to ensure compliance with the performance of all delegated functions. The MCO must maintain a monitoring plan for each Material Subcontractor that is also a delegated entity or a third-party administrator.

The MCO must maintain documentation as to the compliance of the Material Subcontractor with all requirements defined in the monitoring plan. This documentation must contain evidence that all appropriate and necessary actions were taken to correct any noncompliance.

The MCO must allow HHSC to attend meetings between the MCO and its Material Subcontractors and/or to receive the minutes from these meetings upon request. Upon request, the MCO must provide a final report of the routine monitoring results.

7.2.3 Organizational and Financial Readiness Review

In order to complete an organizational and financial Readiness Review and assess the most current corporate environment, the MCO must update the organizational and financial information submitted in its proposal for any awarded Contract. See Section 4.2, "Business Proposal," for a list of Financial Statements, Corporate Background and Status, Corporate Experience, and Material Subcontractor Information the MCO must update for the Readiness Review.

7.2.4 System Testing and Transfer of Data

The MCO must have hardware, software, network, and communications systems with the capability and capacity to handle and operate all MIS systems and subsystems identified in Section 8.1.24, "Management Information System (MIS) Requirements." For example, the MCO’s MIS system must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act) as indicated in Section 8.1.24.4.

During this Readiness Review task, the MCO will accept into its system any and all necessary data files and information available from HHSC or its contractors. The MCO will install and test all hardware, software, and telecommunications required to support the Contract. The MCO will define and test modifications to the MCO’s system(s) required to support the business functions of the Contract.

The MCO will produce data extracts and receive all electronic data transfers and transmissions. The MCO must be able to demonstrate the ability to produce the 837- encounter file by the Operational Start Date.

If any errors or deficiencies are evident, the MCO will develop resolution procedures to address problems identified. The MCO will provide HHSC, or a designated vendor, with test data files for systems and interface testing for all external interfaces. The HHSC Administrative Services Contractor will provide enrollment test files to new MCOs that do not have previous HHSC enrollment files. The MCO will demonstrate its system capabilities and adherence to Contract specifications during readiness review.
7.2.5 System Readiness Review

The MCO must assure that systems services are not disrupted or interrupted during the Operations Phase of the Contract. The MCO must coordinate with HHSC and other contractors to ensure business and systems continuity for the processing of all healthcare claims and data as required under the Contract.

The MCO must submit descriptions of interface and data and process flow for each key business process described in Section 8.1.24.3, “System-wide Functions,” to HHSC.

The MCO must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. 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 and within 15 Business Days of HHSC’s written request at any time during the Contract:

1. Disaster Recovery Plan*;
2. Business Continuity Plan*;
3. Security Plan
4. Joint Interface Plan
5. Risk Management Plan; and

*The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.

7.2.6 Demonstration and Assessment of System Readiness

The MCO must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA and the HITECH Act. The MCO must also provide HHSC with a summary of all recent external audit reports, including findings and corrective actions, relating to the MCO’s proposed systems, including any SSAE16 audits conducted in the past three years. The MCO must promptly make additional information on the detail of these system audits available to HHSC upon request.

In addition, HHSC will provide to the MCO a test plan that will outline the activities that the MCO needs to perform prior to the Operational Start Date of the Contract. The MCO must be prepared to assure and demonstrate system readiness. The MCO must execute system readiness test cycles to include all external data interfaces, including those with the MCO’s Pharmacy Benefits Manager (PBM) and other Material Subcontractors.

HHSC, or its agents, may independently test whether the MCO’s MIS has the capacity to administer the STAR Health MCO business. This Readiness Review of a MCO’s MIS may include a desk review or an onsite review. HHSC may request from the MCO additional documentation to support the provision of STAR Health Services. Based in part on the MCO’s assurances of systems readiness, information contained in the Proposal, additional documentation submitted by the MCO, and any review conducted by HHSC or its agents, HHSC will assess the MCO’s understanding of its responsibilities and the MCO’s capability to assume the MIS functions required under the Contract.

The MCO must provide a Corrective Action Plan in response to any Readiness Review deficiency no later than 10 Days after notification of any deficiency by HHSC. If the MCO documents to HHSC’s satisfaction that the deficiency has been corrected within 10 Days of the deficiency notification by HHSC, no Corrective Action Plan is required.
7.2.7 Operations Readiness

The MCO must clearly define and document the policies and procedures it will follow to support day-to-day business activities related to the provision of STAR Health Services, including coordination with contractors. The MCO will be responsible for developing and documenting its approach to quality assurance.

HHSC or its designee will conduct a Readiness Review not later than the 15th Day before the date on which HHSC plans to begin the enrollment process and again not later than the 15th Day prior to the Operational Start Date. MCO is responsible for all reasonable travel costs incurred by HHSC or its authorized agent for onsite Readiness Reviews. For purposes of this section, “reasonable travel costs” include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. This provision does not limit HHSC’s ability to collect any other costs as damages in accordance with Attachment A, Section 12.02(e), “Damages.”

During Readiness Review, the MCO must, at a minimum:

1. Develop new, or revise existing, operations procedures and associated documentation to support the MCO’s proposed approach to conducting operations activities in compliance with the contracted Scope of Work.
2. Submit a list of all contracted and credentialed Providers to HHSC in an HHSC-approved format, including a description of additional contracting and credentialing activities scheduled to be completed before the Operational Start Date.
3. Prepare and implement a Member Services staff training curriculum and a Provider training curriculum, and provide documentation demonstrating compliance with training requirements (e.g., enrollment or attendance rosters dated and signed by each attendee or other written evidence of training.)
4. Prepare a Coordination Plan documenting how the MCO will coordinate its business activities with those activities performed by HHSC contractors and the MCO’s PBM and other Material Subcontractors, if any. The Coordination Plan will include identification of coordinated activities and protocols for the Transition Phase.
5. Develop and submit a plan to HHSC for providing Behavioral Health (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 Healthcare Services at the organizational and practitioner level.
6. Develop and submit a plan to HHSC for conducting ongoing retrospective reviews of any psychotropic medication regimen that is not compliant with the DFPS Psychotropic Medication Utilization Parameters or standards of care. The plan must address strategies for correcting any non-compliant regimen. The plan must also address strategies and incentives for providers that are routinely non-compliant.
7. Develop and submit a communication plan to HHSC for ongoing coordination with HHSC, DFPS, and HHSC or DFPS contractors that includes strategies for sharing information and resolving issues.
8. Develop and submit the draft Member handbook, draft Provider directory, and draft Member identification card to HHSC for review and approval. At a minimum, the materials must meet the requirements specified in Section 8.1.5, “Member Services,” and include the Critical Elements defined in the UMCM Chapter 3.
9. Develop and submit the draft Provider manual and draft Provider contract templates to HHSC for review and approval. At a minimum, the materials must meet the requirements
specified in Section 8.1.4, “Provider Network,” and include the Critical Elements defined in the UMCM Chapters 3. and 8.

10. Develop and submit all other Provider Materials relating to Medicaid to HHSC prior to use or mailing. If HHSC has not responded to MCO’s request for review within 15 Business Days, the MCO may use the submitted materials. HHSC reserves the right to require discontinuation or correction of any Provider Materials that are not in compliance with state and federal laws or the Contract’s requirements.

11. Develop and submit the MCO’s proposed Member complaint and appeals processes to HHSC.

12. Demonstrate toll-free telephone systems and reporting capabilities for the Nurse Hotline, the Member Services Hotline, the Behavioral Health Hotline, and the Provider Services Hotline.

13. Submit a written Fraud, Waste, and Abuse Compliance Plan to HHSC for approval no later than 30 Days after the Contract Effective Date. See Section 8.1.25, “Fraud, Waste, and Abuse,” for the requirements of the plan, including new requirements for special investigation units. As part of the Fraud, Waste, and Abuse Compliance Plan, the MCO must:
   a. Designate executive and essential personnel to attend mandatory training in Fraud, Waste, and Abuse detection, prevention, and reporting. Executive and essential fraud, waste, and abuse personnel means MCO staff members who supervise staff in the following areas: data collection, Provider enrollment or disenrollment, Encounter Data, claims processing, Utilization Review, appeals or grievances, quality assurance and marketing, and who are directly involved in the decision-making and administration of the Fraud, Waste, and Abuse detection program within the MCO. The training will be conducted by the Office of Inspector General, HHSC, and will be provided free of charge. The MCO must schedule and complete training no later than 90 Days after the Effective Date.
   b. Designate an officer or director within the organization responsible for carrying out the provisions of the Fraud, Waste, and Abuse Compliance Plan.
   c. Ensure that, if the MCO subcontracts this function to another entity, the Subcontractor also meets all the requirements in this section and the Fraud, Waste, and Abuse Section 8.1.25.
   d. Complete hiring and training of Service Management and Service Coordination staff no later than 45 Days prior to the STAR Health Operational Start Date.

14. Submit a written plan to HHSC for providing pharmacy services, including proposed policies and procedures for:
   a. Routinely updating formulary data following receipt of HHSC’s daily files (within two Business Days and off-cycle upon HHSC’s request);
   b. Prior authorization (PA) of drugs, including how HHSC’s preferred drug lists (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, and HHSC’s approval is required for all Clinical Edit policies;
   c. Implementing drug utilization review (DUR);
   d. Overriding standard DUR criteria and clinical edits when Medically Necessary based on the individual Member’s circumstances (e.g., overriding quantity limitations, drug-drug interactions, refilling too soon);
   e. 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
f. monitoring the Pharmacy Benefit Manager (PBM) Subcontractor.

The plan must also include 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.

Additionally, the MCO must include a written attestation by the PBM Subcontractor in the plan stating, in the three years preceding the Contract’s 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.

During the Readiness Review, HHSC may request from the MCO certain operating procedures and updates to documentation to support the provision of STAR Health Services. HHSC will assess 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 the Proposal, and in Transition Phase documentation submitted by the MCO.

The MCO is required to provide a Corrective Action Plan or Risk Mitigation Plan promptly as requested by HHSC in response to Operational Readiness Review deficiencies identified by the MCO or by HHSC or its agent. The MCO must promptly alert HHSC of deficiencies and must correct a deficiency or provide a Corrective Action Plan or Risk Mitigation Plan no later than 10 Days after HHSC’s notification of deficiencies. If the Contractor documents to HHSC’s satisfaction that the deficiency has been corrected within 10 Days of any deficiency notification by HHSC, no Corrective Action Plan is required.

7.2.8 Assurance of System and Operational Readiness

In addition to successfully providing the Deliverables described in Section 7.2, “Transition Phase Schedule and Tasks,” the MCO must assure HHSC that all processes, MIS systems, and staffed functions are ready and able to assume responsibilities successfully for operations prior to the Operational Start Date. In particular, the MCO must assure that Key MCO Personnel, Member Services staff, Provider Services staff, and MIS staff are hired and trained, MIS systems and interfaces are in place and functioning properly, communication procedures are in place, Provider manuals have been distributed, and that Provider training sessions have occurred according to the schedule approved by HHSC.

7.2.9 Health Passport Readiness

The MCO must demonstrate that its web-based Health Passport system has the capability and capacity to meet all requirements set forth in Section 8.1.12, “Health Passport.”

During Readiness Review, the MCO must, at a minimum:
1. Demonstrate that the Health Passport has the capability to include all external data interfaces and produce all required reports.

2. Provide documentation on Health Passport application security and provide evidence of or demonstrate that the Health Passport application is:
   a. compliant with security and privacy rules adopted by the U.S. Department of Health and Human Services (HHS) under HIPAA, HITECH Act, and 45 C.F.R. §§ 164.302–.318; 164.500–.534; all applicable state and federal laws, including Tex. Admin. Code Chapter 390, and current Enterprise Information Security Standards and Guidelines (EISSG), which can be found in the Procurement Library.
   b. able to restrict information according to role-based restrictions as identified by HHSC;
   c. capable of providing an additional security layer for cases deemed sensitive by DFPS to allow access only by DFPS-designated personnel;
   d. capable of providing audit trail functionality to include security audits (logging of Health Passport access attempts) and data audits (logging when, and by whom, records are created, viewed, updated, extracted, or deleted); and is
   e. able to terminate a user’s access to the Health Passport system within 24 hours of notification of the user’s change in status.

7.2.10 TDI Licensure, Certification, or Approval

The MCO must receive TDI licensure, certification, or approval (as applicable) for each county in the state no later than 60 Days after the Contract’s Effective Date.

7.2.11 Post-Transition

The MCO will work with HHSC, Providers, and Members to promptly identify and resolve problems identified after the Operational Start Date and to communicate to HHSC, Providers, and Members, as applicable, the steps the MCO is taking to resolve the problems.

The MCO must:

1. meet with HHSC staff and discuss post-Transition Phase issues and problems;
2. work proactively and collaboratively to resolve issues or problems identified by the Provider community, DFPS Staff, and other stakeholders; and
3. document the problems and their causes encountered during start-up and implementation in writing, and provide information regarding steps to correct the problem, including resources that will be used, the timeline for correcting the problem, and the steps that the MCO will take to prevent the issue or problem from recurring. The MCO will also document when the problem is resolved. The MCO will report this information to HHSC every 14 Days, or as often as determined necessary by HHSC, during the first six months of operations, at which time HHSC will reassess the required frequency of providing this report.

If an MCO makes assurances to HHSC of its readiness to meet Contract requirements, including MIS and operational requirements, but fails to satisfy requirements set forth in this Section, or as otherwise required pursuant to the Contract, HHSC may, at its discretion do any of the following in accordance with the severity of the non-compliance and the potential impact on Members and Providers:

1. impose contractual remedies, including liquidated damages; or
2. pursue other equitable, injunctive, or regulatory relief.

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<td>Section 8.1.3 is modified to clarify the language. Network is redundant as Provider definition states they are contracted.</td>
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<td>Section 8.1.3.3 is modified to add requirements for a mandatory survey of Providers.</td>
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<td>Section 8.1.4.4 is modified to specifically refer to anti-discrimination requirements and to move the last sentence of the section to the end of the second paragraph.</td>
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<td>Section 8.1.4.6 is modified to clarify that if HHSC has not approved Provider Materials within 15 days, the MCO may use them only after first notifying HHSC of its intent to use. In addition, the section is modified to qualify the cultural competency training requirement, to add “Abuse, Neglect, or Exploitation” to the list, and to require training for BH Providers as required by SB 125.</td>
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<td>Section 8.1.4.10 is modified to require the MCOs to notify HHSC when a Provider termination impacts more than 10% of its Members.</td>
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<td>Section 8.1.7.8 is modified to change the section name to “Provider Credentialing and Profiling” and to add credentialing requirements.</td>
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<td>Section 8.1.9.4 is modified to reflect the new IFSP form and instructions developed by ECI.</td>
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<td>Section 8.1.9.5 is modified to reflect the new IFSP form and instructions developed by ECI.</td>
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<td>Section 8.1.11 is modified to clarify that the SSCC requirement only applies to categories 1-2 of the Target Population and when assessments must be further expedited. In addition, the section is modified to delete the MCO Liaison requirement and to clarify the MCOs responsibility related to court orders.</td>
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<td>March 1, 2016</td>
<td>All references to Frew v. Janek are changed to Frew v. Traylor. All references to “abuse and neglect” are changed to “Abuse, Neglect, and Exploitation.” All references to “Fraud and Abuse” are changed to “Fraud, Waste, and Abuse” Section 8.1.1.1 is modified to require the MCO to allow HHCSC access for remote monitoring. Section 8.1.2 is modified to require MCOs to monitor claims data for delivery of prior authorized acute and</td>
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</table>

Section 8.1.12.1 is modified to remove STAR Health Liaison.

Section 8.1.17.8 is modified to change “authorize” to "must contract with" and to clarify eligibility requirements.

Section 8.1.17.9 Mental Health Parity is added.

Section 8.1.20.1 is modified to add certain LHHS and vitamins and minerals.

Section 8.1.20.2 is modified to allow the MCO to reference the VDP formulary on Epocrates when the MCO’s clinical edits are the same as or less stringent than VDP’s.

Section 8.1.20.4 is deleted in its entirety.

Section 8.1.20.7 is modified to comply with the requirements of SB 94.

Section 8.1.24.1 is modified to clarify the language and to add requirements for the Quarterly Encounter Reconciliation Report.

Section 8.1.25 is modified to address issues of material misrepresentation. In addition, sub-section headings are added, and the section is reorganized for clarity.

Section 8.1.26.1 is modified to change the section name from “Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Other Statistical Performance Measures” to "Performance Measurement" and to remove unnecessary language.

Section 8.1.33.3 is modified to clarify MCO payment responsibility for overturned DME prior authorization denials.

Section 8.1.34 is amended to clarify requirement.
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<td>long-term care services and to require the MCOs to utilize evidence based medical policies.</td>
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<td>Section 8.1.3.2 is modified to add access requirements for CANS assessments per SB 125.</td>
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<td>Section 8.1.3.4.1 “School-based Telemedicine Services” is added.</td>
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<td>Section 8.1.4 is modified to add access requirements for CANS assessments per SB 125.</td>
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<td>Section 8.1.4.6 is modified to add provider training requirements for CANS assessments per SB 125.</td>
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<td>Section 8.1.4.10 is modified to clarify the timeframe.</td>
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<td>Section 8.1.5.5 is modified to update the UMCM references.</td>
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<td>Section 8.1.5.10 “Reporting Abuse or Neglect” is renamed “Abuse, Neglect, or Exploitation” and the text is deleted. In addition, Section 8.1.5.10.1 “Member Education on Abuse, Neglect, or Exploitation” is added.</td>
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<td>Section 8.1.5.10.2 “Abuse, Neglect, and Exploitation Email Notifications” is added.</td>
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<td>Section 8.1.6 is modified to correct the UMCM reference.</td>
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<td>Section 8.1.11 is modified to move assessment requirements to new Section 8.1.11.3 – Assessments; to move provider training and manual requirements to Section 8.1.4.6 Provider Relations Including Manual, Materials and Training; and to delete redundant language about Pre-Appeals, which is located in Section 8.1.33.2 Member Pre-Appeals Process per SB 125.</td>
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<td>Section 8.1.11.1 is modified to add training requirements for CANS assessments and to restructure requirements to meet needs and recommendations of the Children's Commission per SB 125.</td>
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<td>Section 8.1.11.3 Assessments is added.</td>
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<td>Section 8.1.12.1 is modified to add Health Passport submission requirements for CANS assessments and to add enhancements to be implemented at a later date per SB 125.</td>
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<td>Section 8.1.12.2 is modified to add requirement to develop a process to ensure forms and assessments are entered more timely.</td>
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<td>Section 8.1.12.3 is modified to change week to day.</td>
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<td>Section 8.1.12.4 is renamed Health Passport Mobile Accessibility and modified to change language, as this will not be an app, but access by mobile device only.</td>
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<td>Section 8.1.13.2 is modified to change telephonic assessment to &quot;screening&quot; to distinguish this from the new assessment process; to add requirement to discuss assessment requirement and schedule the assessment during the telephonic screening call; to add that HCSPs must incorporate the CANS results within 14 days of completion; and to add that SM or SC must be offered to the Member if the CANS indicates a need per SB 125.</td>
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<td>Section 8.1.17 is modified to add requirement for BH providers to either complete a DFPS CANS assessment or refer to a provider who is certified to do so per SB 125.</td>
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<td>Section 8.1.17.1 is modified to review entire section for impact to BH network requirements per SB 125.</td>
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<td>Section 8.1.17.4 is modified to add requirements for coordination regarding the results of the DFPS CANS assessment per SB 125.</td>
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<td>Section 8.1.20.1 is modified to change “Clinical Edits” to “Clinical PAs.”</td>
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<td>Section 8.1.20.2 is modified to add language regarding VDP’s Clinical PA process and dispensing or refilling a prescription without a prior authorization during a Governor-declared disaster.</td>
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<td>Section 8.1.20.6 is modified to correct a CFR reference, to remove the prospective review and POS requirement, and to add a reference to UMCM Chapter 5.13.4</td>
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<td>Section 8.1.20.15 is modified to prohibit the use of extrapolation in pharmacy audits and to remove the requirement to comply with Texas Insurance Code § 843.3401</td>
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<td>Section 8.1.20.17 “Second Generation Direct Acting Antivirals for Hepatitis C” is deleted in its entirety.</td>
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<td>Section 8.1.26.2 is modified to add “Critical Incidents and Abuse, Neglect, and Exploitation Report.”</td>
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<td>Section 8.1.28.8 is modified to remove DFPS Targeted Case Management.</td>
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<td>Section 8.1.33.5 is modified to require MCOs to ensure appropriate staff attends all Fair Hearings as scheduled.</td>
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## DOCUMENT HISTORY LOG

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<th>STATUS¹</th>
<th>DOCUMENT REVISION²</th>
<th>EFFECTIVE DATE</th>
<th>DESCRIPTION³</th>
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<tbody>
<tr>
<td>Revision</td>
<td>2.3</td>
<td>September 1, 2016</td>
<td>Section 8.1.40 is deleted in its entirety and the language moved to Section 8.1.5.10.1 in order to consolidate all ANE language in one location.</td>
</tr>
</tbody>
</table>

All references to Frew v. Traylor are changed to Frew v. Smith.

Section 8.1.2.1 is modified to remove language referencing the transition phase.

Section 8.1.2.2 is modified to remove the requirement to submit an implementation plan prior to the Operational Start Date.

Section 8.1.3 is modified to add language specific to MDCP and CFC services.

Section 8.1.3.1 is modified to add a standard for the Texas Comprehensive CANS 2.0 (child welfare).

Section 8.1.4 is modified to remove the requirement to submit an implementation plan prior to the Operational Start Date; to change "in the MCO’s proposed Service Area(s)" to "throughout the state"; to clarify the name of the CANS assessment; to remove "Home Health Services" and add "Community-Based Service Providers," "MDCP," "Durable Medical Equipment (DME) and Medical Supplies," and "Prescribed Pediatric Extended Care Centers (PPECC)."

Section 8.1.4.1 is modified to require the MCOs to provide each provider with a copy of the executed provider contract within 45 days of execution.

Section 8.1.4.4 is modified to require the MCO to identify a tracking process for BH Providers becoming certified to administer the Texas Comprehensive CANS 2.0 assessment tool.

Section 8.1.4.4.1 is modified to add provider types for which the MCOs must expedite credentialing.

Section 8.1.4.4.2 is modified to change item 7 "legally responsible person" to "Caregiver or Medical Consenter."

Section 8.1.4.6 is modified to remove language referencing the transition phase; to add item 1 d; to modify item 8; to clarify the name of the CANS assessment tool in item 9 f; and to remove item 17.

Section 8.1.4.8.1 Safety-net Hospital Incentives is added.

Section 8.1.4.9 is modified to align the contract language with the Texas Government Code.
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<td></td>
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<td></td>
<td>Section 8.1.4.10 is modified to clarify the reporting requirement.</td>
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<td>Section 8.1.5.1 is modified to remove references to category 4.</td>
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<td>Section 8.1.5.2 is modified to remove the FFCHE program.</td>
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<td></td>
<td>Section 8.1.5.4 is modified to clarify the requirements and to add Subsections 8.1.5.4.1 Hard Copy Provider Directory and 8.1.5.4.2 Online Provider Directory.</td>
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<td></td>
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<td>Section 8.1.5.5 is modified to add a reference to the Online Provider Directory and to add requirements for mobile devise use.</td>
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<td></td>
<td>Section 8.1.5.6 is modified to add Community-Based and LTSS to covered services; to correct typographical errors; to clarify that the NEMT program is non-capitated; and to add SB 125 training requirement.</td>
</tr>
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<td></td>
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<td></td>
<td>Section 8.1.5.7 is modified to add SB 125, PCS, service delivery options, and MDCP services; and the list is reworked to be more concise with regard to covered services listed.</td>
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<td>Section 8.1.5.10.3 MCO Training on Abuse, Neglect, and Exploitation is added.</td>
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<td>Section 8.1.11.1 is modified to remove language requiring a training plan be submitted prior to the Operational Start Date.</td>
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<td>Section 8.1.11.2 is modified to remove the reference to category 4.</td>
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<td>Section 8.1.11.3 is modified to clarify the name of the CANS assessment.</td>
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<td>Section 8.1.12.1 is modified to remove Readiness Review language and to modify the SB125 required data elements.</td>
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<td>Section 8.1.12.4 is modified to align to the data elements in Section 8.1.12.1.</td>
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<td></td>
<td>Section 8.1.13.1 is modified to add language specific to STAR Kids and MDCP.</td>
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<td>Section 8.1.13.2 is modified to incorporate MDCP requirements into the Service Manager’s role; to update the name of the child welfare CANS; to adjust service plan requirements to incorporate the child welfare CANS; and to clarify that MCOs must coordinate services to prevent duplication.</td>
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<td>Section 8.1.15 is modified to clarify that health home services do not apply to dual eligible Members.</td>
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<td>Section 8.1.15.1 is modified to remove requirement to submit an implementation plan prior to the Operational Start Date.</td>
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<td>Section 8.1.16.1 is modified to remove requirement to submit an implementation plan prior to the Operational Start Date.</td>
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<td>Section 8.1.17 is modified to update the name of the child welfare CANS and to remove the requirement to submit the results of the child welfare CANS to the Health Passport.</td>
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<td>Section 8.1.17.1 is modified to remove requirement to submit an implementation plan prior to the Operational Start Date and to add the child welfare CANS to the list.</td>
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<td>Section 8.1.17.3 is modified to update the UMCM chapter name.</td>
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<td></td>
<td>Section 8.1.17.4 is modified to update the name of the child welfare CANS and to convert part of the second paragraph to a list and to update the title and URL for Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care.</td>
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<td>Section 8.1.17.8 is modified to add clinic/group practices to the list of qualified Network entities.</td>
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<td>Section 8.1.18.2 is modified to list the provider types that can serve as Main Dental Home Providers.</td>
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<td>Section 8.1.25 is modified to clarify MCO level of cooperation and assistance.</td>
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<td>Section 8.1.25.2 is modified to clarify and provide support to the Deliverables/Liquidated Damages Matrix.</td>
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<td>Section 8.1.26.2 is modified to update items (d) (f) and (g) to conform to updates to the UMCM; to delete items (e) (f) (m) and (t) and re-letter all subsequent items; and to add item (v).</td>
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<td>Section 8.1.27.1 &quot;For MDCP Members&quot; is added.</td>
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<td>Section 8.1.28.3.2 is modified to require the MCOs to educate providers on OEFV documentation.</td>
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<td>Section 8.1.28.3.5 is modified to update the requirements for items 8 and 9 and to remove the requirement for the MCO to educate and train Providers regarding the requirements of the Frew v. Traylor Consent Decree and Corrective Action Orders.</td>
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<td></td>
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<td>Section 8.1.28.8 is modified to add item 16 &quot;Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members.&quot;</td>
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<td>Section 8.1.28.10 is modified to require the MCOs to educate providers on documentation for immunizations.</td>
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<td>Section 8.1.29 is modified to add STP requirements for MDCP providers.</td>
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<td>Section 8.1.35 is modified to add requirements for MDCP and to update the minimum wage amount.</td>
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<td>Section 8.1.38 is modified to change the name from &quot;Community First Choice (CFC) Services Available to Qualified Members&quot; to &quot;Community First Choice (CFC) Services&quot; and language from Sections 8.1.39.1, 8.1.39.2, 8.1.39.3, 8.1.39.4, and 8.1.39.5 is incorporated.</td>
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<td>Section 8.1.39 Community First Choice Eligibility is deleted and replaced by Covered Community-Based Services.</td>
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<td>Section 8.1.39.1 For Members Who Have Physical Disabilities is deleted and the language is incorporated into Section 8.1.38.</td>
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<td>Section 8.1.39.2 For Members with an Intellectual or Developmental Disability is deleted and the language is incorporated into Section 8.1.38.</td>
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<td>Section 8.1.39.3 For Members with Severe and Persistent Mental Illness or Severe Emotional Disturbance is deleted and the language is incorporated into Section 8.1.38.</td>
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<td>Section 8.1.39.4 Eligibility is deleted and the language is incorporated into Section 8.1.38.</td>
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<td>Section 8.1.39.5 Annual Reassessment is deleted and the language is incorporated into Section 8.1.38.</td>
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<td>Section 8.1.40 Service Delivery Options is added.</td>
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<td>Section 8.1.40.1 Consumer Directed Services (CDS) Model is added.</td>
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<td>Section 8.1.40.2 Service Related Option Model is added.</td>
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<td>Section 8.1.40.3 Agency Model is added.</td>
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<td>Section 8.1.41 Facility Based Care is added.</td>
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<td>Section 8.1.42 Prescribed Pediatric Extended Care Centers is added.</td>
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<td>Section 8.1.42.1 Prior Authorization for PPECC Services is added.</td>
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<td>Section 8.1.43 Medicaid Wrap-Around Services is added.</td>
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# DOCUMENT HISTORY LOG

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<tr>
<td>Revision</td>
<td>2.4</td>
<td>March 1, 2017</td>
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</tbody>
</table>

Section 8.1.44 Carve-in Readiness is added.
Section 8.2 Additional Requirements Regarding the Medically Dependent Children Program (MDCP) is added.
Section 8.2.1 Program Eligibility and Assessment is added.
Section 8.2.2 Service Management Requirements for MDCP Members is added.
Section 8.2.3 MDCP Provider Requirements is added.

All references to OIG or IG will be changed to HHSC OIG.
All references to HHSC NEMT (may be spelled out as HHSC Non-emergency Medical Transportation Program) are updated to Health and Human Services Commission's Medical Transportation Program.
Section 8.1.1 is modified to align to the UMCM and to remove the reference to the NorthSTAR program.
Section 8.1.2.2 is modified to add UMCM Chapter 5.9.5 "Case-by-Case Added Service Delivery Report".
Section 8.1.3.1 is modified to change the section name from "Waiting Times for Appointments" to "Appointment Accessibility" and the requirements are updated.
Senate Bill 760, 84th Legislature, requires HHSC to start several network adequacy initiatives in Medicaid managed care. This contract language clarifies requirements for appointment wait times.
Section 8.1.3.2 is modified to clarify time and mileage standards for network providers. Senate Bill 760, 84th Legislature, requires HHSC to start several network adequacy initiatives in Medicaid managed care. CMS also requires states to implement network adequacy requirements with time and distance standards by Sept. 2018. See CFR 438.68 (b).
Section 8.1.3.3 is modified to change the mandatory challenge survey to a Provider Directory Verification Survey and to update the requirements.
Section 8.1.4 is modified to clarify that qualified PPECCs include those with a temporary, initial, or renewal license.
Section 8.1.4.4.1 is modified to add Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Psychologists to the list of providers allowed to provide services to members on a provisional basis while in the credentialing process.
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<td>Section 8.1.4.6 is modified to require the MCOs to notify Providers of changes to provider relations specialists and to remove the requirement for HHSC's review of provider materials and to add a reference to UMCM chapters 3, 4, and 8 for material and submission requirements.</td>
</tr>
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<td>Section 8.1.5.1 is modified to correct the reference for UMCM Chapter 4 and to remove review timeframe. Review timeframes can be found in UMCM Chapter 4.6 MCO Materials Submission Process.</td>
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<td>Section 8.1.5.8 is modified to add CLAS requirements.</td>
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<td>Section 8.1.5.11 Member Service Email Address is added to comply with SB 760, 84th Legislature which requires MCOs to have an email address for assistance with appointments.</td>
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<td>Section 8.1.13.3 &quot;Transition Planning&quot; is added to align with STAR Kids requirements for the use of a Transition Specialist for MDCP recipients.</td>
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<td>Section 8.1.17.7 is modified to obligate MCOs to pay for court ordered services when they are a Medicaid benefit (outside the IMD exclusions age range of 21-64); to remove a provision that specifically prohibits MCOs paying for court ordered commitments; and to require MCOs to cover SUD treatment as a condition of probation.</td>
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<td>Section 8.1.17.9 is modified to conform to CMS clarifying guidance regarding mental health parity.</td>
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<td>Section 8.1.24.2 is modified to remove the phrase “at the beginning of each State Fiscal Year” from the first and second paragraph.</td>
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<td>Section 8.1.25 is modified to add a reference to Texas Government Code § 531.1131.</td>
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<td>Section 8.1.25.3 is modified to add item 2 and all subsequent items are renumbered.</td>
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<td>Section 8.1.26.2 is modified to add items (v) and (w).</td>
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<td>Section 8.1.27 is modified to add requirements for newly enrolled Members who were receiving a service that did not require a prior authorization in FFS, but does require one by the new MCO.</td>
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<td></td>
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<td>Section 8.1.28.8 is modified to remove item 11 &quot;Court-Ordered Commitments to inpatient mental health facilities as a condition of probation&quot; and all subsequent items are renumbered.</td>
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<td>Section 8.1.30 is modified to clarify the payment requirements.</td>
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<tr>
<td>Revision</td>
<td>2.5</td>
<td>September 1, 2017</td>
<td>Section 8.1.1.1 is modified to add material subcontractor site visit language and to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.1.2 is added to allow HHSC utilization review unit to perform its duties of review and evaluation of the MCOs delivery of services under the contract by reviewing MCO policies, procedures, and documents related to the delivery of such services. Section 8.1.2 is modified to comply with 42 CFR §438.210. Section 8.1.2.1 is modified to reduce the opportunity for changes to Value-added Services from biannual to annual. Section 8.1.3 is modified to comply with a court order requiring FQHC non-emergency unauthorized out-of-network services to be fully reimbursed. Section 8.1.3.2 is modified to align the age requirements for PCPs with the American Academy of Pediatrics; add oncology to Specialist Physician Access standards; and to comply with managed care access requirements to be based on distance or travel time rather than both. Section 8.1.4 is modified to require the LMHAs continue to be contracted by MCOs even after the expiration of the STP provision. Section 8.1.4.2 is modified to add Indian Health Care Providers to comply with 42 CFR §438.14 and to align the age requirements for PCPs with the American Academy of Pediatrics. Section 8.1.4.4 is modified to reference compliance with all of 42 CFR §438.214. Section 8.1.4.6 is modified to clarify that an annual CANS assessment is required. Section 8.1.4.8 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.4.8.4 is added to comply with a new CMS managed care requirement in 438.602(d)(2).</td>
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<td>Section 8.1.4.10 is modified to comply with 42 CFR §438.10(f)(1), which relates to written notice of termination of a contracted provider.</td>
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<td>Section 8.1.5.1 is modified to comply with 42 CFR §438.10.</td>
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<td>Section 8.1.5.4.2 is modified to comply with 42 CFR §438.10, which relates to provider directories, member handbooks, and formularies.</td>
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<td>Section 8.1.5.6 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement; and to clarify the requirement for an annual CANS assessment.</td>
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<td>Section 8.1.5.7 is modified to clarify the requirement for an annual CANS assessment.</td>
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<td>Section 8.1.5.9 is modified to change the performance standard for applying liquidated damages on Member appeals to be applicable to standard and expedited appeals.</td>
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<td>Section 8.1.7.1 is modified to comply with 42 CFR §438.332.</td>
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<td>Section 8.1.7.9.2 &quot;MCO Value-Based Contracting&quot; is renamed &quot;MCO Alternative Payment Models with Providers&quot; and the requirements are updated to establish targets for MCOs regarding levels of payments tied to APMs with Providers.</td>
</tr>
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<td>Section 8.1.7.10 is modified to clarify that MCOs using HEDIS hybrid measures are responsible for conducting chart reviews and submitting results to the EQRO.</td>
</tr>
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<td>Section 8.1.9.1 is modified to add Member Handbook to the list of policies and procedures and substituting HHSC for DARS.</td>
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<td>Section 8.1.12.2 is modified to require the MCO to allow approved DFPS users continued unlimited access to the Member's Health Passport.</td>
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<td>Section 8.1.13.2 is modified to comply with 42 CFR §438.208 regarding training and to clarify the requirements for an annual CANS assessment.</td>
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<td>Section 8.1.16.1 is modified to change the submission of the Plan for Special Populations from an annual report to an ad hoc report.</td>
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<td>Section 8.1.15.3 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information</td>
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<td>from HHSC staff as a requirement for travel reimbursement.</td>
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<td>Section 8.1.17.9 is modified to add specificity to the requirement.</td>
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<td>Section 8.1.20 is modified to comply with 42 C.F.R. §438.3(s) and the Mental Health Parity and Addiction Equality Act (MHPAEA) of 2008.</td>
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<td>Section 8.1.20.1 is modified to comply with 42 C.F.R. §438.10, which relates to provider directories, member handbooks, and formulary information.</td>
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<td>Section 8.1.20.6 is modified to comply with 42 C.F.R. §438.3(s).</td>
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<td>Section 8.1.23 is modified to clarify reasonable costs.</td>
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<td>Section 8.1.23.1 is modified to add item (n) &quot;Medical Loss Ratio (MLR) Report&quot; to comply with 42 CFR §438.8.</td>
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<td>Section 8.1.24 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Section 8.1.24.5.1 is added to ensure MCOs are completing their claims projects and submitting final claims in a timely fashion.</td>
</tr>
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<td>Section 8.1.25.2 is modified to add a five business day timeframe for requests submitted to the MCO/DMO for policy guidance, interpretations or clarifications.</td>
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<td></td>
<td>Section 8.1.25.4 (7) clarifies how settlements under the False Claims Act will be handled.</td>
</tr>
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<td></td>
<td>Section 8.1.26.2 is modified to change the reporting requirements for &quot;Claims Summary Report&quot; and to Section 8.1.27.1 &quot;For MDCP Members&quot; is deleted in its entirety and the language is moved to Section 8.2.4 &quot;Continuity of Care Requirements for MDCP Members&quot;.</td>
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<td>Section 8.1.27.2 is added to comply with 42 CFR §438.110.</td>
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<td>Section 8.1.28.3.4 is modified to clarify requirements as a result of the Frew settlement agreement.</td>
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<td>Section 8.1.28.3.5 is modified to clarify requirements as a result of the Frew settlement agreement.</td>
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<td>Section 8.1.28.7 is modified to comply with 42 CFR §438.102.</td>
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<td></td>
<td>Section 8.1.30 is modified to comply with a court order related to the Legacy lawsuit requiring FQHC non-</td>
</tr>
</tbody>
</table>
emergency unauthorized out-of-network services be fully reimbursed.

Section 8.1.31 “Provider Complaints and Appeals” is renamed “Provider Complaints and Internal MCO Appeals”; Section 8.1.31.1 Provider Complaints is amended to provide greater clarification regarding proper and timely dissemination of information to the noted parties.

Section 8.1.31.2 “Appeal of Provider Claims” is renamed “Provider Appeal of MCO Claims Determinations” and to comply with 42 CFR §438.414

Section 8.1.33.1 "Member Complaint Process" is renamed "MCO Member Complaint Process".

Section 8.1.33.3 "Standard Member Appeal Process" is renamed "Member Internal MCO Appeal Process" modified to change the performance standard for applying liquidated damages on member appeals to be applicable to standard and expedited appeals, to clarify that MCOs must not recover costs from Members without written permission from HHSC, and to comply with 42 CFR §§438.402, 438.406, and 438.420(b)(5).

Section 8.1.33.8 is modified to clarify that both Members and any entity acting on behalf of the Member must receive appeal resolutions in writing.

Section 8.1.37 is modified to remove Private Duty Nursing to align with the STAR+PLUS contracts.

Section 8.1.38 is modified to comply with 42 CFR §438.3(o).

Section 8.1.39 is modified to comply with 42 CFR §438.3(o).

Section 8.1.43 is modified to clarify the LTSS services that are covered as Medicare wrap-around services.

Section 8.2.1 is modified to clarify timeframes and to delete outdated language.

Section 8.2.2 is modified to align timeframe requirements with the STAR Kids contract, to remove the requirement to provide the MDCP Member’s individual budget, and to comply with 42 CFR §441.301.

Section 8.2.4 "Continuity of Care Requirements for MDCP Members" is added and the language moved from Section 8.1.27.1.

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<th>EFFECTIVE DATE</th>
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<td>Revision</td>
<td>2.6</td>
<td>March 1, 2018</td>
<td>The following changes were made throughout the attachment:</td>
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<td>Updates to citations</td>
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<td>Removal of hyperlinks</td>
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<td></td>
<td>Change “patient” to “Member”</td>
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<td>Change “shall” to “must”</td>
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<td>Change “Network Provider Agreement” and “Provider Agreement” to “Provider Contract”</td>
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<td></td>
<td>Change “day(s)” and “calendar day(s)” to “Day”</td>
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<td>Remove numeric number for those numbers under 10</td>
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<td></td>
<td></td>
<td></td>
<td>Capitalized defined terms</td>
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<td>Changed order of terms Fraud, Waste and/or Abuse to consistent use of phrase</td>
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<td>Changed “Expeditied Appeal” to “Expeditied MCO Internal Appeal”</td>
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<td></td>
<td>Changed “Fair Hearing System” to “State Fair Hearing System”</td>
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<td></td>
<td>Section 8.1.2.2 is modified to accommodate 42 CFR 438.3(e).</td>
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<td>Section 8.1.3 is modified to comply with a court order requiring FQHC non-emergency unauthorized out-of-network services to be fully reimbursed and add language to maintain network adequacy for children in DFPS.</td>
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<td></td>
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<td>Section 8.1.3.4 is modified to standardize language across MCOs.</td>
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<td>Section 8.1.4 “Optometrists and Ophthalmologists” is added to comply with implementation of HB 3675, 85r.</td>
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<td>Section 8.1.4.2 is modified to comply American Academy of Pediatrics.</td>
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<td>Section 8.1.4.6 is modified to add ICC vendor staff to training materials for providers.</td>
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<td>Section 8.1.4.9.1 is modified to comply with the new CMS managed care rule 438.3(g) and added a paragraph to clarify “reporting” information.</td>
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<td>Section 8.1.4.13 is modified to state expectations related to retaliation and to withdraw MCO geo-mapping.</td>
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<td>Section 8.1.5.1 is modified to remove references to potential members from requirements.</td>
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<td>Section 8.1.5.4.1 is modified to comply with 42 CFR 438.10(h)(3).</td>
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8-15
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<td>Section 8.1.5.4.2 is modified to add “at least” weekly to online provider directories.</td>
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<td>Section 8.1.5.7 is modified to add ICC vendor staff.</td>
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<td>Section 8.1.5.8 is modified to add standardized requirements for cultural competency plans.</td>
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<td>Section 8.1.11 is modified to add MCO coordinate with ICC vendor, required notification required by SB 11, 85th Regular Session and requires MCO to send DFPS an error report.</td>
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<td>Section 8.1.11.3 is modified to add timely assessments and to add ICC vendor to the list.</td>
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<td>Section 8.1.12.1 is modified to remove record of notification.</td>
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<td>Section 8.1.13.1 is modified to clarify requirements regarding Service Management for Members with Special Health Care Needs (MSHCN).</td>
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<td>Section 8.1.13.2 is modified to add the ICC Vendor</td>
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<td>Section 8.1.17.1 is modified to remove requirement must use to increase access.</td>
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<td>Section 8.1.20 is modified to remove requirements for in-state claims only due to new federal direction.</td>
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<td>Section 8.1.20.2 is modified to give more flexibility to the MCOs by no longer requiring a provider to submit a 72-hour claim.</td>
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<td>Section 8.1.20.3 is modified to add flexibility to deny certain claims for compound medications and to add clarity to the automatic approval of compounded medications.</td>
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<td>Section 8.1.20.4 “Compounded Medications” is added.</td>
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<td>Section 8.1.20.13 is modified to give the MCOs the ability to deny retail claims.</td>
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<td>Section 8.1.24.1 is modified to comply with 42 CFR 438.242 and 438.818.</td>
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<td>Section 8.1.25.6 is modified to convert the timing from ad hoc to annual.</td>
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<td>Section 8.1.26.2 is modified to require documentation accompany an FWA referral.</td>
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<td>Section 8.1.28.10 is modified to clarify who can administer Immunizations.</td>
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<td>Section 8.1.30 is modified to comply with a court order requiring FQHC non-emergency unauthorized out-of-network services be fully reimbursed.</td>
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</table>
| Revision 2.7 | September 1, 2018 | | Section 8.1.33.4 is modified to comply with 42 C.F.R. § 438.410.  
Section 8.1.33.5 is modified to comply with new CMS Managed Care Regulation 438.408.  
Section 8.1.34 is modified to require MCOs to submit a yearly plan/TPL process and clarify deadlines for billing & collection of TPL recoveries.  
Section 8.1.34.1 is modified to a 6th grade reading comprehensive level.  
Section 8.1.39 is modified to add to comply with new managed care reg-438.3(o)-LTSS Contracts.  
The following changes were made throughout the attachment:  
Capitalize defined terms and un-capitalize terms which are note defined.  
Spell out the full name of acronyms and remove acronyms in some instances.  
Remove duplicative language.  
Section 8.1.1 is modified to allow health plans to collaborate with community organizations.  
Section 8.1.2.1 is modified to update UMCM Chapter reference.  
Section 8.1.2.2 is modified to provide clarity for Case-by-case Services.  
Section 8.1.3 is modified to be in full compliance with 42 C.F.R. § 438.14.  
Section 8.1.3.1 is modified to comply with S.B. 11 of the 85th Legislative Session  
Section 8.1.3.2 is modified to comply with S.B. 760 of the 84th Legislative Session, and recent managed care rules related to network adequacy. This section is also modified to allow geo mapping for TH Steps, Pediatricians, and Audiology providers. In addition, this section is modified to comply with requirements of 42 C.F.R. §§ 438.3(l), 438.68, and 457.1201(j). Lastly, this section is modified to bring contract language into alignment with current practice.  
Section 8.1.3.5 is added to outline requirements permitting Members to see OON Indian Health Care Providers in order to comply with 42 C.F.R. 438.14. |
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<td>Section 8.1.4 is modified to clarify pharmacy services are included in the requirements supported by the CDC.</td>
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<td>Section 8.1.4.2 is modified to comply with S.B. 654 of the 85th Legislative Session which will allow MCOs to include advanced practice registered nurses as Network Primary Care Providers.</td>
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<td>Section 8.1.4.9 is modified to reflect the new program area name, Managed Care Compliance &amp; Operations.</td>
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<td>Section 8.1.5.8 is modified to include legally authorized representative (LAR).</td>
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<td>Section 8.1.8 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity.</td>
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<td>Section 8.1.14 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity.</td>
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<td>Section 8.1.17.4 is modified to comply with S.B. 1107 of the 85th Legislature Session which updates the definitions of Telemedicine and Telehealth services in Texas Government Code § 531.001(7) and (8).</td>
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<td>Section 8.1.17.6.2 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity.</td>
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<td>Section 8.1.17.7 is modified to clarify an MCO cannot deny, reduce, or controvert the Medical Necessity of court-ordered services.</td>
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<td></td>
<td>Section 8.1.20.1 is modified to comply with H.B. 1296 of the 85th Legislative Session.</td>
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<td></td>
<td>Section 8.1.20.2 is modified to move language regarding “prescriber authorization during a Governor-declared disaster” to new Section 8.1.45.</td>
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<td></td>
<td>Section 8.1.20.5 is modified to comply with 42 C.F.R. § 447.502.</td>
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<td>Section 8.1.12.1 is modified to include link for EISSG.</td>
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<td>Section 8.1.24 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity.</td>
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<td>Section 8.1.24.5 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity.</td>
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<tr>
<td>Revision</td>
<td>2.8</td>
<td>January 1, 2019</td>
<td>opposed to only those subcontracting Behavioral Health Services for continuity.</td>
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<td>Section 8.1.25.3 is modified to clarify language on operational processes.</td>
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<td>Section 8.1.25.4 is modified to comply with Texas Government Code § 531.102(g).</td>
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<td></td>
<td>Section 8.1.25.5 is modified to comply with 42 C.F.R. 438.608(d)(1)(i) and CMS MCE Checklist 1.1.6.</td>
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<td>Section 8.1.26.2(t) is modified to comply with 1915 (c) waiver requirements, (u) 24-7 PCP Access Report is deleted, (w) is modified to assist with a Member moving from one plan to another plan, (x) is added to create a new deliverable which captures utilization data for clinician-administered drugs paid through the non-risk based model, and (y) is added to comply with 1915 (c) waiver requirements.</td>
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<td>Section 8.1.28.3.1 is modified to ensure compliance with S.B. 11 of the 85th Legislative Session.</td>
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<td>Section 8.1.28.3.5 is modified to remove unnecessary language.</td>
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<td>Section 8.1.29 is modified to remove outdated language and bring the contract up to date.</td>
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<td>Section 8.1.30 is modified to be in full compliance with 42 C.F.R. § 438.14.</td>
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<td>Section 8.1.33.3 is modified to change Days to Business Days.</td>
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<td>Section 8.1.37 is modified to streamline and improve the EVV process/system.</td>
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<td>Section 8.1.40.1 is modified to clarify the requirements of the MCO to calculate a member’s budget through the CDS option.</td>
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<td>Section 8.1.45 is added to ensure MCOs have plans in place for future disasters.</td>
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¹ Document revision status
² Document revision number
³ Description of changes
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<td>2.9</td>
<td>March 1, 2019</td>
<td>Section 8.1.34 is modified to comply with The Bipartisan Budget Act of 2018</td>
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<td>Contract amendment did not revise Attachment B-1</td>
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<td>Section 8 “Operations Phase Requirements”.</td>
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<td>2.10</td>
<td>September 1, 2019</td>
<td>Global – term “Action” is replaced with “Adverse Benefit Determination.”</td>
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<td>Global change for the phrase, “substance abuse” to “substance use disorder.”</td>
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<td>Global change for the phrase, “substance abuser” to a “person with a substance use disorder.”</td>
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<td>Global change to Texas Administrative Code from Title 40 to Title 26.</td>
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<td>Section 8.1.3.1 is modified to clarify required appointment wait time standards for Specialty Therapy</td>
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<td>Section 8.1.3.3 is modified to comply with managed care Network Adequacy initiatives.</td>
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<td>Section 8.1.4 is modified to ensure Providers are not being paid for claims after a sanction or exclusion; clarify pharmacy contract arrangements; and correct the terminology regarding licensing, certification and Medicaid contracting per guidance from HHSC Licensing.</td>
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<td>Section 8.1.4.9 to modified to change timeframes for fee schedule changes.</td>
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<td>8.1.5.1 This language is added to meet the requirements of SB 11, Section 24 (85th Regular Session, 2017) which added Government Code Section 533.0054 regarding Health Screening Requirements for Enrollee Under STAR Health Program.</td>
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<td>Section 8.1.5.4 is modified to comply with managed care Network Adequacy initiatives.</td>
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<td>Section 8.1.5.4.1 is modified to comply with managed care Network Adequacy initiatives.</td>
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<td>Section 8.1.5.4.2 is modified to comply with managed care Network Adequacy initiatives.</td>
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<td>Section 8.1.5.6 is modified to comply with managed care Network Adequacy initiatives.</td>
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<td>Section 8.1.5.7 to modified to change age range to ages 3 through 17.</td>
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<td>Section 8.1.5.8 is modified to clarify the interpreter service requirements available to MCOs, including advance notice. Section 8.1.5.10.3 is modified to align</td>
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<td>Critical Incident and Abuse, Neglect, and Exploitation efforts 2014 federal guidance from CMS</td>
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<td>Section 8.1.7.9.2 is modified to add pharmacies and pharmacist as types of providers MCOs can work with to meet the APM requirement.</td>
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<td>Section 8.1.8 is modified to clarify guidance for Notification Process.</td>
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<td>Section 8.1.11.3 is modified to change age range to ages 3 through 17.</td>
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<td>Section 8.1.13.2 is modified to change age range to ages 3 through 17.</td>
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<td>Section 8.1.17.6.1 is modified to clarify narcotic/opiate treatment programs must be included the network. Also updated references to DSHS to HHSC and STP requirements consistent across contracts.</td>
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<td>Section 8.1.17.6.2 is modified to update references to DSHS to HHSC and STP requirements consistent across contracts.</td>
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<td>Section 8.1.20.10 is modified to clarify MCOs requirement to adhere to the Specialty Drug List.</td>
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<td>Section 8.1.22 is modified to align TPL language across contracts.</td>
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<td>Section 8.1.24 is modified to ensure standardized reporting of provider addresses for analytical network adequacy reporting.</td>
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<td>Section 8.1.25 is modified to ensure MCOs comply with nursing facility utilization review findings and discovery.</td>
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<td>Section 8.1.25.1 is modified to comply with Rider 152, Article II, 85th Legislature.</td>
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<td>Section 8.1.25.2 is modified to add a requirement to retain certain documents for review by the OAG.</td>
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<td>Section 8.1.26.2 is added or modify reports.</td>
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<td></td>
<td>Section 8.1.28.3.1 This language is added to meet the requirements of SB 11, Section 24 (85th Regular Session, 2017) which added Government Code Section 533.0054 regarding Health Screening Requirements for Enrollee Under STAR Health Program.</td>
</tr>
<tr>
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<td>Section 8.1.28.3.1 is modified to comply with CFR and ensure consistency between contracts.</td>
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<td>Section 8.1.28.3.4 This language is added to meet the requirements of SB 11, Section 24 (85th Regular Session, 2017) which added Government Code Section</td>
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<td>533.0054 regarding Health Screening Requirements for Enrollee Under STAR Health Program. Section 8.1.28.8 is modified to update the access to care for Members with Special Health Care Needs (MSHCN) v to add DFPS NFP to the list of community series for MSHCN referrals. Section 8.1.33.1 is modified to align with MCO appeal standards. Section 8.1.33.2 is modified to remove duplicative language already included. Section 8.1.33.6 is modified to change the timeframe from 90 Days to 120 Days. Section 8.1.34 is modified to clarify current language and alignment of the TPL language across all MCO contracts and to implement updated Section 1902(a)(25)(E) of the Social Security Act (42 U.S.C. §1396a(a)(25)(E)) as amended by the Bipartisan Budget Act of 2018 (Pub. L. 115-123) effective February 9, 2018. Section 8.1.37 is modified to comply with the requirement to streamline and standardize the EVV process per the OIG audit findings and the 21st CURES Act and Texas Govt. Code §531.024172 Section 8.1.45 is modified to align with UMCM Chapter 15.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.11</td>
<td>March 1, 2020</td>
<td>Section 8.1.3.4. is modified to require MCOs to reimburse Telemedicine at the same rate at in person services and allow Member’s to utilize Telemedicine services from a provider other than their PCP. Section 8.1.8 is modified to require MCOs to review and issue prior authorization determinations within specific timeframes for Members who are hospitalized. The changes are necessary to comply with SB 1096.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.12</td>
<td>September 1, 2020</td>
<td>Global Change to correct the references to UMCM Global change for the phrase, ImmTrac is now IMMTrac2. Section 8.1.1.1 is being modified to align review requirements across all contracts. Section 8.1.3.2 is modified to align all contract to ensure consistency in performance requirements. Section 8.1.4 is modified to align with all contracts to be consistent and to remove a reference due to a policy change that are no longer done.</td>
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<td>Section 8.1.4.8 is modified to remove language that is no longer required by CMS.</td>
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<td>Section 8.1.4.10 is modified language moved to provider network section</td>
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<td></td>
<td>Section 8.1.5.3 modified to remove “Pre-Appeals”</td>
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<td>Section 8.1.5.6 is modified to remove measures that are no longer required by CMS.</td>
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<td>Section 8.1.5.8 is modified to remove reference to UMCM Chapter that does not exist.</td>
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<td>Section 8.1.7.9.1 is modified to correct citation</td>
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<td>Section 8.1.7.9.2 is modified to facilitate in advance to approval of MCOs APMs involving the outpatient drug benefit.</td>
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<td>Section 8.1.7.9.1 is modified to clarify language when providing new information to providers.</td>
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<td>Section; 8.1.13.3 modified to remove Department of Aging and Rehabilitative Services and add Texas Workforce Commission</td>
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<td>Section 8.1.14 is modified to clarify program requirements and case management language removed</td>
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<td>Section 8.1.17.3 is modified to remove measures that is no longer required by CMS.</td>
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<td>Section 8.1.17.6.3 is Added to comply with SB 1564 86th Legislature requirements.</td>
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<td>Section 8.1.20.1 is modified to align with TDI.</td>
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<td>Section 8.1.20.5 is modified to be consistent with current contract language.</td>
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<td>Section 8.1.20.11 is modified to clearly state HHSC’s right to review MAC lists as they pertain to this contract.</td>
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<td>Section 8.1.23.1 (l) is modified to make language consistent across all contracts.</td>
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<td>Section 8.1.23.1 (o) is modified to update Chapter reference.</td>
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<td></td>
<td>Section 8.1.24.5 is modified to comply with SB 1207 and SB 749.</td>
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<td>Section 8.1.24.5.1 is modified to exclude NF claims from Claims Projects</td>
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<td>Section 8.1.25.1 is modified to delete the language that allows MCOs to submit a letter in lieu of a full Fraud, Waste and Abuse compliance plan.</td>
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<td>Section 8.1.25.3 is modified to remove a report that is no longer required.</td>
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<td>Section 8.1.26.2 (w) is modified to update the reporting due date.</td>
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<td>Section 8.1.26.2 (y) Reports is modified to remove MCO self-reported service plan measures</td>
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<td>Section 8.1.28.3.5 #7 modified to change name</td>
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<td>Section 8.1.28.3.5 is modified to be consistent throughout the contracts.</td>
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<td>Section 8.1.28.8 #4 modified to change name</td>
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<td>Section 8.1.28.8 modified to replace DARS with HHSC</td>
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<td>Section 8.1.28.10 is modified to be in alignment with other schedule for immunization.</td>
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<td>Section 8.1.33.2 is removed in its entirety (Intentionally Left Blank)</td>
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<td>Section 8.1.33.3 is modified to comply with S.B. 1207, 86TH Legislature, Regular Session, 2019, and in compliance with 42 C.F.R 438.402.</td>
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<td>Section 8.1.33.4 is modified to remove language regarding Pre-Appeal Process.</td>
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<td>Section 8.1.33.5 is modified to comply with S.B. 1207, 86TH Legislature, Regular Session, 2019, and in compliance with 42 C.F.R 438.402.</td>
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<td>Section 8.1.33.7 is modified to comply with the updates to SB 1207.</td>
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<td>Section 8.1.33.8 is modified in accordance with 42 C.F.R. § 438.408(e).</td>
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<td>Section 8.1.34 is modified to be consistent across all contracts.</td>
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<td>Section 8.1.39.1 is modified to comply with Audit recommendations.</td>
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<td>Section 8.1.40.1 is modified to comply with HB4533</td>
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<td>Section 8.1.40.2 is modified to be consistent across all contracts</td>
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<td>Section 8.2.2 is modified to comply with SB 1207</td>
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## DOCUMENT HISTORY LOG

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<td>Section 8.2.3 is modified to comply with HB4533</td>
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<td>Section 8.1.3.1 is modified to comply with Rider 157 from the 86th Legislature, Regular Session, 2019.</td>
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<td>Section 8.1.3.2 is modified to comply with Rider 157 from the 86th Legislature, Regular Session, 2019.</td>
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<td>Section 8.1.4.9.3 is added to comply with SB 1621, 86th Legislature, Regular Session, 2019.</td>
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<td>Section 8.1.17 is modified to comply with SB 1177, 86th Legislature, Regular Session, 2019, amended Government Code § 533.005 updating contract requirements to include provisions of this bill.</td>
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<td>Section 8.1.17.7.1 is modified to comply with SB 1177, 86th Legislature, Regular Session, 2019, amended Government Code § 533.005 updating contract requirements to include provisions of this bill.</td>
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<td>Section 8.1.26.2 is modified to comply with Rider 157 from the 86th Legislature, Regular Session, 2019.</td>
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<td>Section 8.1.27 is modified to comply with SB 1207, 86th Legislature, Regular Session, 2019, amended Government Code § 533.038(g) updating contract requirements to include provisions of this bill.</td>
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<td>Section 8.1.46 is added to comply with federal law and CMS requirements.</td>
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<td>Section 8.1.46.1 is added to comply with federal law and CMS requirements.</td>
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<tr>
<td>Revision</td>
<td>2.13</td>
<td>March 1, 2021</td>
<td>Global Changes for NEMT Carve-in:</td>
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<td>House Bill (H.B.) 1576, 86th Legislature, Regular Session, 2019, makes the following changes to the delivery of Non-Emergency Medical Transportation (NEMT) services:</td>
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<tr>
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<td>• Increases opportunities for Transportation Network Companies (TNCs) to deliver NEMT services in addition to more traditional transportation providers.</td>
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<td>• Requires MCOs to provide NMT services.</td>
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<td>• Moves the responsibility to provide NEMT services from managed transportation organizations (MTOs) to managed care organizations (MCOs) for managed care members.</td>
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<td>This amendment implements these changes to the following sections:</td>
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<td>Section 8.1.2 is modified;</td>
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<td>Section 8.1.3.2 is modified;</td>
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<tr>
<td>Revision</td>
<td>2.14</td>
<td>June 1, 2021</td>
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<td>Section 8.1.3.3 is modified;</td>
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<tr>
<td>Revision</td>
<td>2.15</td>
<td>September 1, 2021</td>
<td>Section 8.1.33.5.1 is added to require MCOs to reimburse HHSC for payments made to independent review organizations performing medical reviews as required by SB1207; Section 8.1.33.6 is modified; Section 8.1.33.11 is added; and Section 8.1.34 is modified.</td>
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<td>Section 8.1.1.2 is modified to give HHSC authority to require MCO provide proof of CAP actions; Section 8.1.2.1 is modified to update requirements for contract changes to VAS; 8.1.3.2 is modified to correct the current citation; 8.1.4.2 is modified to aligned with other children’s Medicaid managed care contracts; Section 8.1.5.12 is added due to similar requirement already exists. HHSC committed to making this change in the Rider 35 legislative report, regarding Medicaid coverage for former foster children; 8.1.7.9.3 is added due to HHSC is requiring MCOs to expand their VBP/APMs; Section 8.1.8 is modified to be consistent with existing language; Section 8.1.8.1 is modified to correct language to differentiate between Medicaid and CHIP requirements for PA; Section 8.1.11 is modified due to DFPS has requested more participation from Superior’s Medical Director in the DFPS medical staffing for members with primary medical needs and members with special health care needs; Section 8.1.12.1 is modified to prevent any data security issues; Section 8.1.20.12 is modified to correct existing language; Section 8.1.20.14 is modified to establish a performance measure and clarify language consistent in each applicable contract; Section 8.1.22 is modified to remove language specific to tort/subrogation; 8.1.25.5 is modified to clarify MCO requirements for referring FWA;</td>
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## DOCUMENT HISTORY LOG

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<td>2.16</td>
<td>March 1, 2022</td>
<td>8.1.26.2 (e) is deleted as the information in this report is being captured in another deliverable by MCCO; Section 8.1.26.2 (x) is modified to remove the section as the referenced survey is obsolete; 8.1.27.1 is added to as per CMS requirement; Section 8.1.28.3.4 is modified to clarify THSteps-CCP description and language; Section 8.1.28.3.5 is modified to aligned with other children’s Medicaid managed care contracts; 8.1.28.3.7 is added to clarify THSteps-CCP description and language; Section 8.1.33.5 is modified to replace the requirement for IRO EMR decision notification; Section 8.1.34 is modified to clarify HHSC file submission timeframe; 8.1.35 is modified to add reference to the TAC rule; 8.1.37 is modified to replace existing provision language; Section 8.1.40.1 is modified to change title name; and Section 8.2.1 is modified due to SB 1207 requires HHSC to streamline the MDCP reassessment process.</td>
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<td>Section 8.1.3 is modified to include language to meet CMS requirements to allow single case agreements for members. Section 8.1.4 is modified to add additional language to address current contract reimbursement and reporting issues. Section 8.1.4.9 is modified to clarify language used for pharmacy provider reimbursements Section 8.1.20 is modified Add-on, proactive approach to address current MCO/PBM/Provider contract reimbursement, ensure complete/accurate encounter data, MCO FSRA reporting/transparency issues to HHSC. Section 8.1.20.7 is modified Add-on, proactive approach to address current MCO/PBM/Provider contract reimbursement, ensure complete/accurate encounter data, and MCO FSRA reporting/transparency issues to HHSC. Also, to ensure section language is consistent among the applicable contracts. Section 8.1.20.8 is modified Add-on, proactive approach to address current MCO/PBM/Provider contract reimbursement, ensure complete/accurate</td>
</tr>
<tr>
<td>STATUS</td>
<td>DOCUMENT REVISION</td>
<td>EFFECTIVE DATE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------</td>
<td>----------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| Revision | 2.17 | September 1, 2022 | encounter data, and MCO FSRA reporting/transparency issues to HHSC. Also, to ensure section language is consistent among the applicable contracts.  
Section 8.1.20.11 is modified to add-on, proactive approach to address current MCO/PBM/Provider contract reimbursement and MCO FSRA reporting/transparency issues to HHSC.  
8.1.27 is modified to include language to meet CMS requirements to allow single case agreements for members.  
Section 8.1.33.5 is modified to clarify MCO process and revising timeline requirements for providing Member EMR request information to HHSC.  
Section 8.1.34 language is added back, due to having been removed in error. |
| | | | Section 8.1.3 is modified language is added to clarify the requirements around the provision of services when members are temporarily traveling outside the state  
Section 8.1.3.1 is modified to include a defined term that is inclusive of Substance Use Disorder, and to comply with HB 133, 87th Legislature, Regular Session, 2021  
Section 8.1.3.2 is modified to comply with 1115 Transformation Waiver STC 26b, and to align with language with other contracts and to add a requirement for MCOs to have workforce development capacity to support provider agencies, per Rider 157 report.  
Section 8.1.3.4 is modified to update contract for the provisions of HB 4, from the 87th Texas Legislature.  
Section 8.1.4 is modified to comply with HB 133, 87th Legislature, Regular Session, 2021,  
Section 8.1.4.8.2 is modified to comply with Implementation of SB 1991 - 86th-R  
Section 8.1.5.6 is modified due to language comes from the STAR Health RFP, and the change is proposed due to findings from the STAR Health desk review  
Section 8.1.7.1 is modified to comply with HB 4533, 86th Legislature, 2019  
Section 8.1.7.9.2 is modified to update language in the contract for the respective sections have been replaced with new language to support a more comprehensive approach to APMs  
Section 8.1.7.9.2.1 is adding a general requirement at new section 8.1.7.8.2.1 that points to a new UMCM |
<table>
<thead>
<tr>
<th>STATUS</th>
<th>DOCUMENT REVISION</th>
<th>EFFECTIVE DATE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>chapter where most of the current cover page content will be moved.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.9.1 is modified to TAC rules for the ECI program have been moved to new section</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Section 8.1.9.2 is modified to TAC rules for the ECI program have been moved to new section</td>
</tr>
<tr>
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<td>Section 8.1.9.5 is modified to TAC rules for the ECI program have been moved to new section and correct citation</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Section 8.1.12.1 is modified due to MCO’s review of the Health Passport indicated that no members have a direct line to Service Managers listed in the Health Passport</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.12.5 is modified due to Currently there are a number of PH and BH case managers that can be on a member’s case, and Policy’s desk review revealed there is no requirement that these staff communicate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.13.1 is modified due to The STAR Health desk review found that STAR Health members were not receiving adequate planning for discharge from inpatient hospitalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.13.2 is modified to increase BH/PH integration and keep providers informed about Members’ inpatient psychiatric admission</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.13.2 is modified due the UMCC contract was updated with additional requirements for the HCSP</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.13.4 is modified due to desk review found that STAR Health members were not receiving adequate planning for discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.13.5 is added for the provisions of HB 4, a comprehensive telehealth bill from the 87th Texas Legislature</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.17.3 is modified due to the provided language comes from the STAR Health RFP, and the change is proposed due to findings from the STAR Health desk review</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.17.9 is modified to provide clarification to Code of Federal Regulations references in the mental health parity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.20.2 is modified to address pharmacy related information</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.20.11 is modified due to the pending withdrawal of the liquated damages for Pharmacy (PH) performance standard PH-11 and UMCM. requirement</td>
</tr>
<tr>
<td>STATUS¹</td>
<td>DOCUMENT REVISION²</td>
<td>EFFECTIVE DATE</td>
<td>DESCRIPTION³</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.22 is modified to add clarifying language to be consistent across all MCO contracts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.25 is modified to align Compliance Plan language in one section</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.25.2 is modified to update claims data due date to align with current practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.25.4 is modified to update contact information with current OIG area</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.25.5 is modified due to implementation of SB 1991 - 86th-R</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.26.2 is modified due to replace the Critical Incidents and Abuse, Neglect, and Exploitation quarterly report</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8.1.26.2 Reports, letter (y) is modified due to the requirement to have MCOs submit a quarterly report that includes all NEMT Services providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.27 is modified to clarify language in the context, continuity of care is ensuring seamless transitions for newly enrolled members.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.28.8 is modified to comply with HB 133, 87th Legislature, Regular Session, 2021</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.28.12 is modified to comply with HB 133, 87th Legislature, Regular Session, 2021</td>
</tr>
<tr>
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<td></td>
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<td>Section 8.1.29 is modified due to HB 133, 87th Legislature, Regular Session, 2021</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.32 is modified to remove old TAC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8.1.33.5.1 is modified to inform the MCOs that HHSC will require MCOs to reimburse IROs for partial EMR reviews if the Member decides to withdraw the EMR request</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.33.6 is modified due to no new UMCM chapter completed, deleted reference referring to it.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section 8.1.34 is modified due to minor changes and/or corrections made for consistency across all MCO contracts</td>
</tr>
<tr>
<td>STATUS¹</td>
<td>DOCUMENT REVISION²</td>
<td>EFFECTIVE DATE</td>
<td>DESCRIPTION³</td>
</tr>
<tr>
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<td>--------------------</td>
<td>----------------</td>
<td>---------------</td>
</tr>
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<td>Revision</td>
<td>2.18</td>
<td>March 1, 2023</td>
<td>Contract amendment did not revise Attachment B-1</td>
</tr>
</tbody>
</table>

¹ Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.

² Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

³ Brief description of the changes to the document made in the revision.
## TABLE OF CONTENTS

### 8 OPERATIONS PHASE REQUIREMENTS AND GENERAL SCOPE OF WORK

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1 Administration and Contract Management</td>
<td>41</td>
</tr>
<tr>
<td>8.1.1 Performance Evaluation</td>
<td>41</td>
</tr>
<tr>
<td>8.1.1.1 Operations Phase Readiness, Operational, and Targeted Reviews</td>
<td>42</td>
</tr>
<tr>
<td>8.1.2 Covered Services</td>
<td>43</td>
</tr>
<tr>
<td>8.1.2.1 Value-added Services</td>
<td>44</td>
</tr>
<tr>
<td>8.1.2.2 Case-by-Case Services</td>
<td>46</td>
</tr>
<tr>
<td>8.1.3 Access to Care</td>
<td>47</td>
</tr>
<tr>
<td>8.1.3.1 Appointment Accessibility</td>
<td>48</td>
</tr>
<tr>
<td>8.1.3.2 Access to Network Providers</td>
<td>49</td>
</tr>
<tr>
<td>8.1.3.3 Monitoring Access</td>
<td>52</td>
</tr>
<tr>
<td>8.1.3.4 Telemedicine Access, Telehealth, Telepharmacy and Telemonitoring Access</td>
<td>52</td>
</tr>
<tr>
<td>8.1.3.4.1 School-based Telemedicine Services</td>
<td>53</td>
</tr>
<tr>
<td>8.1.3.5 Indian Health Care Providers</td>
<td>53</td>
</tr>
<tr>
<td>8.1.4 Provider Network</td>
<td>54</td>
</tr>
<tr>
<td>8.1.4.1 Provider Contract Requirements</td>
<td>58</td>
</tr>
<tr>
<td>8.1.4.2 Primary Care Providers and the Medical Home</td>
<td>59</td>
</tr>
<tr>
<td>8.1.4.3 PCP Notification</td>
<td>61</td>
</tr>
<tr>
<td>8.1.4.4 Provider Credentialing and Re-credentialing</td>
<td>62</td>
</tr>
<tr>
<td>8.1.4.4.1 Expedited Credentialing Process</td>
<td>63</td>
</tr>
<tr>
<td>8.1.4.4.2 Minimum Credentialing Requirements for Unlicensed or Uncertified LTSS Providers</td>
<td>63</td>
</tr>
<tr>
<td>8.1.4.5 Board Certification Status</td>
<td>64</td>
</tr>
<tr>
<td>8.1.4.6 Provider Relations Including Manual, Materials and Training</td>
<td>64</td>
</tr>
<tr>
<td>8.1.4.7 Continuing Education Credits</td>
<td>67</td>
</tr>
<tr>
<td>8.1.4.8 Provider Hotline</td>
<td>67</td>
</tr>
<tr>
<td>8.1.4.8.1 Safety-net Hospital Incentives</td>
<td>68</td>
</tr>
<tr>
<td>8.1.4.9 Provider Reimbursement</td>
<td>68</td>
</tr>
<tr>
<td>8.1.4.9.1 Provider Preventable Conditions</td>
<td>69</td>
</tr>
<tr>
<td>8.1.4.9.2 Supplemental Payments for Qualified Providers</td>
<td>70</td>
</tr>
<tr>
<td>8.1.4.9.3 Minimum Fee Schedule for Rural Hospital</td>
<td>70</td>
</tr>
<tr>
<td>8.1.4.10 Termination of Provider Contracts</td>
<td>71</td>
</tr>
<tr>
<td>8.1.4.11 This Section Intentionally Left Blank</td>
<td>71</td>
</tr>
<tr>
<td>8.1.4.12 Out-of-State Providers</td>
<td>71</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>8.1.4.13</td>
<td>Provider Protection Plan</td>
</tr>
<tr>
<td>8.1.5</td>
<td>Member Services</td>
</tr>
<tr>
<td>8.1.5.1</td>
<td>Member Materials</td>
</tr>
<tr>
<td>8.1.5.2</td>
<td>Member Identification (ID) Card</td>
</tr>
<tr>
<td>8.1.5.3</td>
<td>Member Handbook</td>
</tr>
<tr>
<td>8.1.5.4</td>
<td>Provider Directory</td>
</tr>
<tr>
<td>8.1.5.5</td>
<td>Internet Website</td>
</tr>
<tr>
<td>8.1.5.6</td>
<td>Nurse and Member Hotline Requirements</td>
</tr>
<tr>
<td>8.1.5.7</td>
<td>Member Education</td>
</tr>
<tr>
<td>8.1.5.8</td>
<td>Cultural Competency Plan</td>
</tr>
<tr>
<td>8.1.5.9</td>
<td>Member Complaint and Appeal Process</td>
</tr>
<tr>
<td>8.1.5.10</td>
<td>Abuse, Neglect, or Exploitation</td>
</tr>
<tr>
<td>8.1.5.10.1</td>
<td>Member Education on Abuse, Neglect, or Exploitation</td>
</tr>
<tr>
<td>8.1.5.10.2</td>
<td>Abuse, Neglect, and Exploitation Email Notifications</td>
</tr>
<tr>
<td>8.1.5.10.3</td>
<td>MCO Training on Abuse, Neglect, and Exploitation, and Unexplained Death</td>
</tr>
<tr>
<td>8.1.5.11</td>
<td>Member Service Email Address</td>
</tr>
<tr>
<td>8.1.5.12</td>
<td>Member Eligibility</td>
</tr>
<tr>
<td>8.1.6</td>
<td>Marketing and Prohibited Practices</td>
</tr>
<tr>
<td>8.1.7</td>
<td>Quality Assessment and Performance Improvement (QAPI)</td>
</tr>
<tr>
<td>8.1.7.1</td>
<td>QAPI Program Overview</td>
</tr>
<tr>
<td>8.1.7.2</td>
<td>QAPI Program Structure</td>
</tr>
<tr>
<td>8.1.7.3</td>
<td>Clinical Indicators</td>
</tr>
<tr>
<td>8.1.7.4</td>
<td>QAPI Program Subcontracting</td>
</tr>
<tr>
<td>8.1.7.5</td>
<td>Behavioral Health (BH) Services Integration into QAPI Program</td>
</tr>
<tr>
<td>8.1.7.6</td>
<td>Clinical Practice Guidelines</td>
</tr>
<tr>
<td>8.1.7.7</td>
<td>Medical Advisory Committee (MAC)</td>
</tr>
<tr>
<td>8.1.7.8</td>
<td>Provider Credentialing and Profiling</td>
</tr>
<tr>
<td>8.1.7.9</td>
<td>Network Management</td>
</tr>
<tr>
<td>8.1.7.9.1</td>
<td>Physician Incentive Plans</td>
</tr>
<tr>
<td>8.1.7.9.2</td>
<td>MCO Alternative Payment Models with Providers</td>
</tr>
<tr>
<td>8.1.7.9.2.1</td>
<td>MCO Alternative Payment Model with Certified Community</td>
</tr>
<tr>
<td></td>
<td>Behavioral Health Clinics (CCBHCs)</td>
</tr>
<tr>
<td>8.1.7.9.3</td>
<td>Non-Pharmacy Preferred Provider Arrangement</td>
</tr>
<tr>
<td>8.1.7.10</td>
<td>Collaboration with the External Quality Review Organization (EQRO)</td>
</tr>
<tr>
<td>8.1.8</td>
<td>Utilization Management (UM)</td>
</tr>
<tr>
<td>8.1.8.1</td>
<td>Compliance with State and Federal Prior Authorization (PA) Requirements</td>
</tr>
</tbody>
</table>
8.1.8.2 Toll-free Fax Line for Service Authorizations .......................................................... 94
8.1.9 Early Childhood Intervention (ECI) ........................................................................... 94
8.1.9.1 Referrals .................................................................................................................. 94
8.1.9.2 Eligibility ................................................................................................................. 95
8.1.9.3 Providers ................................................................................................................ 95
8.1.9.4 Individual Family Service Plan (IFSP) ................................................................. 95
8.1.9.5 Covered Services and Reimbursement ................................................................. 95
8.1.10 Special Supplemental Nutrition Program for Women, Infants, and Children - Specific Requirements ........................................................................................................... 96
8.1.11 Coordination with the Department of Family and Protective Services (DFPS) .... 96
8.1.11.1 Training for Law Enforcement Officials and Judges ............................................. 98
8.1.11.2 STAR Health Liaisons .......................................................................................... 98
8.1.11.3 Assessments ......................................................................................................... 98
8.1.12 Health Passport .................................................................................................... 99
8.1.12.1 Required Features and Data Elements ............................................................... 99
8.1.12.2 Usage Requirements ........................................................................................ 102
8.1.12.3 Health Passport Reporting Requirements ......................................................... 102
8.1.12.4 Health Passport Mobile Accessibility ................................................................. 104
8.1.12.5 Health Passport Review Requirements ............................................................. 104
8.1.13 Services for Members with Special Healthcare Needs (MSHCN) ......................... 104
8.1.13.1 Identification .................................................................................................... 104
8.1.13.2 Access to Care and Service Management ......................................................... 105
8.1.13.3 Transition Planning ........................................................................................ 109
8.1.13.4 Discharge Planning .......................................................................................... 110
8.1.13.5 Service Management and the of Telecommunications ...................................... 110
8.1.14 Service Coordination ........................................................................................ 110
8.1.15 Health Home Services ....................................................................................... 112
8.1.15.1 Health Home Services and Participating Providers ........................................... 113
8.1.16 Disease Management (DM) ................................................................................ 113
8.1.16.1 Special Populations ............................................................................................ 114
8.1.16.2 Disease Management (DM) Services and Participating Providers .................... 115
8.1.16.3 Disease Management (DM) Evaluation ............................................................... 115
8.1.17 Behavioral Health (BH) Services and Network ..................................................... 115
8.1.17.1 Behavioral Health (BH) Provider Network ......................................................... 117
8.1.17.2 Self-referral for Behavioral Health (BH) Services ............................................. 118
8.1.17.3 Behavioral Health (BH) Hotline and Emergency Services ................................ 118

8-35
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1.17.4</td>
<td>Coordination between the BH Provider and the PCP</td>
<td>119</td>
</tr>
<tr>
<td>8.1.17.5</td>
<td>Follow-up after Hospitalization for BH Services</td>
<td>121</td>
</tr>
<tr>
<td>8.1.17.6</td>
<td>Substance Use Disorder and Chemical Dependency Treatment Services</td>
<td></td>
</tr>
<tr>
<td>8.1.17.6.2</td>
<td>Care Coordination</td>
<td>121</td>
</tr>
<tr>
<td>8.1.17.6.3</td>
<td>Requirements for Medication Assisted Treatment</td>
<td>122</td>
</tr>
<tr>
<td>8.1.17.7</td>
<td>Court-ordered Services</td>
<td>122</td>
</tr>
<tr>
<td>8.1.17.7.1</td>
<td>Psychiatric Services</td>
<td>123</td>
</tr>
<tr>
<td>8.1.17.8</td>
<td>Mental Health Rehabilitative Services and Mental Health Targeted Case Management Services</td>
<td>123</td>
</tr>
<tr>
<td>8.1.17.9</td>
<td>Mental Health Parity</td>
<td>124</td>
</tr>
<tr>
<td>8.1.18</td>
<td>Dental Services and Dental Network</td>
<td>124</td>
</tr>
<tr>
<td>8.1.18.1</td>
<td>First Dental Home</td>
<td>125</td>
</tr>
<tr>
<td>8.1.18.2</td>
<td>Main Dental Home</td>
<td>125</td>
</tr>
<tr>
<td>8.1.19</td>
<td>Vision Services and Vision Network</td>
<td>125</td>
</tr>
<tr>
<td>8.1.20</td>
<td>Pharmacy Services</td>
<td>126</td>
</tr>
<tr>
<td>8.1.20.1</td>
<td>Formulary and Preferred Drug List (PDL)</td>
<td>126</td>
</tr>
<tr>
<td>8.1.20.2</td>
<td>Prior Authorization (PA) for Prescription Drugs and 72-Hour Emergency Supplies</td>
<td>127</td>
</tr>
<tr>
<td>8.1.20.3</td>
<td>Coverage Exclusions</td>
<td>129</td>
</tr>
<tr>
<td>8.1.20.4</td>
<td>Compounded Medications</td>
<td>129</td>
</tr>
<tr>
<td>8.1.20.5</td>
<td>Pharmacy Rebate Program</td>
<td>130</td>
</tr>
<tr>
<td>8.1.20.6</td>
<td>Drug Utilization Review (DUR) Program</td>
<td>130</td>
</tr>
<tr>
<td>8.1.20.7</td>
<td>Pharmacy Benefit Manager</td>
<td>130</td>
</tr>
<tr>
<td>8.1.20.8</td>
<td>Financial Disclosures for Pharmacy Services</td>
<td>131</td>
</tr>
<tr>
<td>8.1.20.9</td>
<td>Limitations Regarding Registered Sex Offenders</td>
<td>132</td>
</tr>
<tr>
<td>8.1.20.10</td>
<td>Specialty Drugs</td>
<td>132</td>
</tr>
<tr>
<td>8.1.20.11</td>
<td>Maximum Allowable Cost (MAC) Requirements</td>
<td>132</td>
</tr>
<tr>
<td>8.1.20.12</td>
<td>Mail-Order and Delivery</td>
<td>133</td>
</tr>
<tr>
<td>8.1.20.13</td>
<td>Health Resources and Services Administration 340B Discount Drug Program</td>
<td>134</td>
</tr>
<tr>
<td>8.1.20.14</td>
<td>Pharmacy Claims and File Processing</td>
<td>134</td>
</tr>
<tr>
<td>8.1.20.15</td>
<td>Pharmacy Audits</td>
<td>134</td>
</tr>
<tr>
<td>8.1.20.16</td>
<td>E-Prescribing</td>
<td>134</td>
</tr>
<tr>
<td>8.1.20.17</td>
<td>This Section Intentionally Left Blank</td>
<td>135</td>
</tr>
<tr>
<td>8.1.21</td>
<td>Cancellation of Product Orders</td>
<td>135</td>
</tr>
<tr>
<td>8.1.22</td>
<td>Financial Requirements for Covered Services</td>
<td>135</td>
</tr>
<tr>
<td>8.1.23</td>
<td>Accounting and Financial Reporting Requirements</td>
<td>135</td>
</tr>
</tbody>
</table>

8-36
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1.23.1</td>
<td>Financial Reporting Requirements</td>
<td>136</td>
</tr>
<tr>
<td>8.1.24</td>
<td>Management Information System (MIS) Requirements</td>
<td>139</td>
</tr>
<tr>
<td>8.1.24.1</td>
<td>Encounter Data</td>
<td>140</td>
</tr>
<tr>
<td>8.1.24.1.1</td>
<td>NEMT Services Encounter Data Submission</td>
<td>141</td>
</tr>
<tr>
<td>8.1.24.2</td>
<td>MCO Deliverables related to MIS Requirements</td>
<td>142</td>
</tr>
<tr>
<td>8.1.24.3</td>
<td>System-wide Functions</td>
<td>142</td>
</tr>
<tr>
<td>8.1.24.4</td>
<td>Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH Act) Compliance</td>
<td>143</td>
</tr>
<tr>
<td>8.1.24.5</td>
<td>Claims Processing Requirements</td>
<td>143</td>
</tr>
<tr>
<td>8.1.24.6</td>
<td>National Correct Coding Initiative</td>
<td>147</td>
</tr>
<tr>
<td>8.1.25</td>
<td>Fraud, Waste, and Abuse</td>
<td>147</td>
</tr>
<tr>
<td>8.1.25.1</td>
<td>Special Investigative Units</td>
<td>148</td>
</tr>
<tr>
<td>8.1.25.2</td>
<td>General requests for and access to data, records, and other information</td>
<td>148</td>
</tr>
<tr>
<td>8.1.25.3</td>
<td>Claims Data Submission Requirements</td>
<td>149</td>
</tr>
<tr>
<td>8.1.25.4</td>
<td>Payment Holds and Settlements</td>
<td>150</td>
</tr>
<tr>
<td>8.1.25.5</td>
<td>Treatment of Recoveries by the MCO for Fraud, Waste and Abuse</td>
<td>151</td>
</tr>
<tr>
<td>8.1.25.6</td>
<td>Additional Requirements</td>
<td>152</td>
</tr>
<tr>
<td>8.1.25.7</td>
<td>Lock-in Actions</td>
<td>152</td>
</tr>
<tr>
<td>8.1.26</td>
<td>Reporting Requirements</td>
<td>152</td>
</tr>
<tr>
<td>8.1.26.1</td>
<td>Performance Measurement</td>
<td>153</td>
</tr>
<tr>
<td>8.1.26.2</td>
<td>Reports</td>
<td>153</td>
</tr>
<tr>
<td>8.1.27</td>
<td>Continuity of Care and Out-of-Network (OON) Providers</td>
<td>156</td>
</tr>
<tr>
<td>8.1.27.1</td>
<td>Single Case Agreements with Out-of-Network Speciality Providers</td>
<td>158</td>
</tr>
<tr>
<td>8.1.27.2</td>
<td>Member Advisory Groups</td>
<td>159</td>
</tr>
<tr>
<td>8.1.28</td>
<td>Provisions Related to Covered Services for Members</td>
<td>159</td>
</tr>
<tr>
<td>8.1.28.1</td>
<td>Emergency and Post-Stabilization Services</td>
<td>159</td>
</tr>
<tr>
<td>8.1.28.2</td>
<td>Family Planning—Specific Requirements</td>
<td>160</td>
</tr>
<tr>
<td>8.1.28.3</td>
<td>Texas Health Steps (EPSDT) Medical and Dental</td>
<td>160</td>
</tr>
<tr>
<td>8.1.28.3.1</td>
<td>Medical Checkups</td>
<td>160</td>
</tr>
<tr>
<td>8.1.28.3.2</td>
<td>Oral Evaluation and Fluoride Varnish</td>
<td>161</td>
</tr>
<tr>
<td>8.1.28.3.3</td>
<td>Lab</td>
<td>161</td>
</tr>
<tr>
<td>8.1.28.3.4</td>
<td>Education/Outreach</td>
<td>162</td>
</tr>
<tr>
<td>8.1.28.3.5</td>
<td>Training</td>
<td>162</td>
</tr>
<tr>
<td>8.1.28.3.6</td>
<td>Data Validation</td>
<td>164</td>
</tr>
<tr>
<td>8.1.28.3.7</td>
<td>Texas Health Steps-Comprehensive Health Care Program</td>
<td>164</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>8.1.28.4</td>
<td>Perinatal Services</td>
<td></td>
</tr>
<tr>
<td>8.1.28.5</td>
<td>Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)</td>
<td></td>
</tr>
<tr>
<td>8.1.28.6</td>
<td>Tuberculosis (TB)</td>
<td></td>
</tr>
<tr>
<td>8.1.28.7</td>
<td>Objection to Provide Certain Services</td>
<td></td>
</tr>
<tr>
<td>8.1.28.8</td>
<td>Medicaid Non-capitated Services</td>
<td></td>
</tr>
<tr>
<td>8.1.28.9</td>
<td>Referrals for Non-capitated Services</td>
<td></td>
</tr>
<tr>
<td>8.1.28.10</td>
<td>Immunizations</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11</td>
<td>NEMT Services</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11.1</td>
<td>Approval of NEMT Services</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11.1.1</td>
<td>Out-of-State Travel Requests</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11.1.2</td>
<td>Meals and Lodging</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11.1.3</td>
<td>Individual Transportation Participants (ITPs)</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11.1.4</td>
<td>Advanced Funds</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11.1.5</td>
<td>Nonmedical Transportation Services</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11.1.6</td>
<td>NEMT Attendant Requirements</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11.2</td>
<td>Approval of Mass Transit NEMT Services</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11.3</td>
<td>NEMT Services Providers</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11.3.1</td>
<td>Transportation Network</td>
<td></td>
</tr>
<tr>
<td>8.1.28.11.3.2</td>
<td>NEMT Services Provider Enrollment</td>
<td></td>
</tr>
<tr>
<td>8.1.28.12</td>
<td>Case Management for Children and Pregnant Women Services</td>
<td></td>
</tr>
<tr>
<td>8.1.29</td>
<td>Medicaid Significant Traditional Providers (STPs)</td>
<td></td>
</tr>
<tr>
<td>8.1.30</td>
<td>Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)</td>
<td></td>
</tr>
<tr>
<td>8.1.31</td>
<td>MCO Internal Provider Complaints and Appeals Process</td>
<td></td>
</tr>
<tr>
<td>8.1.31.1</td>
<td>Provider Complaints</td>
<td></td>
</tr>
<tr>
<td>8.1.31.2</td>
<td>Provider Appeal of MCO Claims Determinations</td>
<td></td>
</tr>
<tr>
<td>8.1.32</td>
<td>Member Rights and Responsibilities</td>
<td></td>
</tr>
<tr>
<td>8.1.33</td>
<td>Member Complaint and Appeal System</td>
<td></td>
</tr>
<tr>
<td>8.1.33.1</td>
<td>MCO Internal Member Complaint Process</td>
<td></td>
</tr>
<tr>
<td>8.1.33.2</td>
<td>Intentionally Left Blank</td>
<td></td>
</tr>
<tr>
<td>8.1.33.3</td>
<td>Member MCO Internal Appeal Process</td>
<td></td>
</tr>
<tr>
<td>8.1.33.4</td>
<td>Expedited MCO Internal Appeals</td>
<td></td>
</tr>
<tr>
<td>8.1.33.5</td>
<td>Access to State Fair Hearing and External Medical Review (EMR) for Medicaid Members</td>
<td></td>
</tr>
<tr>
<td>8.1.33.5.1</td>
<td>Independent Review Organization (IRO) Reimbursement for External Medical Reviews (EMRs)</td>
<td></td>
</tr>
</tbody>
</table>
8.1.33.6 Notices of Adverse Benefit Determination and Disposition of Appeals for Members

8.1.33.7 Timeframe for Notice of Adverse Benefit Determination

8.1.33.8 Notice of Disposition of Appeal

8.1.33.9 Timeframe for Notice of Resolution of Appeals

8.1.33.10 Member Advocates

8.1.33.11 NEMT Services Complaints and Appeals

8.1.34 Third-Party Liability and Recovery and Coordination of Benefits

8.1.34.1 Advance Directives

8.1.35 Minimum Wage Requirements for Attendants

8.1.36 Preadmission Screening and Resident Review (PASRR) Referring Entity Requirements

8.1.37 Electronic Visit Verification (EVV)

8.1.38 Community First Choice (CFC) Services

8.1.39 Covered Community-Based Services

8.1.39.1 This Section is Intentionally Left Blank

8.1.39.2 Home and Community Based Settings

8.1.40 Service Delivery Options

8.1.40.1 Consumer Directed Services (CDS) Option

8.1.40.2 Service Responsibility Option

8.1.40.3 Agency Option

8.1.41 The MCO must offer the agency option and make it available for all STAR Health and MDCP Covered Services. Facility Based Care

8.1.42 Prescribed Pediatric Extended Care

8.1.42.1 Prior Authorization for PPECC Services

8.1.43 Medicaid Wrap-Around Services

8.1.44 Carve-in Readiness

8.1.45 Responsibilities in the Event of a Federal Emergency Management Agency or Governor-Declared Disaster, or other Emergencies

8.1.46 CMS Interoperability and Patient Access

8.1.46.1 Payer-to-Payer Data Exchange

8.2 Additional Requirements Regarding the Medically Dependent Children Program

8.2.1 Program Eligibility and Assessment

8.2.2 Service Management Requirements for MDCP Members

8.2.3 MDCP Provider Requirements

8.2.4 Continuity of Care Requirements for MDCP Members
8 OPERATIONS PHASE REQUIREMENTS AND GENERAL SCOPE OF WORK

HHSC will select one MCO to provide statewide Healthcare Services to STAR Health Program Members. The MCO must have the appropriate Texas Department of Insurance (TDI) license to provide Healthcare Services in all counties in the State of Texas.

The MCO will begin providing Covered Services to Members on the Operational Start Date, September 1, 2015.

8.1 Administration and Contract Management

The MCO must comply, to the satisfaction of HHSC, with (1) all provisions set forth in the Contract, and (2) all applicable provisions of state and federal laws, rules, regulations, and waivers.

8.1.1 Performance Evaluation

HHSC will provide the MCO with two Performance Improvement Project (PIP) topics. The MCO must develop one PIP per topic. The MCO must conduct one PIP in collaboration with other MCOs, Dental Contractors, participants in Delivery System Reform Incentive Payment (DSRIP) projects established under the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, or community organizations. HHSC will determine the PIP topics, and the MCO must complete each PIP template in accordance with UMCM Chapter 10. Each MCO must also complete progress reports as outlined in the UMCM Chapter 10.

PIPs will follow CMS protocol, as described below. The purpose of healthcare quality PIPs is to assess and improve processes, and thereby outcomes, of care. In order for these projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

MCO must use the following ten-step CMS protocol when conducting PIPs:

1. Select the study topic(s);
2. define the study question(s);
3. select the study indicator(s);
4. use a representative and generalizable study population;
5. use sound sampling techniques (if sampling is used);
6. collect reliable data;
7. implement intervention and improvement strategies;
8. analyze data and interpret study results;
9. plan for “real” improvement; and
10. achieve sustained improvement.

See UMCM Chapter 10.
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 accordance with \textbf{UMCM Chapter 10}. HHSC will compile the Performance Indicator Dashboard based on MCO submissions, data from the External Quality Review Organization (EQRO), and other data available to HHSC. HHSC will share the Performance Indicator Dashboard measures with high and minimum performance standards established using the methodology set forth in \textbf{UMCM Chapter 10} with the MCO on an annual basis.

\textbf{8.1.1.1 Operations Phase Readiness, Operational, and Targeted Reviews}

HHSC may conduct desk or onsite reviews related to Contract performance. HHSC may also require Contractors to submit detailed policies and procedures that document day-to-day business activities related to Contract requirements for HHSC 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. Processing system changes, including changes in Material Subcontractors performing MIS or claims processing functions;
3. Carve-ins of new membership; and

HHSC will determine whether the proposed changes will require a desk review and/or an onsite review. The MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent for onsite reviews conducted as part of Readiness Review or HHSC’s normal Contract monitoring efforts. For purposes of this section, “authorized reimbursable travel costs” may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

Unless the MCO receives HHSC approval for an exception in writing, the MCO must provide HHSC secure access rights and an authorized guest user to all Member and Provider access points, including but not limited to 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 risk sand issues are effectively monitored and managed as to limit impact to 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 provider corrective measures, and a root cause analysis 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 dates of an
MIS change. The MCO must provider 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 7.3.7, “Operations Readiness,” and Section 8.1.24, “Management Information Systems,” for additional information regarding MCO Readiness Reviews. Refer to Attachment A, Section 4.09(c), “Subcontractors and Agreements with Third Parties,” for information regarding Readiness Reviews of the MCO's Material Subcontractors.

8.1.1.2 HHSC Performance Review and Evaluation

In accordance with section 12.01 of this Contract's Uniform Terms and Conditions, HHSC, at its discretion, will review, evaluate and assess the development and implementation of the Medicaid MCO's policies and procedures related to the timely and appropriate delivery of services as required under this Contract. Reviews, evaluations and assessments may include the following: MCO ensuing corrective actions taken; including demonstration by the MCO that the corrective action(s) or intervention(s) included in the Corrective Action Plan (CAP) have been completed or implemented using a method approved or provided by HHSC; MCO internal policies; MCO internal procedures; MCO workflows; MCO use of prior authorizations; MCO utilization review process; assessment of the MCO service planning package; the potential for underutilization of services; assessments; delivery of services; and 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 prompt and adequate access to related documents, internal systems containing Member information and records, and appropriate staff, as well as utilization management documentation, case notes, and service locations or facilities that are related to the scope of services provided under this Contract.

HHSC must monitor the Medicaid MCO to confirm the MCO is using prior authorization and utilization review processes that ensure appropriate utilization and prevent overutilization or underutilization of services.

8.1.2 Covered Services

The MCO is responsible for assessing, authorizing, arranging, coordinating, approving, and providing Covered Services, including NEMT Services, Community-based Long-Term Services and Supports and Nursing Facility services, in accordance with the requirements of the Contract. The MCO must provide Medically Necessary Covered Services to all Members beginning on the Member’s date of enrollment regardless of pre-existing conditions, prior diagnosis, or receipt of any prior Healthcare Services. 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.

MCO must authorize Community-based Long-term Services and Supports, including Private Duty Nursing and services provided in a Prescribed Pediatric Extended Care Center, and Nursing Facility services based on the Member's current required needs assessment and consistent with the Member's Service Plan (SP) or Individual Service Plan (ISP). The services supporting Members with ongoing or chronic conditions or who require long-term services and supports must be authorized in a manner that reflects the Member's ongoing need for such services and supports. Members receiving Community-based Long-term Services and Supports
must have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice. 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 provide full coverage for Medically Necessary Covered Services to all Members 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 Span of Coverage requirements found in Attachment A, “STAR Health Contract Terms,” will apply.

Except for those services identified in Section 8.1.28.8, “Medicaid Non-capitated Services,” the MCO must provide Covered Services described in the most recent Texas Medicaid Provider Procedures Manual (TMPPM) and any updates.

The MCO must allow Covered Services to be provided by an Out-of-Network (OON) provider if a Network Provider is not available to provide the services.

Covered Services are subject to change due to changes in federal and state laws, rules or regulations; changes in Medicaid policy; and changes in medical practice, clinical protocols, or technology.

The MCO must have a process in place to monitor a Member’s claims history for acute and long-term care services that receive a prior authorization to ensure that these services are being delivered. On an ongoing basis, the MCO must monitor claims data for all approved prior authorizations for delivery of the services. The MCO must research and resolve any services not received as a result of the lack of claims data.

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 health care professionals in the particular field;
2. Consider the needs of the MCO’s enrollees;
3. Are adopted in consultation with contracting health care professionals; and
4. Are reviewed and updated periodically as appropriate.

8.1.2.1 Value-added Services

The MCO may propose additional services for coverage. These are referred to as “Value-added Services.” Value-added Services may be Healthcare Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improved health outcomes among Members. These may include family or community support services and supports that may be identified through a wraparound service delivery approach provided to youth with complex mental health needs. Value-added Services 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 Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.
If offered, Value-added Services must be offered to all Members for whom the services are appropriate.

The MCO must provide Value-added Services at no additional cost to HHSC. The MCO may offer discounts on non-covered benefits to Members as Value-added Services, provided that the MCO complies with Texas Insurance Code § 1451.155 and § 1451.2065. The MCO must ensure that Providers do not charge Members for any other cost-sharing for a Value-added Service (including copayments or deductibles).

The MCO must not pass on the cost of the Value-added Services to Members or Providers. The MCO must specify the conditions and parameters regarding the delivery of each Value-added Service and must clearly describe any limitations or conditions specific to each Value-added Service 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.

The MCO must use HHSC’s template for submitting proposed Value-added Services. (See UMCM Chapter 4.)

During the Operations Phase, Value-added Services can be added, or removed. MCOs will be given the opportunity to add, enhance, delete or reduce Value-added Services once per State Fiscal Year with changes to be effective September 1. HHSC may allow additional modifications to Value-added Services if Covered Services are amended by HHSC during a State Fiscal Year. This approach allows HHSC to coordinate annual revisions to HHSC’s MCO Comparison Charts to Members. A MCO’s request to add, enhance, delete, or reduce a Value-added Service must be submitted to HHSC by April 1 of each year to be effective September 1 for the following contract period. The MCOs cannot reduce or delete any Value-added Services until September 1 of the next SFY. When the MCO requests deletion of a Value-added Service, the MCO must include information regarding the processes by which the MCO will notify Members and revise materials. (See UMCM Chapter 4.)

An MCO’s request to add a Value-added Service must:

1. define and describe the proposed Value-added Service;
2. identify the category or group of Members eligible to receive the Value-added Service if it is a type of service that is not appropriate for all Members;
3. note any limitations or restrictions that apply to the Value-added Service;
4. specify which staff will determine whether a Member is eligible to receive the Value-added Service, if the Value-added Service is not a Healthcare Service or benefit;
5. identify the Providers or entities responsible for providing the Value-added Service, including any limitation on Provider or other persons’ capacity, if applicable;
6. describe how the MCO will identify the Value-added Service in administrative data (including Encounter Data) and/or in its Financial Statistical Report (FSR), as applicable, or will otherwise document delivery of the Value-added Service;
7. propose how and when the MCO will notify Providers, Members, Caregivers, Medical Consenters, and DFPS Staff about the availability of such Value-added Service;
8. describe the process by which a Member, Caregiver, or Medical Consenter may obtain or access the Value-added Service, including any action required by the Member, as appropriate; and
9. include a statement that the MCO will provide the Value-added Service for at least 12 months after the Operational Start Date.
An MCO cannot include a Value-added Service in any material distributed to Members or prospective Members until the Value-added Service is approved by HHSC. If a Value-added Service is deleted, the MCO must notify the Medical Consenter and Caregiver of each Member receiving the service, at a minimum of 30 Days prior to discontinuing the Value-added Service, that the service will no longer be available as a Value-added Service through the MCO. Similarly, if a Value-added Service is added, the MCO must notify the Medical Consenter and Caregiver of each Member of the availability of that service. Materials are subject to review and approval by HHSC. The MCO must also revise all materials distributed to members to reflect the change in Value-added Services.

8.1.2.2 Case-by-Case Services

Except as provided below, the MCO may offer additional benefits to individual Members on a case-by-case basis. Case-by-case Services may be based on Medical Necessity, Functional Necessity, cost-effectiveness, the wishes of the Member, Member’s Legally Authorized Representative (LAR), or Medical Consenter, as applicable, 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. MCO has the discretion to offer Case-by-case Services, which are not included in the Capitation Rate. The MCO must maintain documentation of each authorized Case-by-case Service provided to each Member. At a minimum, this documentation must include the reason for providing the service. Case-by-case Services are not included in the rate setting process.

The MCO must provide the following two Case-by-case Services on an ongoing basis to Members who meet requirements:

1. Non-Covered Supports for Members with Primary Needs: Children with Primary Medical Needs (PMN) are children who cannot live without mechanical supports or the services of others because of non-temporary, life-threatening conditions, including the:
   a. inability to maintain an open airway without assistance, not including the use of inhalers for asthma;
   b. inability to be fed except through a feeding tube, gastric tube, or a parenteral route;
   c. use of sterile techniques or specialized procedures to promote healing, prevent infection, prevent cross-infection or contamination, or prevent tissue breakdown; or
   d. multiple physical disabilities including sensory impairments.

The MCO must:
1. coordinate with DFPS to assist Members with PMN during a placement change, to ensure a safe and timely transition;
2. arrange prior-authorized appropriate non-emergency transportation and supports to Members with PMN, which may include the use of an ambulance or 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 of 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. A placement change does not include transitioning into or out of an inpatient setting.

2. Crisis Stabilization and Hospitalization Diversion Program: Children with acute Behavioral Health needs require additional supports to improve placement stability and avert potentially preventable psychiatric hospitalizations. In areas where this service is available, the MCO must:
   a. utilize Trauma Informed Mobile Crisis Outreach Teams (MCOTs) to provide assistance, education, and training to Members and their Medical Consenters and Caregivers; and
   b. provide residential crisis stabilization services and enhanced wraparound services to Members who qualify.

8.1.3 Access to Care

All Covered Services must be 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 comply with the access requirements as established by the Texas Department of Insurance (TDI) for all MCOs doing business in Texas, except as otherwise required by this Contract.

The MCO must comply with Texas Medicaid State Plan Section 2.7, 42 C.F.R § 431.52, and 42 C.F.R. § 435.403 when authorizing and monitoring Covered Services provided to Members who are temporarily out-of-state.

The MCO must contractually require Providers to comply with medical consent and informed consent requirements in Texas Family 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 Texas Family Code § 266.009.

The MCO must provide coverage for Emergency Services to Members 24 hours a Day and seven Days a week, without regard to prior authorization 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, whether the provider is in Network or Out-of-Network.

A Medicaid MCO is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network providers, except when that provider is an Indian Health Care Provider (IHCP) enrolled as a Federally Qualified Health Center (FQHC), as provided in Section 8.1.30.

The MCO must also have an emergency and crisis BH Services Hotline available 24 hours a Day, 7 Days a week, toll-free throughout the state. The BH Services Hotline must meet the requirements described in Section 8.1.17.3, “Behavioral Health Hotline and Emergency Services.” An MCO must also provide coverage for Emergency Services in compliance with 42 C.F.R. § 438.114, and as described in more detail in Section 8.1.17.3. The MCO may arrange Emergency Services and crisis BH Services through mobile crisis teams.
The MCO must require and make best efforts to ensure that Primary Care Providers (PCPs) are accessible to Members 24 hours a day, 7 Days a week and that Network PCPs have after-hours telephone availability consistent with Section 8.1.4.2, “Primary Care Providers and the Medical Home.” The MCO must ensure that Network Providers offer office hours to Members that are at least equal to those offered to the MCO’s commercial lines of business or Medicaid fee-for-service participants, if the Provider accepts only Medicaid Member.

If Medically Necessary Covered Services are not available through Network Providers, the MCO must, upon the request of DFPS Staff, the Medical Consenter, or the Network Provider, 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 5 Business Days after receipt of reasonable request documentation, allow a referral to an OON provider in accordance with the OON methodology for Medicaid as defined by HHSC.

The MCO must ensure that each Member has access to a second opinion regarding the use of any Covered Service. A Member must be allowed access to a second opinion from a Network Provider or Out-of-Network provider if a Network Provider is not available, at no cost to the Member, in accordance with 42 C.F.R. §438.206(b)(3). The MCO may use single case agreements with Out-of-Network providers for obtaining a second opinion. The MCO is not required to include Members seeking a second opinion as part of its Out-of-Network Utilization Reporting requirements under UMCM Chapter 5.

The MCO must ensure the provision of Covered Services meet the specific preventive, Acute Care, Community-Based Services, Long-Term Services and Supports (LTSS), and specialty healthcare needs appropriate for treatment of the Member’s condition(s).

The MCO must coordinate with HHSC and DFPS to implement a defined protocol to ensure that Members taken into DFPS conservatorship have access to an initial medical examination no later than the third Business Day after the Member is taken into DFPS conservatorship. The MCO must provide such services within the timeframes specified in Section 8.1.3.1, “Appointment Accessibility,” and within the time appropriate to the circumstances and Member’s need. In such circumstances, the MCO must fully reimburse the OON provider in accordance with OON requirements found in 1 Tex. Admin. Code § 353.4.

The Member, the Medical Consenter, or the Caregiver will not be responsible for any payment for Medically Necessary Covered Services or Functionally Necessary Covered Services.

### 8.1.3.1 Appointment Accessibility

Through its Provider Network composition and management, the MCO must ensure that the following standards for appointment accessibility are met. The standards are measured from the date of presentation or request, whichever occurs first.

1. Community-Based Services for Members must be initiated within seven Days from the authorization;
2. Emergency Services must be provided upon Member presentation at the service delivery site, including OON and out-of-state facilities.
3. An Urgent Condition, including urgent specialty care and Behavioral Health Services, must be provided within 24 hours. Treatment for Behavioral Health Services may be provided by a licensed behavioral health clinician.
4. Primary Routine Care and initial outpatient Behavioral Health visits must be provided within 14 Days.

5. Specialty Routine Care must be provided within 21 Days.

6. 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 should be scheduled to allow the Specialty Therapy evaluation to occur within 21 Days from date of submission of a signed referral.

7. Prenatal care must be provided within 14 Days for initial appointments, except for high-risk pregnancies or new Members in the third trimester, for whom an initial appointment must be offered within five days, or immediately, if an emergency exists. Appointments for ongoing care must be available in accordance to the treatment plan as developed by the provider.

8. Preventive health services including annual adult well checks for Members 21 years of age or older must be offered within 90 Days.

9. Preventive health services for Members less than 6 months of age must be provided within 14 days. Preventive health services for Members 6 months through age 20 must be provided within 60 Days. Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule and the requirements set forth in Section 8.1.28.3, “Texas Health Steps (EPSDT) Medical and Dental.”

10. The MCO must begin ensuring the Texas Comprehensive CANS 2.0 (child welfare) assessment is complete for each Member in category 1 of the Target Population ages 3 through 17 within 30 Days of receipt of the Daily Notification File (DNF).

11. The MCO must ensure children taken into DFPS conservatorship have access to an initial medical exam no later than three Business Days from the child’s removal from the home.

12. Case Management for Children and Pregnant Women services must be provided to Medicaid Members within 14 Days.

8.1.3.2 Access to Network Providers

This section does not apply to NEMT Services providers.

The MCO’s Network must include all provider types described in this section and in UMCM Chapter 5 Access to Network Providers Performance Standards and Specifications in sufficient numbers, and with sufficient capacity, to provide timely access to all Covered Services in accordance with the appointment accessibility standards in Section 8.1.3.1. The MCO’s Network must provide timely access to regular and preventive care to all Members and Texas Health Steps services to all child Members. The MCO must allow each Member to choose his or her Network 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 ensure that access is consistent with 1 Tex. Admin. Code § 353.411.

For each provider type, the MCO must provide access to at least 90 percent of Members within the prescribed distance or travel time standard. Counties will be designated as metro, micro, or rural. The county designation is based on population and density parameters. A map of counties by designation and parameters is available in Attachment B-5. Members’ residence in eligibility files with HHSC will be used to assess distance and travel times. The MCO must comply with the requirements set forth in UMCM Chapter 5, Access to Network Providers Performance Standards and Specifications.
HHSC will track MCO performance. HHSC will use the MCO Provider Files to run the Geo-Mapping Report which will measure provider choice, distance and travel time. HHSC will compile the reports based on each MCOs network. HHSC will share identified deficiencies with the MCO. The MCO may be subject to liquidated damages as specified in Attachment B-3.

**Community Attendant Care Services:** MCOs must ensure that a minimum of 90% of Members who are authorized to receive community attendant care services have timely access to such services. For purposes of this paragraph, timely access is within seven Days from the authorization as stated in section 8.1.3.1. Reference UMCM 10.1.12 for reporting information and templates.

The STAR Health MCO must have capacity and make concerted efforts to assist agencies contracted to provide community attendant care services in the agencies’ role to improve recruitment and retention of provider agency community attendant staff.

**Long Term Services & Support (LTSS) Providers:** At a minimum, the MCO must ensure that all Members have access to the following LTSS providers for all covered services: Assisted Living Facility; Attendant Care; CFC Habilitation Services; Financial Management Services Agencies; In-Home Therapies – OT, PT, and ST; In-Home Skilled Nursing; and Private Duty Nursing.

**Outpatient Substance Use Disorder Treatment:** The MCO must ensure all Members have access to a choice of outpatient Substance Use Disorder service providers in the Network.

**Primary Care Provider (PCP) and TH Steps Providers:** At a minimum, the MCO must ensure that Members have access to a choice of age-appropriate Network PCPs and TH Steps Providers with an Open Panel.

An internist who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member birth through age 17, and a pediatrician is not considered an age-appropriate choice for a Member age 18 and over.

**Dental:** The Dental Contractor’s Network must comply with the accessibility standards set forth in 1 Tex. Admin. Code § 353.411(b-d). At the minimum, the MCO must ensure that Members have access to a Main Dentist with an Open Practice. This may include arranging for services from Providers who are able to accommodate the Member’s special needs.

The Dental Contractor must ensure that Members have access to a pediatric dentist, endodontist, orthodontist, and prosthodontist specialty provider.

**Obstetrician/Gynecologist (OB/GYN):** At a minimum, the MCO must ensure that all female Members have access to an OB/GYN in the Provider Network.

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 Healthcare Services without a referral from the Member’s PCP or a PA.

**Prenatal:** Members who are pregnant must have access to a Network Provider for prenatal care.

The MCO must allow a pregnant Member who is past the 24th week of pregnancy to remain under the Member’s current OB/GYN’s care through the Member’s post-partum checkup, even if the OB/GYN provider is, or becomes, Out-of-Network.
Mental Health - Outpatient: At a minimum, the MCO must ensure that all Members have access to a covered outpatient mental health Service Provider in the Network.

Outpatient mental health Service Providers must include psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at clinics/group practices, or at outpatient Hospital departments as detailed in the UMCM Chapter 5, Access to Network Providers Performance Standards and Specifications, Outpatient Mental Health. 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.

Mental Health Targeted Case Management and Mental Health Rehabilitative Services (TCM/MHR): The MCO must ensure the Member has access to a Network Provider of Mental Health Targeted Case Management and Mental Health Rehabilitative Services.

Specialist Physician Access: At a minimum, the MCO must ensure that Members have access to a Network specialist physician for all covered services. PCPs must 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:
Audiologist, Cardiovascular Disease, Otolaryngologist (ENT), General Surgeon, Ophthalmologist, Orthopedist, Pediatric Sub-specialty, Psychiatrist, Urologist, and all other specialties not listed above.

In addition, all Members must be allowed to: 1) select a Network ophthalmologist or therapeutic optometrist to provide eye Healthcare Services, other than surgery, and 2) have access without a PCP referral to eye Healthcare Services from a Network specialist who is an ophthalmologist or therapeutic optometrist for non-surgical services.

Therapies - Occupational, Physical, and Speech Therapy Provided in an Outpatient Clinic or Facility: The MCO must ensure the Member has access to a Network Provider for occupational therapy, physical therapy, and speech therapy.

Acute Care Hospital: The MCO must ensure that Members have access to an Acute Care Hospital in the Provider Network.

Pharmacy: At the minimum, the MCO must ensure that all members have Pharmacy access. The MCO must ensure that access is consistent with UMCM Chapter 5.28.1, Access to Network Providers Performance Standards and Specifications.

All other Covered Services, except for services provided in the Member's residence: At a minimum, the MCO must ensure that all Members have access to a Network Provider for all other Covered Services. This access requirement includes, but is not limited to, specialists not previously referenced in this section, oncology including surgical and radiation, Hospitals with specialized children's services, Children's Hospitals and Special Hospitals, Psychiatric Hospitals, diagnostic services, and single or limited service healthcare Providers, as applicable to the Program.
The MCO is not precluded from making arrangements with providers outside the state for Members to receive a higher level of skill or specialty than the level available within the state, including but not limited to, treatment of cancer, burns, and cardiac diseases.

Exception Process: HHSC will consider requests for exceptions to the access standards for all provider types under limited circumstances. Each exception request must be supported by
information and documentation as specified in the template provided by HHSC’s Managed Care Compliance and Operations Network Adequacy. Exceptions may be granted on a case-by-case basis for an area that does not meet the performance standards as outlined in UMCM Chapter 5, Access to Network Providers Performance Standards and Specifications. The MCO must establish, through applicable supporting documentation, a normal pattern for securing Healthcare Services or that the MCO is providing care of a higher skill level or specialty than the level available within the Service Area.

8.1.3.3 Monitoring Access

This section does not apply to NEMT Services providers.

The MCO must verify that Covered Services furnished by Network Providers are available and accessible to Members in compliance with the standards described in Sections 8.1.3, “Access to Care,” and 8.1.4, “Provider Network.” For Covered Services furnished by PCPs, the MCO must also comply with standards described in Section 8.1.4.2, “Primary Care Providers and the Medical Home.”

The MCO must design, develop, and implement a Provider directory verification survey to verify that the provider information maintained by the MCO is correct and in alignment with the Provider information maintained by the HHSC Administrative Services Contractor.

The survey must be conducted each fiscal year. At a minimum, the survey must include verification of Provider directory critical elements in accordance with UMCM Chapter 5.

The MCO may conduct the survey through its online Provider portal, telephone calls, onsite visits, email, or other method that collects and verifies information. The MCO must conduct a statistically-valid random sample (95 percent confidence level with a margin of error +/- 5 percent) of Network PCPs and specialists. The MCO must collect, analyze, and submit survey results and supporting documentation as specified in UMCM Chapter 5.

The MCO must enforce access any other Network standards required by the Contract and take appropriate action with Providers whose performance is determined by the MCO to be out of compliance.

8.1.3.4 Telemedicine Access, Telehealth, Telepharmacy and Telemonitoring Access

Telemedicine, Telehealth, Telepharmacy and Telemonitoring are Covered Services and are benefits of Texas Medicaid. The MCO must contract with Providers with Telemedicine, Telehealth, Telepharmacy and Telemonitoring capabilities to increase access to healthcare, including specialty Providers and Behavioral Health Services Providers, for its Members. The MCO must include information about Providers with Telemedicine, Telehealth, and Telemonitoring capabilities in its hard copy and electronic provider directory. Section 8.1.17.1, “Behavioral Health Network,” provides additional information regarding Telemedicine or Telehealth.

The Medicaid MCO must be able to accept and process Provider claims for Covered Services using modifier 95 when delivered by Telemedicine or Telehealth. In addition, the Medicaid MCO must be able to accept and process Provider claims for Telemonitoring and Telepharmacy.

The MCO must conduct outreach to its Providers to encourage more Providers to offer Telemedicine, Telehealth and Telemonitoring, with emphasis on rural and medically
underserved areas. The MCO must also outreach to specialty Providers as that term is defined in 1 Tex. Admin. Code. §353.7 and Behavioral Health Services Providers to assure engagement of qualified Providers offering Telemedicine, Telehealth, and Telemonitoring. During the outreach process the MCO must offer trainings and supports to help establish Telemedicine, Telehealth, and Telemonitoring literacy and capabilities. In addition, the MCO will actively recruit additional rural providers in order to increase Member access to the services that can be delivered through Telemedicine or Telehealth.

MCOs are required to comply with Texas Government Code §531.0216 and §531.02161 (a), (c) and (d).

MCOs must not deny reimbursement for a Covered Service delivered by a Network Provider via Telemedicine or Telehealth solely because the Covered Service is not provided through an In-Person consultation. MCOs must not deny reimbursement for a Covered BH Service delivered by a Network Provider via Telemedicine or Telehealth, including Audio-Only Behavioral Health Services, solely because the Covered Service is not provided through In-Person consultation. MCOs cannot limit, deny, or reduce reimbursement for a Covered Service or procedure delivered remotely by a Provider based upon the Provider’s choice of Platform, except in the event a Provider utilizes an Audio-only Platform for providing a Telemedicine or Telehealth service that HHSC has found must not be provided via Audio-only.

MCOs must allow Members to receive Telemedicine or Telehealth services from providers other than the Member’s PCP.

MCOs must adhere to the provisions for services by Telecommunication located in UMCM Chapter 16.

### 8.1.3.4.1 School-based Telemedicine Services

As required by Texas Government Code § 531.0217, school-based Telemedicine medical services are a covered service for Members. MCOs must reimburse the distant site physician providing treatment even if the physician is not the patient’s primary care physician or provider or is an out-of-network physician. To be eligible for reimbursement, distant site physicians providing treatment must meet the service requirements outlined in Texas Government Code § 531.0217 (c-4).

MCO’s may not request prior authorization for school-based Telemedicine medical services.

The School-Based Telemedicine Services in this section are separate and distinct from School Health and Related Services (SHARS) services. The MCO must only reimburse school-based telemedicine services that are not considered SHARS.

### 8.1.3.5 Indian Health Care Providers

The MCO must demonstrate a sufficient number of Indian Health Care Providers (IHCP) are participating in its Provider 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 Primary Care Provider (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 Out-of-Network (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 this 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 Network 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 Provider Network. The MCO must (1) pay the IHCP an agreed to negotiated rate, or (2) in the absence of a negotiated rate, pay a rate not less than the level and amount that would be paid to a Network Provider that is not an IHCP; and (3) 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, 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 State Plan in Medicaid FFS. If an IHCP is enrolled in Medicaid as an FQHC, the IHCP must be reimbursed as described in Section 8.1.30.

### 8.1.4 Provider Network

This section does not apply to NEMT Services providers.

The MCO must enter into written contracts with properly credentialed providers as described in this Section. The Provider Contracts must comply with the UMCM’s requirements and include reasonable administrative and professional terms.

The MCO must maintain a Provider 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 current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules or regulations related to the Contract.

The MCO must implement programs and incentives that will develop the Provider Network's expertise in child welfare and Trauma Informed Care (TIC).

The Provider Network must be responsive to the linguistic, cultural, and other unique needs of any minority, or disabled individuals, or other special populations served by the MCO. This includes the capacity to communicate with Members in languages other than English, when necessary, as well as with those who are deaf or hearing impaired.

The MCO must seek to obtain the participation in its Provider Network of qualified providers currently serving the Medicaid and CHIP Members throughout the state. Medicaid MCOs utilizing OON providers to render services to their Members must not exceed the utilization standards established in 1 Tex. Admin. Code § 353.4. HHSC may modify this requirement for Medicaid MCOs that demonstrate good cause for noncompliance, as set forth in 1 Tex. Admin. Code § 353.4(e)(3).
**All Providers:** If licensure or certification is required to provide a Covered Service, then a Network Provider must be licensed or certified in Texas, except as provided in Section 8.1.4.12, “Out-of-State Providers.” Network Providers cannot be under sanction or exclusion from the Medicaid Program. All Acute Care Providers must be enrolled as Medicaid providers and have a Texas Provider Identification Number (TPIN). All pharmacy Providers must be enrolled with HHSC’s Vendor Drug Program (VDP). All Providers must also have a National Provider Identification Number (NPI) (see 45 C.F.R. Part 162, Subpart D).

The MCO is prohibited from employing, contracting with, or entering into a Provider Agreement with Providers whose license is expired or cancelled, or who are excluded, suspended, or terminated from participation in the Texas Medicaid and CHIP programs. The MCO must reconcile their list of credentialed Providers to the master Provider file as often as HHSC Administrative Services Contractor makes it available.

**Inpatient Hospital and medical services:** The MCO must ensure access to Acute Care Hospitals and Specialty Hospitals in the MCO’s Network. Covered Services provided by such Hospitals must be available and accessible 24 hours per Day, 7 Days per week, within the MCO’s Network throughout the state. The MCO must enter into a Provider Contract with any willing State Hospital that meets the MCO’s credentialing requirements and agrees to the MCO’s contract rates and terms.

**Children’s Hospitals/Hospitals with specialized pediatric services:** The MCO must ensure Member access to Hospitals designated as Children’s Hospitals by Medicare and Hospitals with specialized pediatric services, such as teaching Hospitals and Hospitals with designated children’s wings. Covered Services provided by these Hospitals must be available and accessible 24 hours per Day, 7 Days per week. If the MCO does not have a designated Children’s Hospital or Hospital with specialized pediatric services in proximity to the Member’s residence in its Network, the MCO must enter into written arrangements for services with OON Hospitals. Provider directories including the online Provider Directory, Member Materials, and Marketing Materials must clearly distinguish between Hospitals designated as Children’s Hospitals and Hospitals that have designated children’s units.

**Trauma:** The MCO must ensure Member access to Texas Department of State Health Services (DSHS) designated Level I and Level II trauma centers within the state or Hospitals meeting the equivalent level of trauma care in the state. The MCO must make written OON reimbursement arrangements with the DSHS-designated Level I and Level II trauma centers or Hospitals meeting equivalent levels of trauma care if the MCO does not include such a trauma center in its Network. For additional information on the Emergency Medical Service (EMS) Trauma System in Texas visit the DSHS website and search, EMS Trauma Systems.

**Transplant centers:** The MCO must ensure Member access to 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. HHSC-designated transplant centers also include members of the United Network for Organ Sharing (UNOS), which can be accessed at Organ Procurement and Transplantation Network website under the Member tab. If the MCO’s Network does not include a designated transplant center or center meeting equivalent levels of care in proximity to the Member’s residence, the MCO must make written arrangements with OON providers for such care.

**Hemophilia centers:** The MCO must ensure Member access to 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. If the MCO’s Network does not include CDC-supported hemophilia centers in proximity to the
Member’s residence, the MCO must make written arrangements with OON providers for such care.

**Outpatient BH Service Provider Access:** The MCO must ensure Member access to outpatient BH Service Providers in the Network, including psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; LCSWs; LMFTs; LPCs; Licensed Adolescent Chemical Dependency Treatment Facilities; LCDCs with experience treating adults and adolescents; and entities employing QMHPs-CS. QMHPs-CS include LPHAs. QMHPs can also include CSSPs, Peer Providers, or Family Partners if acting under the supervision of an LPHA. The Provider Network can include both Local Mental Health Authorities (LMHAs) employing QMHPs-CS as well as other entities employing QMHPs-CS. In addition, day program Providers who address pharmacology issues must be certified as Licensed Medical Personnel.

The MCO must ensure Member access to outpatient BH Service Providers who are trained and certified in the administration of the Texas Comprehensive CANS 2.0 (child welfare) assessment.

**Physician services:** The MCO must ensure that PCPs are available and accessible 24 hours per Day, 7 Days per week, within the Provider Network. 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 8.1.3 and meet Members’ needs for all Covered Services.

The MCO must ensure that an adequate number of participating physicians and specialty physicians have admitting privileges at one or more participating Acute Care Hospitals in the Provider 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, seven days per week for each Acute Care Hospital in the Provider Network. The MCO must require that all physicians who admit to Hospitals maintain Hospital access for their Members through appropriate call coverage.

**Urgent Care Clinics:** The MCO must ensure that Urgent Care Clinics, including multi-specialty clinics serving in this capacity, are included within the Provider Network.

**Laboratory services:** The MCO must ensure that Network reference laboratory services are of sufficient size and scope to meet Members’ non-emergency and emergency needs and the access requirements in Section 8.1.3. Reference laboratory specimen procurement services must facilitate the provision of clinical diagnostic services for physicians, Providers and Members through the use of convenient reference satellite labs, strategically located specimen collection, and the use of a courier system under the management of the reference lab. For Medicaid Members, Texas Health Steps requires Providers to use the DSHS Laboratory Services for specimens obtained, as part of a Texas Health Steps medical checkup, including Texas Health Steps newborn screens; blood lead testing; hemoglobin electrophoresis; total hemoglobin tests that are processed at the Austin Laboratory. Providers may submit specimens for glucose, cholesterol, High-density Lipoprotein (HDL), lipid profile, HIV, and Rapid Plasma Reagin (RPR) to the DSHS Laboratory or to a laboratory of the Provider’s choice. Hematocrit may be performed at the Provider’s clinic if the Provider needs an immediate result for anemia screening. Providers should refer to the Texas Health Steps Online Provider Training Modules referencing specimen collection on the DSHS website and the TMPPM, Children’s Services Handbook for the most current information and any updates.

**Pharmacy Providers:** The MCO must ensure that all pharmacy Network Providers meet all requirements under 1 Tex. Admin. Code § 353.909. Providers must not be under sanction or
exclusion from the Medicaid or CHIP Programs. 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 § 354.1853) with one or more pharmacy providers, but any selective arrangement must comply with Texas Government Code § 533.005(a)(23)(G) and 1 Tex. Admin. Code § 353.905(e) and § 370.701.

MCOs may have only retail pharmacy networks and specialty pharmacy networks. Except for selective arrangements for drugs on the HHSC Specialty Drug List, MCOs may not have preferred pharmacy or selective pharmacy networks. MCOs must allow pharmacies in the retail pharmacy network to dispense any drug listed on the HHSC Specialty Drug List to pharmacies enrolled in the MCOs specialty pharmacy network.

The MCO and its Subcontractors must not require Medicaid/CHIP pharmacy providers to enroll in other lines of business as a condition for Medicaid/CHIP enrollment.

**Diagnostic imaging:** The MCO must ensure that diagnostic imaging services are available and accessible to Members in accordance with the access standards in Section 8.1.3. The MCO must ensure that 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.

**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, not including MDCP service Providers referenced in this Section. 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 this Section.

**MDCP:** The MCO must have a sufficient number of contracts with MDCP service Providers so that all Members who receive MDCP have access to Medically Necessary and Functionally Necessary Covered Services.

**Ambulance providers:** The MCO must enter into a Network Provider Contract with any willing ambulance provider that meets the MCO’s credentialing requirements and agrees to the MCO’s contract terms and rates.

**Optometrists and Ophthalmologists:** The MCO must enter into a Provider Contract with any willing optometrists, ophthalmologists, therapeutic optometrists, and enrolled providers within 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 that meets the MCO’s credentialing requirements and agrees to the MCO’s contract terms and rates.

**Durable Medical Equipment (DME) and Medical Supplies:** The MCO must ensure Members have access to DME and Medical Supplies.

**Prescribed Pediatric Extended Care Centers (PPECC):** MCOs must make reasonable effort to contract with qualified PPECCs within the service delivery area, if available. Qualified PPECCs include those with a temporary, initial or renewal license.

**LMHAs and LBHAs:** The MCO must enter into a Provider Contract with any willing LMHA or LBHA that meets the MCO’s credentialing requirements and agrees to the MCO’s contract rates and terms.
Outpatient Substance Use Disorder Service Providers: The MCO must make reasonable effort to contract with outpatient Substance Use Disorder (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: licensed narcotic (opiod) treatment programs, chemical dependency treatment facilities licensed by HHSC, and appropriately trained physicians and other qualified prescribers as specified in the Texas Medicaid Provider Procedures Manual.

The MCO must include Significant Traditional Providers (STPs) of this benefit in its Network and provide such STPs with expedited credentialing. Medicaid MCOs 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 all SAs, and unlike other STP requirements are not limited to the first three years of operation.

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 those licensed 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. Medicaid MCOs 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 all SAs, and unlike other STP requirements are not limited to the first three years of operation.

Case Management for Children and Pregnant Women: The MCO must make a reasonable effort to contract with Case Management for Children and Pregnant Women providers within its Service Area. The MCO must ensure Members in categories 3-6 of the Target Population have access to Case Management for Children and Pregnant Women Services.

8.1.4.1 Provider Contract Requirements

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 Provider Network.

The MCO’s contract with healthcare Providers, and NEMT Services providers as applicable, must be in writing, must be in compliance with applicable federal and state laws, rules, and regulations, and must include minimum requirements specified in Attachment A, “STAR Health Contract Terms,” and UMCM Chapter 8. The MCO must give each Provider a copy of this executed contract within 45 Days of execution. For an executed contract, the Provider needs to be credentialed, and the Provider and MCO must both sign the contract. Credentialing requirements do not apply to NEMT Services providers.
As described in Attachment B-1 Section 7, “Transition Phase Requirements,” the MCO must submit model Provider Contracts to HHSC for review during Readiness Review. The MCO must resubmit the model Provider Contracts any time it makes substantive modifications to such agreements. HHSC retains the right to reject or require changes to any Provider Contract that does not comply with MCO Program requirements or the STAR Health Contract.

8.1.4.2 Primary Care Providers and the Medical Home

The MCO must provide Medical Home services for Members through PCPs or Specialty Care Providers.

The MCO must promote, monitor, document, and make best efforts to ensure that PCPs and Specialty Care Providers comply with the use of the Medical Home Services Model, which is an approach to providing comprehensive primary care and is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

The MCO must also promote the development of Integrated Primary Care (IPC) at the Member's Medical Home. IPC involves the integration of BH Services into primary care during the regular provision of primary care services where appropriate. IPC occurs at the same time and by the same Provider ideally, or by the BH Provider seeing the Member in tandem with the PCP. The MCO must regularly measure Member BH improvement using psychometrically sound instruments. The IPC is a model distinct from co-location of services, which is considered to be parallel care rather than integrated care. IPC is also distinct from sequential care, which denotes BH care that occurs either before or after the primary care and at the same or a different location. Information on IPC, integrated physical and BH care, and other useful resources and tools can be found online at Integrated Primary Care Website.

As a Medical Home, the PCP works with Members, Medical Consenters, Caregivers, Providers, Service Coordinators, Service Managers and other state and non-state entities to assure that all the Member’s medical and BH needs are met. This includes screening, identification, and referral to Medically Necessary services, and assessment and coordination of non-clinical services that impact the Member’s health.

The MCO’s PCP Network may include Providers from any of the following practice areas: General Practice; Family Practice; Internal Medicine; Pediatrics; OB/GYN; Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) (when APRNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or OB/GYN who also qualifies as a PCP under this contract); Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and similar community clinics; and specialist physicians who are willing to provide a Medical Home to selected Members with special needs and conditions. In addition, if applicable the MCOs Network must include a sufficient number of Indian Health Care Providers to ensure that eligible Members enrolled in the MCO have timely access to services. The MCO may include an advanced practice registered nurse (APRN) as a Network PCP even if the APRN’s supervising physician is not a Network Provider. The MCO must treat APRNs and PAs 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 Provider Network, and
3. inclusion as a PCP in any Provider directory maintained by the MCO.
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 18. 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 a specific age range from birth through age 20;
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 Hospital that includes admissions to pediatric units.

A pediatrician is not considered an age-appropriate choice for a Member aged 18 and over.

For Members with Special Healthcare Needs (MSHCN) that require services from specialists or BH Providers, the PCP may choose to use an interdisciplinary team approach to managing the 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 or Service Manager 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 a Member’s DFPS caseworker and MCO Service Coordinator or MCO Service Manager. The PCP Team must:

1. develop specialty care and support service recommendations to be incorporated into the Member’s Healthcare Service Plan (HCSP), 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, and, if applicable, the young adult Member concerning the specialty care recommendations.

The PCP for an MSHCN, or for a Member with Disabilities, special healthcare needs, or Chronic (or Complex) Conditions, may be a specialist physician who agrees to provide PCP services to the Member. The specialist physician must agree to perform all PCP duties required in the Contract and such PCP duties must be within the scope of the specialist’s license. The Medical Consenter, Caregiver, or Member may initiate the request through the MCO for a specialist to serve as a PCP for MSHCN or a Member with Disabilities, special healthcare needs, or Chronic (or Complex) Conditions. The MCO must process such requests in accordance with 28 Tex. Admin. Code Chapter 11, Subchapter J. Specialists may limit the number of Members for which they will serve as a PCP.

PCPs must either have admitting privileges at a Hospital that is part of the MCO’s Provider Network or make referral arrangements with a Provider who has admitting privileges to a Network Hospital. The MCO may cover this requirement through the use of hospital lists.

The MCO must require, through contract provisions, that PCPs are accessible to Members 24 hours a Day, 7 Days a week. The MCO is encouraged to enter into Provider Contracts with sites that offer primary care services during evening and weekend hours. The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours.

Acceptable after-hours coverage:

1. The PCP’s office telephone is answered after-hours by an answering service that meets language requirements of the Major Population Groups and can contact the PCP or
another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.

2. The PCP’s office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the Member to call another number to reach the PCP or another Provider designated by the PCP. Someone must be available to answer the designated Provider’s telephone. Another recording is not acceptable.

3. The PCP’s office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable after-hours coverage:
1. The PCP’s office telephone is only answered during office hours.
2. The PCP’s office telephone is answered after-hours by a recording that tells Member to leave a message.
3. The PCP’s office telephone is answered after-hours by a recording that directs Member to go to an Emergency Room for any services needed.
4. Returning after-hours calls outside of 30 minutes.

The MCO must contractually require PCPs:
1. to provide Members with preventive services in accordance with the Texas Health Steps periodicity schedule published in the TMPPM, Children’s Services Handbook and Section 8.1.28.3, “Texas Health Steps (EPSDT) Medical and Dental;” and
2. to refer for follow-up assessments or interventions clinically indicated as a result of the Texas Health Steps checkup, including the developmental and behavioral components of the screening.

Specialists who serve as PCPs are encouraged, but not required, to be Texas Health Steps providers. The MCO must contractually require PCPs to submit information from Texas Health Steps forms and documents to the Health Passport. The MCO must also contractually require PCPs to provide Members with preventive services in accordance with the U.S. Preventive Services Task Force requirements. The MCO must make best efforts to ensure that PCPs comply with these periodicity requirements for children and young adult Members. Best efforts must include, but not be limited to, Provider education, Provider reviews, monitoring, and feedback activities.

The MCO must contractually require PCPs to assess the medical and BH needs of Members for referral to specialty care Providers and provide referrals as needed. Members, Caregivers or Medical Consenters can 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 make such referrals. Best efforts must include, but not be limited to, Provider education activities centered around TIC and child welfare and review of Provider referral patterns.

8.1.4.3 PCP Notification

The MCO must furnish each PCP with a current list of Members enrolled or assigned to that PCP no later than five Business Days after the MCO receives the monthly Enrollment File. The MCO may offer and provide such enrollment information in alternative formats, such as through access to a secure internet site, when such format is acceptable to the PCP.
8.1.4.4 Provider Credentialing and Re-credentialing

This section does not apply to NEMT Services providers.

All Medicaid MCOs must utilize the Texas Association of Health Plans’ (TAHP’s) contracted Credentialing Verification Organization (CVO) as part of its Provider credentialing and recredentialing process regardless of membership in the TAHP. The CVO is responsible for receiving completed applications, attestations and primary source verification documents.

At least once every three years, the MCO must review and approve the credentials of all participating licensed and unlicensed Providers who participate in the MCO’s Provider Network.

The MCO may subcontract with another entity to which it delegates credentialing activities if the delegated credentialing is maintained in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and any comparable 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 28 Tex. Admin. Code §§ 11.1902 and 11.1402(c), relating to provider credentialing and notice. Medicaid MCOs must also comply with 42 C.F.R. § 438.12 and 42 C.F.R. § 438.214. The MCO must complete the initial credentialing process, and its claim systems must be able to recognize the provider as a Network 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 Network Provider Contract. The re-credentialing process must take into consideration Provider performance data including Member Complaints and Appeals, quality of care, and utilization management.

Outpatient BH therapy Providers, including LCSWs, LMFTs, LPCs, LCDCs, and some Psychologists, completing the credentialing and re-credentialing processes must submit to a DFPS Background History Check. DFPS will conduct the Background History Check and provide the findings to the MCO. A finding of physical or sexual abuse of a child or adult will result in an automatic bar from participation as a STAR Health Network Provider. For all other finding types, the MCO will collaborate with DFPS to review the findings and decide whether participation in the Network will be allowed. The MCO must consider the following prior to issuing a decision to include or bar a provider from the STAR Health Network:

- the severity of the finding;
- the length of time that has passed since the finding occurred;
- any pattern of abuse or neglect;
- the age of the victim(s); and
- any other relevant risk factors.

The credentialing profile sheet that is completed by a primary care, specialty care, BH care, or dental Provider’s office during the credentialing and re-credentialing process must include foster care specific questions that address to the Provider’s experience with conditions that are prevalent in the foster care population, such as the treatment of physical or sexual abuse, developmental disabilities, and Post-traumatic Stress Disorder (PTSD), as well as experience with evidenced-based practices (EBPs) or promising practices that utilize a trauma informed approach. The credentialing profile sheet that is completed by a BH Provider must also track training and certifications in EBPs and promising practices such as Trauma Focused Cognitive
Behavioral Therapy (TF-CBT), Parent Child Interaction Therapy (PCIT), Trust-Based Relational Intervention (TBRI), and Child Parent Psychotherapy (CPP). The MCO must also identify a process to track BH Providers becoming certified to administer the Texas Comprehensive CANS 2.0 (child welfare) assessment tool. BH Providers must recertify annually to continue administering the assessment. The MCO must ensure that Providers performing this assessment have not allowed their certification to lapse.

The MCO may not discriminate for the participation, reimbursement, or indemnification of any provider 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 providers written notice of the reasons for its decision.

8.1.4.4.1 Expedited Credentialing Process

This section does not apply to NEMT Services providers.

The MCO must comply with the requirements of Texas Insurance Code Chapter 1452, Subchapters 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 Texas Government Code § 533.0064, that allows applicant providers to provide 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, 4) licensed professional counselors, 5) licensed marriage and family therapists, and 6) psychologists. To qualify for expedited credentialing the provider must: (1) be a member of an established health care provider group that has a current contract in place with an MCO, (2) be a Medicaid enrolled provider, (3) agree to comply with the terms of the contract between the MCO and the health care provider group, and (4) timely submit all documentation and information required by the MCO 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.

8.1.4.4.2 Minimum Credentialing Requirements for Unlicensed or Uncertified LTSS Providers

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

1. has not been convicted of a crime listed in Texas Health and 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 health care program:
• HHS-OIG Exclusion; and
• HHSC-OIG Exclusion Search;
by searching or ensuring a search of such registries is conducted, before hire and at
least monthly thereafter;
4. is knowledgeable of acts that constitute Abuse, Neglect, or Exploitation of a Member;
5. is instructed on and understands how to report suspected Abuse, Neglect, or
Exploitation;
6. adheres to applicable state laws if providing transportation; and
7. is not a spouse of, Caregiver or Medical Consenter for, or employment supervisor of the
Member who receives the service, except as allowed in the Texas Healthcare
Transformation and Quality Improvement Program 1115 Waiver.

8.1.4.5 Board Certification Status

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

8.1.4.6 Provider Relations Including Manual, Materials
and Training

If the MCO has dedicated provider relations staff, the MCOs must notify within ten Days, the
Providers and NEMT Services providers who are impacted by a permanent change in Provider
relations specialists within their service area. Notification may be in writing, email, or in the
provider portal. The notification must include the Provider relations specialist's name, phone
number, and email address. Provider relations specialists must be able to assist Providers and
NEMT Services providers with all Covered Services. Provider relations specialist assistance
may include coordinating with other MCO staff or Subcontractors to address specific issues
raised by Providers, such as claims or contracting concerns.

The MCO must maintain a Provider manual, including any necessary specialty manuals (e.g.,
BH) for all existing Network Providers. The MCO must notify newly contracted Providers about
the Provider manual and how to access it within five business days from inclusion of the
Provider into the Network. The Provider manual must contain the critical elements defined in
UMCM Chapter 3 including the special requirements of the STAR Health Program and
Members.

The MCO must collaborate with HHSC and DFPS and receive HHSC’s approval on any
substantive changes to the Provider Manual and training materials prior to their publication and
use.

See UMCM Chapters 3, 4, and 8 for material and submission requirements. HHSC reserves the
right to 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 MCO Program requirements, and mass communications directed to all or a
large group of Network Providers (e-mail or fax “blasts”). Provider Materials do not include
written correspondence between the MCO or its Administrative Services Subcontractors and a
Provider regarding individual business matters.

The MCO will seek to partner with groups that provide direct services to the foster care
population or represent direct service providers in order to deliver effective training programs to
Providers. The MCO will collaborate with DFPS, Single Source Continuum Contractors (SSCCs), the Court, and other child welfare stakeholders to provide Providers with additional insight into the STAR Health Program.

The MCO will hire a minimum of two internal trainers who have experience in healthcare and in BH for the STAR Health population. The MCO will provide training on an ongoing basis through web-based sessions and regional outreach. The MCO will design its training program to ensure that participating Providers understand the unique needs of the STAR Health population, including the sensitivities associated with the foster care population and expectations surrounding care and coordination for this population.

The MCO must provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The MCO’s training must be completed within 30 Days of placing a newly contracted Provider on active status. The MCO must provide ongoing training to new and existing Providers as required by the MCO or HHSC to comply with the Contract. The MCO must maintain and make available upon request 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 establish ongoing Provider training that includes the following issues:

1. Covered Services and the Provider’s responsibilities for providing or coordinating those services;
   a. with special emphasis placed on areas that vary from commercial coverage rules (e.g., ECI, therapies and DME/Medical Supplies, referrals and coordination with Non-capitated Services);
   b. pharmacy services and processes, including information regarding outpatient drug benefits, HHSC’s drug formulary, preferred drugs, PA processes, and 72-hour emergency supplies of prescription drugs;
   c. the availability of Mental Health Rehabilitative Services and Mental Health Targeted Case Management for qualified Members;
   d. required referrals for SED, mental illness, or chemical dependency, and for Members three years of age and older suspected of having a developmental delay or developmental disability;
   e. the availability of Community First Choice (CFC) services for qualified members;
   f. billing for services for hospice recipients; and
   g. effective November 1, 2016, billing for services for Dual Eligible members;
2. Medical Home Services Model and the IPC Model (see Integrated Primary Care Website);
3. relevant requirements of the Contract, including the Health Passport;
4. Cultural Competency Training, based on National Standards for Culturally and Linguistically Appropriate Services (CLAS), including the need for Providers and their staff to address Medical Consenters, Caregivers, DFPS Staff and Members with dignity, sensitivity and respect;
5. availability of Service Management, Service Coordination, and DM;
6. the MCO’s QAPI program and the Provider’s role in the program;
7. the MCO’s policies and procedures, especially regarding Network and Out-of-Network referrals;
8. Texas Health Steps benefits, periodicity, forms, required components of a checkup, the importance of documenting all required components of the checkup in the medical record, and the necessity of documentation to support a complete checkup qualifying for reimbursement is provided;
9. Population-specific issues related to the STAR Health Population, including:
   a. Health Passport, as defined in Section 8.1.12, “Health Passport;”
b. coordinating care with:
   i. Medical Consenters;
   ii. Guardians ad litem;
   iii. Case workers;
   iv. Attorneys ad litem;
   v. Judges;
   vi. Law enforcement officials;
   vii. SSCC staff;
   viii. Integrated Care Coordination (ICC) Vendor Staff; and
   ix. other involved parties from DFPS and other state agencies;

c. requirements for providing Healthcare Services to the STAR Health Population, including:
   i. medical consent and informed consent requirements as defined in Texas Family Code and DFPS policies (see DFPS website);
   ii. required timelines for scheduling physical and BH Services appointments as defined in DFPS policies;
   iii. specific medical information required for judicial review of medical care under Texas Family Code § 266.007;
   iv. provision of medical records to DFPS staff; and
   v. compliance with the *Psychotropic Medication Utilization Parameters for Foster Children* found on DFPS website;

d. Evidence-based practices (EBPs) and promising practices, including
   i. for Behavioral Health Providers, TF-CBT, PCIT, TBRI and CPP;
   ii. for all other Providers, TIC, PTSD and Attention-Deficit/Hyperactivity Disorder (ADHD);

e. specific behavioral and physical health needs of the STAR Health Population;

f. requirements for screenings and assessments, such as:
   i. the administration of the initial Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 days of entering conservatorship to each Member in category 1 of the Target Population ages 3 and older, and annual assessments thereafter;
   ii. the provision of or referral for all physical and BH services indicated by the results and recommendations of the Texas Comprehensive CANS 2.0 (child welfare) assessment; and

g. recognition of Abuse, Neglect, and Exploitation and the mandatory reporting requirements under the Texas Family Code.

10. specific training related to Utilization Management (UM) reviews, fraud, and abuse, including oversight activities such as pre-payment reviews, audits, and monitoring;

11. the MCO’s policy and procedures for a PA;

12. HHSC’s NEMT Services available to Medicaid Members;

13. the importance of updating contact information to ensure accurate Provider directories and the Medicaid Online Provider Lookup;

14. missed appointment referrals and assistance provided by the Texas Health Steps Outreach and Informing Unit;

15. administrative issues such as detailed claims filing and how to receive assistance with claims;

16. services available to Members; and

17. Providers’ obligation to identify and report a Critical Event or Incident such as Abuse, Neglect, or Exploitation to the State related to LTSS delivered in the STAR Health Program.
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 according to the implementation plan required by Section 8.1.4, "Provider Network."

The MCO must make available to Network Providers a variety of web-based training modules. Such trainings will include those suggested by HHSC and DFPS, such as the effect of Abuse, Neglect, and Exploitation on the developing brain, the effect of intrauterine assault, fetal alcohol syndrome, and shaken baby syndrome. The MCO will consult with experts in the field, including its foster care Medical Advisory Committee (MAC), to determine which additional topics may be relevant to Providers in providing services to the STAR Health Population.

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 Family Code Chapter § 266.012.

8.1.4.7 Continuing Education Credits

The MCO is encouraged to inform and arrange for access to training programs to provide continuing education credits for Providers. The MCO may coordinate with national and local provider associations to deliver continuing education training. Continuing education training must focus on enhancing Provider understanding of the complex and special physical and BH care needs of the STAR Health Population. 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.

8.1.4.8 Provider Hotline

The MCO must operate a toll-free telephone line for Provider and NEMT Services provider inquiries from 8 a.m. to 5 p.m. local time for all areas of the state, Monday through Friday, except for state-approved holidays. The State-approved holiday schedule is updated annually and can be found on the Texas State Auditor’s Office website. The Provider Hotline must be staffed with personnel who are knowledgeable about Covered Services, Non-capitated Services, and Value-added Services as applicable. The content of Provider Hotline staff training related to Texas Health Steps (EPSDT) is subject to HHSC approval.

The MCO must ensure that after regular business hours the line 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 handle after-hours inquiries from Providers seeking to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition, provided, however, that the MCO and its Providers must not require verification prior to providing Emergency Services. Refer to Section 8.1.5.6, “Nurse and Member Hotline Requirements,” for information regarding Provider access to the 24-hour Nurse Hotline.

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

1. the average hold time is two minutes or less; and
2. the call abandonment rate is seven percent or less.

The MCO must conduct ongoing call quality assurance to ensure these standards are met. The MCO must monitor its performance regarding Provider Hotline standards and submit performance reports summarizing call center performance for the Hotline as indicated in
Section 8.1.26.2, “Reports.” 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 meet the requirements in Section 8.1.17.3, “Behavioral Health Hotline and Emergency Services,” and the MCO must provide performance reports regarding its performance.

If HHSC determines that it will conduct onsite monitoring of the MCO’s Provider Hotline functions, the MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) relating to such monitoring. For purposes of this section, “authorized reimbursable travel costs” may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

8.1.4.8.1 Safety-net Hospital Incentives

On an annual basis, HHS must provide a list to the MCOs that identifies the safety-net hospitals that are awarded incentive payments specified in H.B. 1, 84th Legislature, Regular Session, 2015, Article II, Special Provisions Sec. 59(b). This list will consist of hospitals that are recipients of incentives funds, based on exemplary performance on potentially preventable complications and potentially preventable readmissions. The program and methodology for determining awards for hospitals is developed by HHSC. The list provided by HHS will contain the hospital NPI, hospital name, and amount of incentive payments awarded to each hospital based on PPC and PPR performance. HHS must build in costs for these incentives into the MCO capitation payments. Consistent with HHS direction, MCOs must pay the amount identified by HHS to the eligible hospitals identified by HHS.

8.1.4.8.2 Provider Overpayments

The MCO must have a mechanism in place through which Network Providers and NEMT Services providers report Overpayments. The MCO must inform Providers and NEMT Services providers of this mechanism. The mechanism must allow Providers and NEMT Services providers to include a reason for the Overpayment. The MCO must require that the Providers and NEMT Services providers submit Overpayments within 60 Days from identification. For purposes of this section, "identification" refers to when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an Overpayment and quantified the amount of the Overpayment.

In seeking to recover a provider overpayment that is connected to an Electronic Visit Verification (EVV) transaction, the MCO must comply with 1 Tex. Admin. Code § 353.1453.

8.1.4.9 Provider Reimbursement

The MCO must pay for all Medically Necessary Covered Services provided to Members. The MCO must also pay for all Functionally Necessary Covered Services provided to Members. The MCO’s Network Provider Contract must include a complete description of the payment methodology or amount, as described in UMCM Chapter 8.

The MCO must pay OON providers using the Medicaid methodology as defined by HHSC in 1 Tex. Admin. Code § 353.4 and ensure claims payment is timely and accurate as described in
Section 8.1.24.5 “Claims Processing Requirements,” and UMCM Chapter 2. The MCO must require tax identification numbers (TINs) from all participating Providers. The Provider may use the federal TIN of the residential treatment center (RTC) 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.

Provider payments must comply with all applicable state and federal laws, rules, and regulations, including the following sections of the Patient Protection and Affordable Care Act (PPACA) and, upon implementation, corresponding federal regulations:
1. Section 2702 of PPACA, entitled “Payment Adjustment for Healthcare Acquired Conditions;”
2. Section 6505 of PPACA, entitled “Prohibition on Payments to Institutions or Entities Located Outside of the United States;” and
3. Section 1202 of the Healthcare and Education Reconciliation Act as amended by PPACA, entitled “Payments to Primary Care Physicians.”


As required by Texas Government Code § 533.005(a)(25), the MCO cannot implement significant, non-negotiated, across-the-board Provider and NEMT Services provider reimbursement rate reductions unless: (1) it 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 that applies to all similarly-situated Providers or types of Providers. This requirement includes across-the-board rate reductions made by Subcontractors including pharmacy provider reimbursement methodologies and reductions due to changes in PBM Subcontractor or PBM provider networks. The MCO must submit a written request for an across-the-board rate reduction to HHSC’s Director of Managed Care Compliance and Operations 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 cost containment initiative implemented by HHSC. The MCO must submit the request at least 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 reduction on the planned effective date.

Further, the MCO must give Providers at least 30 Days’ 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.

8.1.4.9.1 Provider Preventable Conditions

MCO must identify Present on Admission (POA) indicators as required in the UMCM Chapter 2 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 the Texas Medicaid Provider Procedures Manual.

As a condition of payment to hospital Providers, MCOs must require Providers to report Provider Preventable Conditions on Institutional Claims using appropriate POA indicators.
MCOs must include all identified POA indicators on Encounter Data submitted to the State. Upon request by the State, MCOs must report the amount of Provider payments denied, reduced, or recouped from an individual Provider for the requested service dates for provider preventable conditions that were not POA.

**8.1.4.9.2 Supplemental Payments for Qualified Providers**

In accordance with PPACA as amended by Section 1202 of the Healthcare and Education Reconciliation Act and corresponding federal regulations at 42 C.F.R §§ 438.6 and 438.804, the MCO will make supplemental payments to qualified Medicaid providers for dates of service beginning on January 1, 2013, and ending on December 31, 2014. The UMCM Chapter 13 will identify the types of providers and services that qualify for the supplemental payments.

HHSC or its Administrative Services Contractor will conduct the provider self-attestation process, and determine which providers and services are eligible for supplemental payments. HHSC will use encounter 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 will pay claims from qualified Network Providers at the MCO’s contracted rates, and OON providers in accordance with 1 Tex. Admin. Code § 353.4. The MCO’s encounter data should reflect the actual amount paid to providers and should not be adjusted to include supplemental payment amounts.

As described in **Attachment A, Section 10.15, “Pass-through Payments for Provider Rate Increases,”** 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 UMCM Chapter 13, 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 the 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 the 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 will return the full amount of the recovery to HHSC.

**8.1.4.9.3 Minimum Fee Schedule for Rural Hospital**

MCOs must adopt HHSC’s Medicaid minimum fee schedule for rural hospitals, as defined in Texas Government Code § 531.02194, as of September 1, 2020. The Medicaid minimum fee schedule for rural hospitals includes only the following categories of service or provider type: clinical laboratory, ambulatory surgical centers, and hospital outpatient imaging services. The Medicaid minimum fee schedule also includes inpatient standard dollar amount rural rates. The Medicaid minimum fee schedule for rural hospitals can be found at the following links:

- https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/outpatient-services
- https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/inpatient-services
- http://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx
8.1.4.10 Termination of Provider Contracts

The MCO must notify HHSC within five days after termination of (1) a Primary Care Provider (PCP) contract that impacts more than ten percent of its Members or (2) any Provider contract that impacts more than ten percent of its Network for a provider type by Service Area and Program. The MCO must also notify HHSC of all provider terminations in accordance with UMCM Chapter 5.

Additionally, the MCO must make a good faith effort to give written notice of termination of a Network Provider to each Member who receives his or her primary care, or who is seen on a regular basis by, the Network Provider as follows:

1. For involuntary terminations of a Provider (terminations initiated by the MCO), the MCO must provide notice to the Member of the Provider’s termination from the network within 15 Days of either expiration of the provider’s advance notice period, or once the provider has exhausted rights to appeal. In cases of imminent harm to Member health, the MCO must give the Member notice immediately that the Provider will be terminated even if a final termination notice to the Provider has not been issued.

2. For voluntary terminations of a Provider (terminations initiated by the Provider), the MCO must provide notice to the Member 30 Days prior to 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 more than 15 Days after the MCO was notified.

The MCO must send notice to: (1) all its Members in a PCP’s panel; and (2) all its Members who have had two or more visits with the Network Provider for home-based or office-based care in the past 12 months.

8.1.4.11 This Section Intentionally Left Blank

8.1.4.12 Out-of-State Providers

To participate in Medicaid, the provider must be enrolled with HHSC as a Medicaid provider. The MCO may enroll out-of-state providers in its Medicaid Network in accordance with 1 Tex. Admin. Code § 352.17 and pharmacy Network Providers in accordance with 1 Tex. Admin. Code § 353.909.

The MCO may enroll out-of-state diagnostic laboratories in its Medicaid Network under the circumstances described in Texas Government Code § 531.066. This subsection does not limit the MCO’s ability or responsibility to provide NEMT Services to a Member and his or her NEMT Attendant for out-of-state travel.

8.1.4.13 Provider Protection Plan

The MCO must comply with HHSC’s provider protection plan requirements for reducing the administrative burdens placed on Network Providers and NEMT Services providers, as applicable, and ensuring efficiency in Network enrollment and reimbursement. At a minimum, the MCO must have a Provider Protection plan that complies with the following:

1. ensure no Retaliation by the MCO and MCO staff against a Provider for filing Appeals, or Complaints against the MCO on the Provider’s or Member’s behalf.
2. provide for timely and accurate claims adjudication and proper claims payment in accordance with UMCM Chapter 2;
3. include Network Provider training and education on the requirements for claims submission and appeals, including the MCO’s policies and procedures and see also Section 8.1.4.6, “Provider Relations Including Manual, Materials, and Training;”
4. ensure Member access to care, in accordance with Section 8.1.3, “Access to Care;”
5. ensure prompt credentialing, as required by Section 8.1.4.4, “Provider Credentialing and Re-credentialing;”
6. ensure compliance with state and federal standards regarding PA, as described in Section 8.1.8, “Utilization Management,” and Section 8.1.20.2, “Prior Authorization (PA) for Prescription Drugs and 72-Hour Emergency Supplies;”
7. provide 30 Days’ notice to Providers before implementing changes to policies and procedures affecting the PA process. However, in the case of suspected Fraud, Waste, or Abuse by a single Provider, the MCO may implement changes to policies and procedures affecting the PA process without the required notice period;
8. include other measures developed by HHSC or a provider protection plan workgroup, or measures developed by the MCO and approved by HHSC; and
9. participate in HHSC’s work group, which will develop recommendations and proposed timelines for other components of the provider protection plan.

8.1.5 Member Services
The MCO must maintain a Member Services Department to assist Members in obtaining Covered Services. 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 this Section, including Member Hotline response times, and Linguistic Access capabilities (Refer to Section 8.1.5.6, “Nurse and Member Hotline Requirements”).

8.1.5.1 Member Materials
The MCO must design, print and distribute Member identification (ID) cards and a Member handbook to Members. The MCO must only accept a PCP assignment 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 all Members in DFPS conservatorship and Members with voluntary agreements (categories 1 and 2 in the definition of “Target Population,”) no later than the fifth Business Day following the receipt of the Daily Eligibility File, the MCO must mail a Member’s ID card and enrollment packet (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) to the Caregiver for each new Member. 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 three 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 category 3 in the definition of “Target Population,” no later than the fifth Business Day following receipt of the Daily Eligibility File, the MCO must mail a Member’s ID card and enrollment packet (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) 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 Daily Notification File (DNF).

The DNF is a file used to provide notification on a daily basis to the MCO concerning each client that is taken into DFPS conservatorship and Members with voluntary agreements (i.e., Members included in category 1 and 2 of the “Target Population” definition). The MCO should 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 of the “Target Population” definition.

The MCO is responsible for mailing materials only to those Members or Caregivers for whom valid address data are contained in the Daily Eligibility File 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 auto-assigned to the Member and provide information regarding how Members may:

1. access their PCP;
2. change their PCP;
3. seek help scheduling Texas Health Steps appointments with 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 Service Management and Service Coordination services.

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

Member Materials must be at or below a 6th 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 the languages of other Major Population Groups making up ten percent or more of the managed care eligible population, as specified by HHSC. HHSC will provide the MCO with reasonable notice when the population reaches the ten percent threshold. All Member Materials must be available in a format accessible to the visually impaired, which may include large print, Braille, and CD or other electronic format. Member Materials must comply with the requirements set forth in UMCM Chapters 1, 3, and 4.

The MCO must make Member Materials that are critical to obtaining services, including at a minimum, Provider directories, Member handbooks, Appeal and grievance notices, and denial and termination notices, available in the Prevalent Languages in its particular service area. These materials must also be made available in alternative formats upon request of the Member at no cost. Auxiliary aids and services must also be made available upon request of the Member at no cost. These materials must include taglines in the Prevalent Languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the
MCO’s Member Services Hotline. Large print means printed in a font size no smaller than 18 points. These materials must use a font size no smaller than 12 points. These materials must also include a large print tagline and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.

The MCO must submit Member Materials to HHSC for approval prior publication or distribution, including revisions to previously approved Member Materials. See UMCM Chapters 3 and 4 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’s Member Materials and other communications cannot contain discretionary clauses, as described in Section 1271.057(b) of the Texas Insurance Code.

8.1.5.2 Member Identification (ID) Card

All Member ID cards must, at a minimum, include the following information:
1. The Member’s name;
2. the Member’s Medicaid number, if known (for categories 1–3 of the “Target Population” definition);
3. the effective date of the PCP assignment;
4. the PCP’s name and telephone number;
5. the name of the MCO;
6. the 24-hour, seven-Day a week toll-free Member services telephone number and BH Hotline number; and
7. any other critical elements identified in UMCM Chapter 3.

The MCO must reissue the Member ID card if a Member, DFPS Staff, Caregiver or Medical Consenter reports a lost card; there is a Member name change; if the Member, their Medical Consenter, or DFPS Staff requests a new PCP; the Member moves to a new placement; or for any other reason that results in a change to the information disclosed on the Member ID card.

8.1.5.3 Member Handbook

HHSC must approve the Member handbook, and any substantive revisions, prior to publication and distribution. As described in Section 7, “Transition Phase Requirements,” the MCO must develop and submit to HHSC the draft Member handbook for approval during the Readiness Review and must submit a final Member handbook, incorporating changes required by HHSC, prior to the Operational Start Date.

The Member handbook must, at a minimum, meet the Member Materials requirements specified by Section 8.1.5.1 above and must include critical elements in the UMCM Chapter 3 including the Member Complaints and Member Appeals processes.

The MCO must produce and distribute a revised Member handbook, or an insert, informing Members and their Caregivers of changes to Covered Services, upon HHSC notification and at least 30 Days prior to the effective date of such change in Covered Services. In addition to modifying the Member Materials for new Members, the MCO must notify the Members and the Caregivers of all existing Members of the Covered Services change during the timeframe specified in this subsection.

The Member handbook must be written to provide Members and their 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.

8.1.5.4 Provider Directory

This section does not apply to NEMT Services providers.

The MCO must assist the Provider through the process of updating inaccurate information with the HHSC Administrative Services Contractor, including but not limited to, inaccurate information identified through the MCO Provider Verification survey in Section 8.1.3.3. The MCO must contact the Provider as necessary until the Provider information is corrected with the HHSC Administrative Services Contractor.

The MCO must have a process in place to compare the information in the master Provider file provided by the HHSC Administrative Services Contractor with the MCO’s Provider directory. When the MCO identifies a discrepancy, the MCO must assist the Provider through the process of updating inaccurate information with the HHSC Administrative Services Contractor. MCOs 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 survey in Section 8.1.3.3 or other data sources provided to the MCOs by HHSC or identified by the MCO. The MCO must include in its Provider contract that the Provider will update its information with the HHSC Administrative Services Contractor in a timely fashion or immediately upon request by the MCO.

The Provider directory for each MCO Program, including substantive revisions, must be approved by HHSC before publication and distribution. Substantive revisions are revisions to the information required by UMCM Chapter 3 (with the exception of information contained in actual the Provider listings and indices) and any additional information that the MCO adds to the directory at its discretion.

As described in Section 7, “Transition Phase Requirements,” during the Readiness Review, the MCO must develop and submit to HHSC the draft Provider directory template for approval and must submit a final Provider directory, incorporating changes required by HHSC, prior to the Operational Start Date. Draft and final Provider directories must be submitted according to the deadlines established in Section 7.

The Provider directory must comply with HHSC’s marketing policies and procedures, as set forth in the UMCM Chapter 4.

The Provider directory must, at a minimum, meet the Member Materials requirements specified by Section 8.1.5.1 above and must include critical elements in the UMCM Chapter 3. The Provider directory must include only Network Providers credentialed by the MCO in accordance with Section 8.1.4.4, “Provider Credentialing and Recredentialing.” If the MCO contracts with limited Provider Networks, the Provider directory must comply with the requirements of 28 Tex. Admin. Code § 11.1600(b)(11), relating to the disclosure and notice of limited Provider Networks.

8.1.5.4.1 Hard Copy Provider Directory

The hard copy Provider directory must contain the requirements of UMCM Chapter 3.

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 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.

**8.1.5.4.2 Online Provider Directory**

The MCO must develop, implement, and maintain an online Provider directory to provide an electronic provider look-up search of its Provider Network. The MCO must develop and maintain policies and operating procedures with respect to its Provider Network database which must include a predictable schedule for systematically updating the database. The MCO online Provider directory must be updated at least on a weekly basis to reflect the most current MCO Provider Network.

The MCO must maintain a mobile-optimized site for the online Provider directory, minimize download and wait time, and must not use tools or techniques that require significant memory, disk resources, or special intervention such as plug-ins or additional software. HHSC strongly encourages the development of mobile device applications in addition to the use of tools that take advantage of efficient data access methods, reduce server load, and consume less bandwidth.

The online Provider directory must comply with the requirements set forth in **UMCM 3**.

The MCO must inform Members that the Provider directory is available in paper form without charge upon the Member's request and provide it within five Business Days of the Member's request.

**8.1.5.5 Internet Website**

The MCO must develop and maintain, consistent with HHSC standards and Texas Insurance Code § 843.2015 and other applicable state laws, a website to provide general information about the MCO, its Provider Network (including an online Provider directory as outlined in **UMCM Chapter 3**), its customer services, and its Complaints and Appeals process. The website must contain a link to financial literacy information on the Office of Consumer Credit Commissioner’s webpage. The MCO may develop a page within its existing website to meet the requirements of this section. The MCO must also maintain a mobile optimized site for mobile device use.

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 maintain a Provider directory for the STAR Health Program on its website. The online Provider directory or online Provider search functionality must designate PCPs with open versus closed panels and Behavioral Health providers certified in EBPs and promising practices, such as TF-CBT, PCIT, CPP, and TBRI.

The MCO may develop a page within its existing website to meet the requirements of this section. The MCO’s website must also:

1. maintain an updated Member handbook; and
2. include a link to the STAR Health Contract located on the HHSC website.

The MCO’s website must comply with HHSC’s marketing policies and procedures, as set forth in the **UMCM Chapter 4**.
The website’s content for Providers must provide:

1. Training program schedules and topics and directions for Provider enrollment in training, including continuing education credits for training on issues related to the STAR Health Population;
2. Information on how to apply to become a Network 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 STAR Health Population.

The MCO’s internet website must contain the requirements of UMCM Chapter 3.

The MCO’s pharmacy website must contain the requirements of UMCM Chapter 3.29.

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

8.1.5.6 Nurse and Member Hotline Requirements

The MCO must operate a toll-free Nurse hotline that Providers, Members, DFPS Staff, Caregivers, and Medical Consenters can call 24 hours a Day, seven Days a week. The Nurse hotline must be staffed with nurses who are knowledgeable about the STAR Health Program, Covered Services, Non-capitated Services, the STAR Health Population, the child welfare system, Medical Consenter requirements, and Provider resources. Nurses must be available 24 hours per Day and able to respond to calls from Providers, Members, DFPS Staff, Caregivers, and Medical Consenters seeking clinical information, guidance on specialty referrals or requests for specialty Provider consultations. The MCO must ensure Members can speak to a nurse either by a warm transfer from the Member Hotline or by selecting a menu option. Nurses must have access to an on-call licensed BH clinician 24 hours per Day to assist with crisis calls. Only those persons who can identify themselves through the caller verification process approved by HHSC may obtain personal health information through the Nurse hotline.

At a minimum, the MCO’s Nurse Hotline representatives must be trained and knowledgeable about:

1. Covered Services, including BH Services, Texas Health Steps, pharmacy, dental and vision, Community-Based Services, and Long-Term Services and Supports (LTSS);
2. the Medical Home Services Model and IPC Model, and able to identify PCPs who Members may access who operate according to these models;
3. the role of the PCP;
4. referrals or the process for receiving authorization for procedures or services;
5. issues related to child abuse and how to assist Members and Medical Consenters seeking care and services;
6. Providers in a particular geographical area;
7. Cultural Competency in accordance with Section 8.1.5.8, including arranging for interpreter services;
8. triaging and assisting MSHCN and Medical Consenters, DFPS Staff, and Caregivers;
9. accessing Non-capitated Services, community and social service resources, and community-based case management services for which the STAR Health population may be eligible;
10. responding to Provider questions regarding specialty referrals and to arrange for consultations with MCO clinical staff, Service Coordinators or Service Managers, or other Providers. For example, a PCP with a Member in their office may call with a need for an immediate consult with MCO clinical staff or a BH Provider;
11. the DM programs included in the STAR Health Program;
12. the emergency prescription process and what steps to take to immediately address Members’ problems when pharmacies do not provide a 72-hour supply of emergency medicines, and responding immediately to problems concerning emergency medicines, by explaining the rules to Members so that they understand their rights and, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy and DME processes;
13. the HHSC OIG Lock-in Program (OIG-LP) pharmacy override process, which ensures Member access to Medically Necessary outpatient drugs;
14. processes for obtaining DME services and how to address common problems;
15. Non-Capitated services, including the HHSC Medical Transportation Program;
16. Processes to ensure that each Member in category 1 of the Target Population ages 3 and older receives an initial Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 Days of receipt of the DNF, and annual assessments thereafter; and
17. responding to questions regarding the availability of and access to Substance Use Disorder treatment services, including information on self-referral; and informing and offering the Member a Provider directory at no cost to the Member.

In addition, the MCO must operate a toll-free Member hotline that Members, DFPS Staff, Caregivers and Medical Consenters can call 24 hours a day, seven 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/. Member Service representatives must be knowledgeable about the STAR Health Program, Covered Services, Non-capitated Services, the STAR Health Population, the child welfare system, and Medical Consenter requirements. Only those persons who can identify themselves through the caller verification process approved in writing by HHSC may obtain personal health information through the Member hotline.

The MCO must ensure, at a minimum, that after business hours and on weekends and holidays, the Member Services hotline is answered by an automated system with the capability to provide callers with operating hours, instructions regarding how to access the Nurse hotline, and instructions on what to do in cases of emergency. All recordings must be in English and in Spanish, and the languages of any Major Population Group. A voice mailbox must be available after-hours for callers to leave messages. The MCO’s Member Services representatives must return Member 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 MCO must ensure that its Member Service representatives treat all callers with dignity and respect the callers’ need for privacy. At a minimum, the MCO’s Member Service representatives must be trained and knowledgeable about:

1. Covered Services, including BH Services, Texas Health Steps, the HHSC Medical Transportation Program, pharmacy, dental and vision;
2. the emergency prescription process and what steps to take to immediately address problems when pharmacies do not provide a 72-hour supply of emergency medicines;
3. how Members in the HHSC OIG LP can fill prescriptions at a non-designated pharmacy in an emergency situation;
4. processes for obtaining DME services and how to address common problems
5. answering non-technical questions pertaining to the role of the PCP, Medical Home Services Model and IPC Model;
6. answering non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services;
7. issues related to child abuse and how to assist Members and Medical Consenters seeking care and services;
8. Providers in a particular geographical area;
9. Fraud, Waste, and Abuse including the HHSC OIG LP and the requirements to report any conduct that, if substantiated, may constitute Fraud, Waste, and Abuse in the Program;
10. Cultural Competency;
11. confirming the status of MSHCN and transferring these Members or their Medical Consenters to Service Managers for clinical triage and enrollment;
12. triaging calls to the appropriate MCO staff person;
13. answering non-clinical questions pertaining to accessing Non-capitated Services, community and social service resources, and community-based case management services for which the STAR Health population may be eligible;
14. processes to ensure that each member in category 1 of the Target Population ages 3 and older receives a Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 Days of receipt of the DNF;
15. referring callers to Covered Services and Non-capitated Services, as appropriate;
16. providing information on Member Appeals and Complaints;
17. responding to questions regarding the availability of and access to Substance Use Disorder treatment services, including information on self-referral; and
18. how to identify and report a Critical Event or Incident such as Abuse, Neglect, or Exploitation to the State.

Nurse hotline and Member hotline services must meet Cultural Competency requirements and must appropriately handle calls from non-English speaking and particularly, Spanish-speaking callers, as well as calls from individuals who are deaf or hard-of-hearing. To meet these requirements, the MCO must employ bilingual Spanish-speaking Member Services representatives and must secure the services of other contractors as necessary to meet these requirements. The MCO must provide these oral interpretation services to all hotline callers free of charge.

For both hotlines, the MCO must process all incoming correspondence and telephone inquiries in a timely and responsive manner. The MCO cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Providers, Medical Consenters, DFPS Staff, Caregivers, and Members. The MCO must ensure that both toll-free hotlines meet the following minimum performance requirements for the MCO Program:

1. at least 80 percent of calls must be answered by toll-free line staff within 30 seconds measured from the time the call is placed in queue after selecting an option;
2. the call abandonment rate is seven percent or less; and
3. the average hold time is two minutes or less.
The MCO must conduct ongoing quality assurance to ensure these standards are met.

Members, DFPS Staff, Caregivers, and Medical Consenters may access the Nurse hotline and the Member hotline through the same toll-free number, but must be given the option to direct their calls based on whether they are related to a clinical or non-clinical issue, an emergent issue, or a routine issue. However, the MCO must report hotline call statistics separately for both the Member hotline and the Nurse hotline. The Nurse and Member hotlines must be dedicated to serving only the Members, DFPS Staff, Caregivers and Medical Consenters. 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.

The MCO must monitor its performance regarding the Nurse and Member Hotline standards and submit performance reports summarizing call center performance for the Nurse and Member Hotlines as indicated in Section 8.1.26.2, “Reports,” and UMCM Chapter 5.

If HHSC determines that it will conduct onsite monitoring of the MCO’s Nurse hotline or Member hotline functions, the MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) relating to such monitoring. For purposes of this section, “authorized reimbursable travel costs” include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

### 8.1.5.6.1 NEMT Services Call Center Requirements

The MCO must ensure Members are able to request NEMT Services by phone. This requirement may be met through augmenting existing MCO Member Hotline staff, creating a dedicated NEMT Services call center, contracting with an entity to arrange NEMT Services requested by telephone, or another HHSC-approved model. In any arrangement, the NEMT Services call center must be staffed between the normal business hours of 8:00 a.m. to 5:00 p.m. local time for the Service Area, Monday through Friday, excluding state-approved holidays. The NEMT Services call center must be staffed sufficiently to answer calls regarding NEMT Services, including providing approval of services, scheduling and tracking rides, and answering Member questions related to ride status. If a dedicated NEMT Services call center or contracted entity is used, those staff are responsible for ensuring a warm transfer to the MCO’s standard call center for questions related to program benefits that are received during MCO call center operating hours to ensure consistent and comprehensive support is provided to Members.

The NEMT Services call center must have the staffing capacity to handle all telephone calls at all times during the required hours of operation and have the ability to upgrade for handling additional call volume as needed. Calls cannot be answered by an answering service during business hours and recording devices cannot be used as the final point of destination for callers during business hours.

The MCO must have a “Where’s My Ride” line and/or phone prompt, for Members to call for their rides home and/or check on the status of their scheduled rides. The MCO must ensure the Members’ calls are answered by live operators 5:00 a.m. through 7:00 p.m. local time Monday through Saturday. The MCO must ensure that Members can reach this line and/or phone prompt and NEMT Services providers during observed holidays in which NEMT Services must be provided.
The MCO must properly train NEMT Services call center staff on NEMT Services policies, including the following:

1. Handling difficult callers;
2. Reporting Fraud, Waste, and Abuse;
3. Overview of managed care and NEMT Services;
4. Scheduling and coordination of NEMT Services;
5. Civil rights;
6. Cultural diversity training; and
7. Customer service.

The MCO must ensure a desk or training manual for NEMT Services call center staff is developed that includes all processes, policies, and procedures used in scheduling trips, authorization of services, and management of transportation services.

At the time of trip scheduling, NEMT Services call center staff must advise persons accompanying children that car safety seats are required and that the persons accompanying children are responsible for installing the child safety seat.

NEMT Services call centers, including the "Where’s my Ride" line, are subject to all Member Hotline performance standards and reporting.

Special Instructions for Limited Counties

The requirements in this section are necessary for compliance with Frew.

In addition to Member Hotline reporting requirements found in Section 8.1.5.6, the MCO will provide HHSC with “trunk reports.” “Trunk” refers to telephone lines that are routed through a carrier network. Trunk reports are only required for the following counties: Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, and Walker.

The MCO will make trunk reports available to HHSC upon request for all trunks used to answer Member calls about NEMT Services. The MCO must require the trunk vendor to provide and report, at a minimum, the following information:

1. Number of trunks available;
2. Number of call attempts;
3. Number of blocked or overflow call attempts; and
4. Number of trunks out of service.

The MCO must back up all data reports from the trunk vendor. It is the responsibility of the MCO to ensure its reporting system and trunks are configured in a manner that will enable the MCO to track the performance measures specified by HHSC. The MCO must ensure receipt and backup of all trunk reports data provided by the vendor. This backup will occur before any data is purged.

8.1.5.7 Member Education

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

1. how the MCO system operates, including the role of the PCP, referrals for services using Network Providers, and access to OON providers;
2. Covered Services, including BH services, Texas Health Steps, pharmacy, dental, vision, Community-Based Services and LTSS;
3. any Value-added Services offered by the MCO, and limitations placed on such Value-added Services;
4. the value of screening, preventive care, and other Medical Home services;
5. how to obtain services, including:
   a. contacting the MCO’s Hotlines;
   b. the MCO’s Complaint, grievance and Appeals policies and procedures;
   c. requesting a Medicaid Fair Hearing;
   d. Emergency Services;
   e. OB/GYN and specialty care including oncology;
   f. the availability of and access to Substance Use Disorder treatment services, Mental Health Rehabilitation and Mental Health Targeted Case Management services, and information on self-referral;
   g. processes to ensure each Member in category 1 of the Target Population ages 3 through 17 receives an initial Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 days of receipt of the DNF, and annual assessments thereafter;
   h. Non-capitated Services, including the HHSC Medical Transportation Program;
      i. dental services;
      j. DM programs;
   k. Service Coordination and Service Management for MSHCN, pregnant Members, Dual Eligibles, hospice recipients, and other special populations;
   l. Service Coordination;
   m. ECI Services;
   n. Texas Health Steps medical and dental checkups;
   o. suicide prevention;
   p. identification and health education related to Obesity;
   q. how to obtain 72-hour supplies of emergency prescriptions from Network pharmacies;
   r. vision;
   s. information maintained in the Health Passport;
   t. how Members in the HHSC OIG LP can receive outpatient drugs in an emergency situation;
   u. the availability of Transitioning Youth Program (TYP) services and supports; and
   v. Community-Based Services and LTSS such as PCS, CFC, and MDCP, and the availability of different service delivery options.

The MCO must provide a range of health promotion and wellness information and activities for Medical Consenters, Members, DFPS Staff, SSCC Staff, ICC Vendor Staff, Caregivers, guardians ad litem, judges, and attorneys ad litem in formats that meet their needs. The MCO must propose, implement, and assess innovative education strategies for wellness care and immunization, as well as general health promotion and prevention, and for addressing risk factors and stressors that influence future Abuse, Neglect, and Exploitation. 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, 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 Management, Service Coordination and DM programs described in Sections 8.1.13.2, “Medicaid Non-capitated Services,” 8.1.14, “Service Coordination,” and 8.1.16, “Disease Management.” Condition and disease specific information must be oriented to various
groups within the STAR Health Population, such as persons with Disabilities and non-English speaking Members.

Per Texas Health & Safety Code § 48.052(c), MCOs may use certified Community Health Workers to conduct outreach and Member education activities.

### 8.1.5.8 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 Cultural Competency plan must be developed in adherence to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) in the format as required by HHSC as described in **UMCM Chapter 16.1**. The Cultural Competency plan must adhere to the following: Title VI of the Civil Rights Act guidelines and the provision of auxiliary aids and services, in compliance with the Americans with Disabilities Act, Title III, Department of Justice Regulation 28 C.F.R. § 36.303, 42 C.F.R. § 438.206 (c)(2), and 1 Tex. Admin. Code § 353.411. Additionally, the Cultural Competency plan must describe how the MCO will implement each component of the National CLAS Standards as described in **UMCM Chapter 16.1**.

The Cultural Competency plan must describe how the individuals and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, languages, communication needs, and religions, as well as those with Disabilities in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. The MCO must submit the Cultural Competency plan to HHSC for Readiness Review. During Readiness Review, the Cultural Competency plan will be assessed to determine the extent to which it aligns with the National CLAS Standards as described in **UMCM Chapter 16.1**. The Cultural Competency plan must detail how the MCO implements each component of the National CLAS Standards 2 through 15. By implementing Standards 2 through 15, MCOs are working toward CLAS Standard 1, the Principal Standard: *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.*

During the Operations Phase, the MCO must submit modifications and amendments to the Cultural Competency plan to HHSC no later than 30 Days prior to implementation. The Cultural Competency plan must also be made available to the MCO’s Provider Network. HHSC may require the MCO to update the Cultural Competency 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.

The MCO must arrange and pay for Competent Interpreter services, including written, spoken, and sign language interpretation, for Members, Medical Consenter, or Legally Authorized Representative (LAR), as applicable, to ensure effective communication regarding treatment, medical history, or health condition. The MCO must maintain policies and procedures outlining the manner in which Members, Medical Consenter, or LAR as applicable, and the Members’ Providers can access Competent Interpreter services including written, spoken, and sign language interpretation when the Member, Medical Consenter, or LAR as applicable, 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, LAR, or Provider.

Upon a Provider, Member, Medical Consenter, or LAR request, in-person interpreters for scheduled appointments shall be arranged as quickly as possible, with “rush” appointments available for Urgent Conditions. For Routine Care, in-person requests will 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, Medical Consenter, or LAR, 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 not require, an advance notice timeframe for arranging an in-person interpreter. MCOs must make a good faith effort to arrange an in-person interpreter when one is requested, regardless of the advance notice.

8.1.5.9 Member Complaint and Appeal Process

The MCO must develop, implement and maintain a system for tracking, resolving, and reporting Member Complaints regarding its services, processes, procedures, and staff. The MCO must ensure that Member Complaints are resolved within 30 Days after receipt. The MCO is subject to remedies, including liquidated damages, if at least 98% of Member Complaints are not resolved within 30 Days of receipt of the Complaint by the MCO. The state will refer Member Complaints that it receives regarding the MCO to the MCO for resolution. Please see Attachment A, “STAR Health Contract Terms,” and Attachment B-3, “Deliverables/Liquidated Damages Matrix.”

The MCO must develop, implement, and maintain a system for tracking, resolving, and reporting Member Appeals regarding the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service. Within this process, the MCO must respond fully and completely to each Appeal and establish a tracking mechanism to document the status and final disposition of each Appeal.

The MCO must ensure that standard and expedited Member Appeals are resolved within the specified of receipt, 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 is subject to liquidated damages for Member Appeals not resolved within the performance standard. Please see Attachment A, “STAR Health Contract Terms,” and Attachment B-3, “Deliverables/Liquidated Damages Matrix.”

The MCO must follow the Member Complaint and Appeal Process described in Section 8.1.33, “Member Complaint and Appeal System.”

8.1.5.10 Abuse, Neglect, or Exploitation

8.1.5.10.1 Member Education on Abuse, Neglect, or Exploitation

At the time of assessment but no later than when the Medicaid Member is approved for LTSS, the MCO must ensure that the Member is informed orally and in the Member Handbook of the processes for reporting allegations of Abuse, Neglect, or Exploitation. The toll-free numbers for HHSC and DFPS must be provided.
8.1.5.10.2 Abuse, Neglect, and Exploitation Email Notifications

The MCO must provide HHSC with an email address to receive and respond to APS notifications involving Abuse, Neglect or Exploitation notifications. The MCO must respond to emails received by this email address by providing the information requested by Adult Protective Services (APS) within 24 hours of delivery 7 days a week to the MCO’s email address.

8.1.5.10.3 MCO Training on Abuse, Neglect, and Exploitation, and Unexplained Death

By September 30, 2016, the STAR and STAR+PLUS MCOs must provide Abuse, Neglect, and Exploitation, and Unexplained Death training to all MCO staff who have direct contact with a Member. Direct contact includes in person and telephone contact. MCOs must use the approved training materials provided by HHSC as set forth in the UMCM Chapter 16 regarding Policy Guidance. All newly hired staff who have direct contact with a Member must be trained no later than 30 Days from the date of hire. All employees that receive the required training must sign, upon completion of the training, an acknowledgement of their understanding of their duty to report. The MCOs must retain records of the training, including copies of all training materials during the employment of the staff member and for three years thereafter. For Service Coordinators working with Members receiving community-based Long Term Services and Supports (LTSS), this training must be provided before contact with Members served, no later than 30 Days from the date of hire and annually thereafter.

8.1.5.11 Member Service Email Address

The MCO must have a secure email address through which a Member or the Member's Provider may contact the MCO to receive assistance with identifying Network Providers and schedule an appointment for the Member or to access services. The MCO must reply to the Member’s request with an email response informing the Member or Provider that by communicating via email the Member or Provider consents to receive information through the same means. When the MCO receives the Member's email, Member Services staff must provide the Member or Member's Provider requested information within three Business Days following the receipt of the email.

8.1.5.12 Member Eligibility

The MCO must provide Medicaid eligibility renewal assistance for each Member in categories 3 and 4 of the Target Population whose eligibility is about to expire.

8.1.6 Marketing and Prohibited Practices

The MCO and its Subcontractors must adhere to the Marketing Policies and Procedures as set forth by HHSC in the Contract, and the UMCM Chapter 4.

8.1.7 Quality Assessment and Performance Improvement (QAPI)

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, maintaining 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, an Integrated Primary Care Model for medical needs, and the Main Dental Home Model for dental needs. The MCO
also must work in collaboration with Providers to improve the quality of care provided to Members, consistent with the Quality Improvement Goals and all other requirements of the Contract. The MCO must provide mechanisms for Members, Caregivers, Medical Consenters, DFPS staff, and Providers to offer input into the MCO’s Quality Improvement activities.

8.1.7.1 QAPI Program Overview

The MCO must develop, maintain, and operate a QAPI Program consistent with the Contract and TDI requirements, including 28 Tex. Admin. Code § 11.1901(b)(5) and § 11.1902. The MCO must also meet the requirements of 42 C.F.R. § 438.330.

The MCO must be accredited by a nationally recognized accreditation organization, either URAC or National Committee for Quality Assurance (NCQA), as required by Tex Gov’t Code § 533.0031. The MCO must provide HHSC and its EQRO a copy of its most recent accreditation review in accordance with 42 C.F.R. § 438.332. HHSC may use information from an accreditation organization in its oversight processes.

The MCO must have on file with HHSC an approved plan describing its QAPI Program, including how the MCO will accomplish the activities required by this section. The MCO must submit a QAPI Program Annual Summary in a format and timeframe specified by HHSC or its designee. The MCO must keep participating physicians and other Network Providers informed about the QAPI Program and related activities. The MCO must include a requirement securing cooperation with the QAPI in its Network Provider Contracts.

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. involve Member, stakeholder, DFPS Staff, Caregiver, Medical Consenter and Provider in the quality management and improvement process 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 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.

8.1.7.2 QAPI Program Structure

The MCO must maintain a well-defined QAPI 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. At a minimum, 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 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.

8.1.7.3 Clinical Indicators

The MCO must engage in the collection of clinical indicator data. The MCO must use such clinical indicator data in the development, assessment, and modification of its QAPI Program.

8.1.7.4 QAPI 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 a file of the Subcontractors. The file must be available for review by HHSC or its designee upon request.

8.1.7.5 Behavioral Health (BH) Services Integration into QAPI 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 to Members. The MCO must collect data and monitor and evaluate for improvements to physical health outcomes resulting from BH integration into the Member’s overall care.

8.1.7.6 Clinical Practice Guidelines

The MCO must adopt not fewer than four evidence-based clinical practice guidelines that apply to the STAR Health population, two for physical health and two for BH. These practice guidelines must be based on valid and reliable clinical evidence; consider the needs of the MCO’s Members; be adopted in consultation with contracting healthcare professionals, and; be reviewed and updated periodically, as appropriate. The MCO must develop practice guidelines based on the 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 90 percent or more of the Providers are consistently in compliance, based on MCO measurement findings. The MCO must employ substantive Provider motivational incentive strategies, such as financial incentives and non-financial incentives, to improve Provider compliance with clinical practice guidelines. The MCO’s decisions regarding UR, Member education, coverage of services, and other areas included in the practice guidelines must be consistent with the MCO’s clinical practice guidelines.

8.1.7.7 Medical Advisory Committee (MAC)

The MCO will establish MACs comprised of community providers and other physical health and BH experts and chaired by the MCO. The MCO will require that all provider members of the MAC have experience working with the STAR Health Population. The MCO may either establish separate and multiple MACs, which will be composed of members with specific expertise in major areas, such as dental and BH Services, or one MAC 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 MACs must include, at a minimum, acute, BH, and pharmacy providers, as well as a specialist or pediatrician experienced in the needs of medically fragile children. The MCO must maintain a record of MAC meetings, including agendas and minutes, for at least three years. The MAC will 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 state’s EQRO to develop Quality Improvement strategies and studies.

8.1.7.8 Provider Credentialing and Profiling

In accordance with Section 8.1.4.4, the MCO must review and approve the credentials of all participating licensed and unlicensed Providers who participate in the MCO’s Network. Through the QAPI process, the MCO must report annually to HHSC the results of any credentialing activities conducted during the reporting year. The MCO must use the QAPI form found in UMCM Chapter 5.

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 to use for profiling these Providers.

Provider review 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 STAR Health population;
2. including the MACs 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 reviewed, 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 Provider Network.

8.1.7.9 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;
4. at least annually, measure and report to HHSC on the Provider Network and individual Providers’ progress, or lack of progress, towards such improvement goals, and submit a plan to HHSC for quarterly monitoring of Providers who are not meeting goals; and
5. 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 should be terminated.

8.1.7.9.1 Physician Incentive Plans

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

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 for information concerning “substantial financial risk” and “stop-loss protection.”).

The MCO must make information regarding physician incentive plans available to Members upon request, in accordance with the UMCM. 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. The MCO is only required to report on items 2–4 below if the physician incentive plan covers services that are not furnished by a physician or physician group;
2. the type of incentive arrangement (e.g., withhold, bonus, capitation);
3. the percent of withhold or bonus (if applicable);
4. the panel size, and if Members are pooled, the method used (HHSC approval is required for the method used); and
5. if the physician or physician group is at substantial financial risk, the MCO must report proof that the physician or group has adequate stop-loss coverage, including the amount and type of stop-loss coverage.

8.1.7.9.2 MCO Alternative Payment Models with Providers

HHSC requires the MCOs to transition the provider payment methodologies from volume-based payment approaches, i.e. fee for service, to value-based alternative payment models (APMs), increasing year-over-year percentages of provider payments linked to measures of quality and/or efficiency, or maintaining every year the percentage of achieved the year before. The APMs should be designed to improve health outcomes for Members, empower Members and improve experience of care, lower healthcare cost trends, and reward high performing Providers.

The MCOs must demonstrate satisfactory progress towards advancing APM initiatives within an APM Performance Framework. MCOs will earn credit by meeting or making minimum progress on benchmarks in the APM Performance Framework components listed below. Specifications and benchmarks of the framework are detailed in UMCM Chapter 8. APM Performance Framework Technical Specifications.

APM Performance Framework Components:
1. **Achieve a minimum Overall APM Ratio and a Risk-Based APM Ratio.** The ratios are expressions of APM-based provider payments relative to total provider payments. The
calculations and yearly benchmark for the APM Target Ratios are delineated in UMCM Chapter 8.

2. **Implement APMs that promote improvements in priority areas and quality measures metrics specified by HHSC in UMCM Chapter 8.** Examples of HHSC priority areas include maternal health and improved birth outcomes, Behavioral Health integration, and addressing social drivers of health.

3. **Implement process to support and incentivize Providers.** The MCOs must engage and support Providers’ efforts to implement value-based care models and reward high-performing Providers, as defined by the MCO. To achieve this support the MCOs must:
   a. Share data and performance reports with Providers on a regular basis and provide or make available the data Providers need to coordinate care in an APM. MCOs must provide evidence of these reports and processes upon request by HHSC.
   b. Dedicate enough resources for Provider outreach and negotiation, assistance with data and/or report interpretation, and other activities to support Provider's improvement.
   c. To the extent possible collaborate with other MCOs within the same Service Area on the development of standardized formats for the Provider performance reports and data exchanged with Providers and align quality measures. MCOs are encouraged to sponsor or support collaborative learning opportunities for Providers in a Service Area.

4. **Submit to HHSC its inventories of APMs with Providers by August 1st of each year.** The reporting will be completed using the data collection tool in UMCM Chapter 8. Alternative Payment Models Data Collection Tool (DCT). The DCT will capture APM activity for the previous year and will be used to calculate the APM ratios and determine whether the MCOs have achieved minimum progress on the components of the APM Performance Framework. Some requirements in the DCT will vary by program. Provider types include, but are not limited to: Primary Care Providers, specialists, Hospitals, Long Term Services and Supports Providers, Chemical Dependency Treatment facilities clinics, pharmacies, and pharmacists. Upon request by HHSC, the MCOs must submit to HHSC underlying data for the information reported on the data collection tool (e.g., names of providers, NPIs, TPIs, etc.). HHSC will post on its web site basic information from reported APMs.

5. **Evaluate the impact of APMs on utilization, quality and cost, as well as return on investment (ROI).**
   a. The MCOs must evaluate the impact of their APMs. Upon request, the MCOs must report on methodologies used for APM evaluations along with results and findings related to the APM’s impact on utilization, quality, costs, provider satisfaction, or ROI.
   b. The MCOs must report to HHSC, annually, the net financial impact to Providers of APMs, including the sum of incentive payment, shared savings, and payments reductions. The financial impact to Providers must be reported in the DCT for each APM and Medicaid program.
   c. The MCOs are encouraged to develop and continually updated a strategic plan for advancing value-based care and APMs to advance quality and efficiency.

6. **Implement processes to share data and performance reports with Providers on a regular basis.** MCOs must dedicate sufficient resources for Provider outreach and negotiation, assistance with data and/or report interpretation, and other activities to support Provider’s improvement. HHSC may request evidence of these reports and processes from the MCOs. To the extent possible MCOs within Service Areas should collaborate on development of
standardized formats for the Provider performance reports and data requested from Providers.

7. Dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment.

8. MCOs must obtain HHSC approval of all APMs altering the outpatient drug benefit (pharmacy and clinician-administered) in advance of implementation. MCOs must provide a brief description of the program including its general 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. Proposals must be submitted to HHSC Pharmacy Operations inbox at vdp-operations@hhsc.state.tx.us.

If the MCO's DCT does not adhere to HHSC requirements or is not submitted by the required deadline, or if the MCO does not demonstrate minimum required progress within the APM Performance Framework, the MCO must be required to submit a corrective action plan and may be subject to additional contractual remedies, including liquidated damages.

8.1.7.9.2.1 MCO Alternative Payment Model with Certified Community Behavioral Health Clinics (CCBHCs)

MCOs must work with CCBHCs to establish an APM arrangement consistent with the requirements in UMCM Chapter 16.

8.1.7.9.3 Non-Pharmacy Preferred Provider Arrangement

A preferred provider arrangement is a contracted agreement between the MCO and one or more Providers. After the effective date of the agreement, services specified in the agreement will be delivered to Members by the Provider(s) in the preferred provider arrangement. If an MCO enters into a preferred provider arrangement, the MCO must notify Members of the arrangement in writing at least 60 Days in advance of effective date of the arrangement. The MCO must also develop and implement a process whereby Members have the choice to opt out of using the preferred provider arrangement and use another Network Provider. The MCO must provide clear written instructions on how a Member may opt out of using the preferred provider arrangement. The MCO must manage its 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 in effect prior to September 1, 2021, MCO must provide notification to its impacted Members that gives clear written instructions on how the Member may opt out of using the preferred provider arrangement. Furthermore, the MCO may not change a Member's Provider without notifying the Member of the change and giving clear written instructions on how the Member may opt out of using the Provider. Implementation of preferred provider arrangement applies to MMP as well.

When implementing a preferred provider arrangement, the MCO must notify the Providers through its internet website, at minimum every time such an arrangement is implemented. The MCO must coordinate with other Network Providers of the Covered Service during the transition to ensure continuity of care.

The MCOs must provide to the HHSC health plan manager all the Member and provider notices pertaining to the new preferred provider arrangement at least 90 Days before initiating any such arrangement. The MCO must ensure notices comply with UMCM Chapter 4.
To be counted as an APM under section 8.1.7.9.2, a preferred provider arrangement must be based on a provider’s performance on metrics of quality or value and meet the requirements set forth in Section 8.1.7.9.2.

8.1.7.10 Collaboration with the External Quality Review Organization (EQRO)

The MCO will collaborate with HHSC’s 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. To facilitate this process, the MCO will supply claims data to the EQRO in a format identified by HHSC in consultation with the MCO and will supply medical records for focused clinical reviews conducted by the EQRO. The MCO must also work collaboratively with HHSC and the EQRO to annually measure HHSC selected HEDIS measures that require chart reviews if requested by the EQRO. MCOs must conduct chart reviews, for HEDIS hybrid measures and submit results to the EQRO in a format and timeline specified by HHSC. MCOs are responsible for all costs associated with these reviews.

8.1.8 Utilization Management (UM)

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, including BH Services;
2. the clinical review criteria used, the information sources, and the process used to review and approve the provision of Covered Services, including BH Services;
3. the method for periodically reviewing and amending the UM clinical review criteria; and
4. the staff position functionally responsible for the day-to-day management of the UM function.

The MCO must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UM determinations. When making UM determinations, the MCO must comply with the requirements of 42 C.F.R. § 456.111 (Hospitals) and 42 CFR § 456.211 (Mental Hospitals), as applicable. UM should specifically assess prescribing patterns for psychotropic medications against the Psychotropic Medication Utilization Parameters for Foster Children 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, according to the following timelines:

1. within one Business Day of receiving, or identifying a need to extend, the request for concurrent hospitalization decisions;
2. within one hour of receiving the request for post-stabilization or life-threatening conditions, except that for Emergency Medical Conditions and Emergency BH Conditions, the MCO must not require a PA;
3. for a Member who is hospitalized at the time of the request, within one Business Day of receiving the request 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 Out-of-Network Provider, Provider of Acute Care Inpatient Services, or a Member; and
4. within three Business Days after receipt of all other prior authorization requests. For prior authorization requests received with insufficient or inadequate documentation, MCOs
must follow timeframes established by the commission as set forth in UMCM Chapter 3.22.

The MCO must have a process in place that allows a Provider to submit a prior authorization or service authorization request for services at least 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’s UM Program must include written policies and procedures to ensure:

1. consistent application of review criteria that are compatible with Members’ needs and situations;
2. determinations to deny or limit services are made by physicians under the direction of the Medical Director; and
3. the prior authorization process does not result in undue delays in services;

4. appropriate personnel are available to respond to UR inquiries 8:00 a.m. to 5:00 p.m. local time throughout the state, Monday through Friday, and respond to calls within one Business Day, with a telephone system capable of accepting UM inquiries outside of these hours;
5. confidentiality of clinical information;
6. compensation to individuals or entities conducting UR 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), and quality is not adversely impacted by financial and reimbursement related processes and decisions;
7. the effectiveness and the efficiency of the UM Program is routinely assessed;
8. the appropriate use of medical technologies, including medical procedures, drugs and devices, is evaluated;
9. areas of suspected inappropriate service utilization are targeted;
10. over- and under-utilization is detected;
11. reports regarding Provider utilization patterns and compliance with UM criteria and policies are routinely generated;
12. Member and Provider utilization is compared with norms for comparable individuals.
13. inpatient admissions, emergency room use, ancillary, 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. when Members are receiving BH Services from the LHMA the MCO is using the same UM guidelines as those prescribed by DSHS for use by LHMAAs and published on the DSHS website.
16. suspected cases of Provider or Member Fraud, Waste, or Abuse are referred to the HHSC Office of Inspector General (HHSC OIG) as required by Section 8.1.25, “Fraud, Waste, and Abuse.”

At the MCO’s discretion, pharmacy PA determinations may be made by pharmacists, subject to the limitations described in Attachment A, Section 4.04, “Medical Director.”

Qualified medical professionals must supervise UM Program staff making preauthorization and concurrent review decisions.

In accordance with the requirements in UMCM Chapter 16 MCOs must share utilization management data among all relevant MCO employees, including both physical and Behavioral
Health staff, or, if applicable, between the MCO and the third party or subsidiary contracted with the MCO to manage Behavioral Health Services.

8.1.8.1 Compliance with State and Federal Prior Authorization (PA) Requirements

For Medicaid, the MCO must adopt PA requirements that comply with state and federal laws governing authorization of healthcare services and prescription drug benefits, including 42 U.S.C. § 1396r-8 and Texas Government Code §§ 531.073 and 533.005(a)(23). In addition, the MCO must comply with Texas Human Resources Code § 32.073 and Texas Insurance Code §§ 1217.004 and 1369.304, which require MCOs to use national standards for electronic PA of prescription drug and healthcare benefits no later than two years after adoption, and accept PA requests submitted using the 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. MCOs may choose to reissue PAs or publish guidance to providers on updating current PAs. 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.

8.1.8.2 Toll-free Fax Line for Service Authorizations

The MCO must provide access to a toll-free fax line and Provider portal where Providers may send requests for authorization of services and any supplemental information related to service authorization, including medical documentation supporting certain NEMT Services requested by the Member. The fax line must be available 24 hours per day, 7 days a week.

8.1.9 Early Childhood Intervention (ECI)

8.1.9.1 Referrals

The MCO must ensure Network Providers are educated regarding the federal laws on child find and referral procedures (e.g., 20 U.S.C. § 1435 (a)(5); 34 C.F.R. § 303.303). The MCO must require Network 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 Chapter 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 MCOs is required to provide medically necessary services to a Member if the Member’s Medical Consenter chooses not to participate in ECI.
8.1.9.2 Eligibility

The local ECI program will determine eligibility for ECI services using the criteria contained in 26 Tex. Admin. Code Chapter 350.

The MCO must cover medical diagnostic procedures required by ECI, 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 available as needed.

8.1.9.3 Providers

The MCO must contract with an adequate number of qualified ECI Providers to provide ECI services to Members under the age of three who are eligible for ECI services. The MCO must allow an Out-of-Network provider to provide ECI covered services if a Network Provider is not available to provide the services in the amount, duration, scope and service setting as required by the Individual Family Service Plan (IFSP).

8.1.9.4 Individual Family Service Plan (IFSP)

The IFSP identifies the Member’s present level of development based on assessment, describes the services to be provided to the child to meet the needs of the child 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 LAR; the ECI service coordinator; ECI professionals directly involved in the eligibility determination and Member assessment; ECI professionals who will be providing direct services to the child; other family members, Caregivers, advocates, or other persons as requested by the authorized representative. If the Member’s family or Caregiver provides written consent, the Member’s PCP or MCO staff may be included in IFSP meetings. The IFSP is a contract between the ECI contractor and Member’s LAR.

Ongoing case management does not include ECI Targeted Case Management services.

The Member’s LAR 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 Member’s LAR 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. These sections may be included in the Member’s medical record or service plan.

The MCO must allow services to be provided by an OON provider if a Network Provider is not available to provide the services in the amount, duration, scope and service setting as required by the IFSP.

8.1.9.5 Covered Services and Reimbursement

The interdisciplinary team, including a licensed practitioner of the healing arts, as defined in 26 Tex. Admin. Code § 350.103, practicing within the scope of their license, determines medical necessity for ECI covered services established by the IFSP. The IFSP will serve as authorization for program provided services, and the MCO must require, through contract provisions with the Provider, that all Medically Necessary health and Behavioral Health 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. “Program-provided” services refers to services that are provided by the ECI contractor.

The MCO cannot create unnecessary barriers for the Member to obtain IFSP program provided services, including requiring prior authorization for the ECI assessment or additional authorization for services, or establishing insufficient authorization periods for prior authorized services.

ECI Providers must submit claims for all covered services that are program provided included in the IFSP to the MCO. The MCO must pay for claims for ECI covered services in the amount, duration, and scope and service setting established by the IFSP.

ECI Targeted Case Management services and Early Childhood Intervention Specialized Skills Training are Non-capitated Services, as described in Section 8.1.28.8.

Members in ECI will be classified as Members with Special Healthcare Needs (MSHCN) as described in Section 8.1.13. MCOs must offer Service Management and develop a Service Plan as appropriate for these Members. With the consent of the Member’s authorized representative, the MCO must include key information from the IFSP in the development of the Member’s Service Plan.

8.1.10 Special Supplemental Nutrition Program for Women, Infants, and Children - Specific Requirements

The MCO must, by 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, such as height, weight, hematocrit or hemoglobin. The MCO must make referrals to WIC of Members potentially eligible for WIC. The MCO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract.

8.1.11 Coordination with the Department of Family and Protective Services (DFPS)

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 to the success of this initiative that the MCO and DFPS develop a positive and productive relationship to ensure that the STAR Health population receives the best possible physical and BH outcomes. The MCO must cooperate and coordinate with DFPS for the care of a child or young adult who is receiving services from or has been placed in DFPS conservatorship. The MCO Service Coordinators and Service Managers 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 Sections 8.1.13.2, “Access to Care and Service Management,” and 8.1.14, “Service Coordination,” including development of the Case Plan. The MCO will also provide training opportunities including web-based and trainings at the regional level to DFPS staff. The MCO must cooperate and coordinate with staff from the SSCCs and ICC Vendor when doing so would improve the coordination of Medically Necessary Healthcare 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 SSCCs and ICC Vendor develop positive working relationships with these organizations. The SCC is not responsible for the case management function of foster care but should coordinate with STAR Health Providers and
DFPS to ensure the provision of relevant eligible services to children under SSCC or ICC Vendor care as described in the definition of Integrated Care Coordination.

The STAR Health MCO will use the DNF to determine a placement change has occurred by identifying if a Member’s address and the caregiver’s name on the DNF have changed. The MCO will give notice to the Primary Care Physician (PCP) listed in the Health Passport before the end of the second Business Day after the day the MCO receives notification from DFPS.

The MCO must ensure continuity of care and notify each specialist treating the Member of any placement change and coordinate the transfer of care from the previous treating PCP and specialists to the new treating PCP and specialists. To ensure coordination and tracking of the CANS assessment as described in Section 8.1.11.3 the MCO will send a CANS error report to DFPS once a week.

The MCO must ensure that an MCO Medical Director participates in a DFPS medical staffing about a placement change for an MSHCN or a Member with Primary Medical Needs, as described in Section 8.1.2.2, if DFPS requests such participation at least 48 hours before the staffing.

The MCO must require Service Managers, Service Coordinators, Member Advocates, CONNECTIONS Representatives, and any other staff positions that may have direct contact with Members or Member information to pass a background check as a condition of hire, and every two years thereafter. These staff members will not be placed in contact with Members, nor be permitted to access Member information, until DFPS has completed the initial background check. All staff not having passed a background check, and all staff alleged to have committed a criminal offence that would prohibit him or her from having contact with Members pursuant to DFPS regulations in 26 Tex. Admin. Code, Chapter 745, Subchapter F, Division 3, will be removed from all STAR Health functions in which direct contact with Members or Member information is expected.

The MCO must contractually require Providers to testify in court as needed for child protection litigation. The MCO must comply with all provisions related to Covered Services included in a Court Order. DFPS is responsible for ensuring the MCO receives timely a copy of any newly issued Court Order.

The MCO cannot deny, reduce, or controvert the Medical Necessity of any Covered Service included in a Court Order. Any modification or termination of a Court Ordered service must be presented to and approved by the court having jurisdiction over the matter.

If there is a dispute over the Medical Necessity of any Covered Services for any Member, the Member, the Member’s Medical Consenter, or DFPS Staff, as appropriate, will use the HHSC MCO Complaint and Appeal processes or the Fair Hearing process as described in Sections 8.1.33, “Member Complaint and Appeal Process,” and 8.1.33.5, “Access to Fair Hearing for Members.”

The MCO, DFPS, and HHSC will meet on a schedule determined by HHSC to address issues and concerns that arise during the Transition and Operations Phases. HHSC may require the MCO to revise processes and procedures, modify trainings or educational materials, or make other Program changes as a result of these meetings. 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 STAR Health Program requirements and streamline processes as necessary.
8.1.11.1 Training for Law Enforcement Officials and Judges

The MCO must provide training for law enforcement officials, judges, district and county attorneys representing DFPS, and attorneys and guardians ad litem regarding the requirements of the Contract and special needs of Members. HHSC and DFPS may also participate in these trainings. The MCO may 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 STAR Health population;
2. requirements for providing Medically Necessary Covered Services; to the STAR Health population including:
   a) required timelines for Healthcare Services and assessments as defined in the contract and in DFPS policies;
   b) legal review of Member needs, treatment plans and healthcare progress as part of court hearings; and
   c) other DFPS policies as required;
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 MCOs judicial email box for questions about psychotropic medication utilization issues, and other concerns.

8.1.11.2 STAR Health 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 issues identified by the MCO, DFPS, or HHSC that arise related to STAR Health or to the individual healthcare of a Member. STAR Health Liaisons must be housed regionally and be available to coordinate with DFPS to develop workflows and processes, including those related to the transmission of clinical and non-clinical Member information. STAR Health Liaisons will also take a leading role in identifying training needs for the MCO and DFPS staff.

STAR Health Liaisons will outreach to and assist Members who are transitioning into Target Population category 3 and will refer Members to the Transitioning Youth Program (TYP) as appropriate. STAR Health Liaisons will coordinate with DFPS Transitioning Services staff and with DFPS contracted Transition Centers listed on the DFPS website to develop workflows and processes that will ensure outreach to this population is successful.

8.1.11.3 Assessments

The MCO must ensure that all Members in category 1 of the Target Population age 3 through 17 are assessed by a BH Provider using the Texas Comprehensive CANS 2.0 (child welfare) tool within 30 days of receipt of the DNF. For Members enrolled in Service Management, the results of the assessment must be used to inform the Member’s Healthcare Service Plan.
The MCO must establish a process to ensure that the results of the Texas Comprehensive CANS 2.0 (child welfare) assessment tool are communicated to the Member's PCP, PCP Teams, BH Providers, Caregivers, Medical Consenters, and DFPS Staff.

To ensure continuity of care, the MCO must ensure that the Member, who requires an assessment as described in Section 8.2.1, is reassessed using the STAR Kids Screening and Assessment Instrument prior to the expiration date of the Member's Individual Service Plan (ISP). The MCO must ensure that the reassessment is timed to prevent any lapse in service authorization or program eligibility.

The MCO must coordinate the assessment and gathering of any required documentation in a manner that ensures that the authorization and initiation of a Member's services are in no way delayed and that the Member's access to care is in no way delayed or limited. The MCO must ensure there is not a lapse in service, service authorization, or delay in the initiation of any services for the Member due to the MCO's inability to obtain information required by HHSC or to obtain any additional information that may be requested by the MCO in a particular case. 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 26 Tex. Admin. Code Part 749, Subchapter B, Division 2, “Services”, may require expedited assessments, as determined by DFPS Staff or SSCC staff. The MCO must work with DFPS Staff, ICC Vendor, or SSCC staff, as appropriate, to determine which assessment(s) it will authorize and schedule the requested assessment(s) within three Business Days. The MCO must provide the resulting diagnosis and recommendations from the Provider performing the assessment to DFPS staff, ICC Vendor, or SSCC staff within two Business Days of MCO receipt. Expedited assessments may include psychosocial, psychological, psychiatric, neurological, physical or other assessments that would assist DFPS or its agent in identifying needed treatment services for a Member.

8.1.12 Health Passport

The MCO must develop and maintain a web-based Health Passport system to provide an Electronic Health Record (EHR) for all Members. The Health Passport will facilitate Service Management and Continuity of Care for Members, as well as streamline data sharing and coordination between the Members’ Providers and DFPS. The Health Passport will function as an easily accessible, paperless repository of information related to each Member, his or her Providers, demographics, medical services rendered, and pertinent administrative documentation.

8.1.12.1 Required Features and Data Elements

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 in the Contract. The Health Passport must be available 24 hours per day, seven days per week, except during limited scheduled system downtime. Routine scheduled downtime must be posted on the MCO website. The MCO must communicate non-routine scheduled downtime to HHSC and the DFPS Help Desk before the scheduled downtime occurs.

The Health Passport must be maintained in a web-based electronic format with the following minimum system functions and features:
1. Advanced security capabilities to protect Member confidentiality and comply with security and privacy rules adopted by the U.S. Department of Health and Human Services (HHS) under HIPAA, 45 C.F.R. §§ 164.302–318; 164.500–534, the HITECH Act, all applicable state and federal laws, including Texas Administrative Code Chapter 390, and current Information Security Controls (Enterprise Information Security Standards and Guidelines (EISSG), which can be found at https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/contracting/information-security-controls.pdf; retention of records until the Member reaches age 26 or the timeframe prescribed in Attachment A, Section 9.01, “Financial record retention and audit,” (whichever occurs later);

2. role-based access to Health Passport data by designated parties as defined by HHSC, in which the Member’s designated PCP and additional Providers must be clearly identifiable by role in the Health Passport;

3. additional security layer for the following cases:
   a. cases deemed sensitive by DFPS to allow access only by personnel as designated by DFPS; and
   b. cases regarding Members who are not in DFPS conservatorship, including newborn Members, AA Members, PCA Members, and FFCC Members;

4. secure user access to prevent unauthorized use of data, data loss, tampering and destruction;

5. audit trail functionality to include security audits (logging of Health Passport access attempts) and data audits (logging when, and by whom, records are created, viewed, updated, extracted, or deleted), in which the MCO must report any security breach in the Health Passport system to HHSC and DFPS within 24 hours of the breach;

6. integration of the Health Passport with the 24-hour Nurse Hotline and BH Hotline to allow case-specific access to Health Passport records by designated Hotline staff;

7. integration of the Health Passport with the MCO’s Provider portal;

8. sorting and printing capacity supported at a record and data category basis;

9. ad hoc reporting functionality;

10. transferability and exportability of the complete Health Passport database in a file format designated by HHSC; and

11. export of Member clinical data to a portable, electronic format that can be imported into Certified Electronic Health Record Technology (CEHRT) to allow providers to maximize their use of electronic Member data. Implementation of this functionality should carefully follow up-to-date guidance of the Office of the National Coordinator for Health IT, which specifies the standards and criteria for interoperability of software involved in Member care. Current criteria call for the use of Consolidated Clinical Document Architecture (CCDA) to describe clinical data elements and the use of the XML-based Continuity of Care Document (CCD) template as the format by which the data elements are organized.

The MCO must establish a Health Passport Steering Committee and processes by which potential enhancements, new functionality, or additional features can be proposed, reviewed, and prioritized for implementation. The Committee must include representation from HHSC, DFPS, and stakeholders who use the application on a regular basis. The MCO must maintain a record of Steering Committee meetings, including agendas, minutes, and timelines for project completion.

The MCO is required to include the following data items in the Health Passport:
1. Member-specific information including name, address of record, date of birth, race/ethnicity, gender, and other demographic information, as appropriate, for each Member;

2. name and address of each Member’s Primary Care Physician, Caregiver and Medical Consenter with clear designation of Member’s authorized Medical Consenter;

3. name and the direct phone number of each Member’s DFPS caseworker as well as the direct phone number of non-medical personnel such as Service Coordinator and Service Manager, as appropriate;

4. acquisition and retention of the Member’s Medicaid ID and DFPS personal identification number ("Person ID"), when available, are required;

5. the initial HCSP, as well as any updates, for each Member who is receiving Service Management, including the plan of treatment to address the Member’s physical, psychological, and emotional healthcare problems and needs, and identification of enrollment in a Disease Management (DM) program, the Transitioning Youth Program (TYP) or other type of specialized assistance the Member is receiving;

6. record of all Psychotropic Medication Utilization Reviews (PMUR), to include the outcome of each review and any actions taken to address identified concerns with the Member’s medication regimen;

7. provider-specific information including, name of Provider, professional group, or facility, Provider’s address and phone number, and Provider type including any specialist designations and credentials;

8. record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Texas Health Steps program, that include the date of the service event, location, Provider name, the associated problem(s) or diagnosis, and treatment given, including drugs prescribed;

9. record of future scheduled service appointments and referrals, when known;

10. record of all diagnoses applicable to the Member, with emphasis on BH diagnoses utilizing either the applicable DSM or ICD national code sets as based on claims submitted;

11. record of current and past medications and doses (including psychotropic medications), interaction alerts, and where available, the prescribing physician, date of prescription(s) and target symptoms;

12. record and results of all Texas Health Steps medical, dental, and BH exams, including all required information from Texas Health Steps forms;

13. monthly progress notes from BH exams or treatments, submitted more frequently if necessary, to document significant changes in a Member’s treatment or progress. Notes must include the following:
   a. Primary and secondary (if present) diagnosis;
   b. assessment information;
   c. brief narrative summary of Member’s progress or status;
   d. scores on each outcome rating form(s);
   e. referrals to other Providers or community resources; and
   f. any other relevant care information;

14. Family Strengths and Needs Assessment (FSNA) assessment, as submitted by DFPS;

15. The Texas Comprehensive CANS 2.0 (child welfare) assessment, including:
   a. scores from the rating sheet; and
   b. the results page, including narrative and recommendation fields;

16. listing of Member’s known health problems and allergies;

17. complete record of all immunizations, supplemented by and exchangeable with data from ImmTrac2, the Texas Immunization Registry that meets the
requirements of Texas Health & Safety Code Chapter 161 as well as the recommended immunization schedules for Members age birth through 18 years, and the catch-up immunization schedule as posted on the Centers for Disease Control and Prevention (CDC) website;

18. listing of Member’s DME must be reflected in the claims or “Visits” module, and in the Member’s HCSP, if Member is in Service Management;

19. any utilization of an informational code set, such as ICD-10, should provide the used code value as well as an appropriate and understandable code description (this is applicable to codes pertaining to a service event, healthcare Provider, and Member records.);

20. laboratory test results; and

21. functionality that assists DFPS Caseworkers.

The Health Passport may contain additional information proposed by the MCO and approved by HHSC.

### 8.1.12.2 Usage Requirements

The MCO and the Member’s Providers, as appropriate, will be responsible for updating each Member’s Health Passport with the required medical information. The MCO must contractually require Providers to submit information for the Health Passport. The MCO must design an efficient system that will allow Providers to either input data directly into the Health Passport at the point of service through a web-based interface or submit the required information to the MCO for entry into the Health Passport.

The MCO must develop a process to encourage that Providers submit monthly BH progress notes, required forms, and assessment information to the Health Passport in a timely manner.

The MCO may design the Health Passport in such a way as to allow for electronic communication via the Health Passport among the Member’s Network Providers for Service Management and service planning purposes.

If the status of an authorized user of the Health Passport changes, the MCO must terminate the user’s access to the Health Passport system within 24 hours of notification of the user’s change in status. Examples of status changes include a Provider leaving the MCO’s Network, or a DFPS employee leaves employment with DFPS. When a Member is disenrolled from the MCO, web access to the Member’s Health Passport must be suspended for all users except for the approved DFPS users who shall continue to have access to all records. The MCO must retain the Member’s records in a manner such that the Health Passport may be readily reinstated should the Member return to conservatorship and be re-enrolled with the MCO.

To facilitate Service Management, the MCO will provide a daily upload to HHSC/DFPS of designated Health Passport data, as determined by HHSC, via the use of an exchange File Transfer Protocol (FTP) site that will be designated by HHSC.

The MCO must develop instructional and training materials for Health Passport users, including web-based materials.

### 8.1.12.3 Health Passport Reporting Requirements

The MCO is required to report to HHSC on measures of Health Passport usage and compliance by Providers. The MCO must produce the following deliverables for this purpose:
Passport Usage Summary Report — The MCO must submit this deliverable on a quarterly basis. The report is utilized to show the overall usage of the Health Passport system. The report must include the following data elements for each user role, and including geographical trending of the data:

1. Number of registered Health Passport users,
2. number of unique Member charts viewed,
3. number of forms used, and
4. number of log ins.

Care Coordination Report — The MCO must submit this deliverable on a quarterly basis. The report is utilized to show the extent to which the Health Passport system is assisting in the coordination of BH and physical health services. The report must include the number and percentage of:

1. Member records that have been accessed by both the Member’s BH Provider and physical health provider, and
2. Members who have received both BH and physical health services, as demonstrated by claims data.

Quarterly Forms Review — The MCO must submit this deliverable on a quarterly basis. The report is utilized to show the extent to which Providers are submitting contractually required documents for Texas Health Steps and BH visits. The report must include the following data elements:

1. The number of compliant and non-compliant Health Passport form submissions for Texas Health Steps and Behavioral Health,
2. a list of Providers, and their provider type, responsible for the highest number of non-compliant submissions.

Excessive Usage Report — The MCO must submit this deliverable on a daily basis. The report is utilized to show users who have exceeded the typical number of log-ons to the Health Passport system. The MCO must maintain standardized usage thresholds for each user type (e.g., Medical Consenter, DFPS Caseworker, CASA staff, physician) that will be used to measure excessive usage. The MCO must review a user exceeding his or her assigned threshold in a given day to ensure the user’s use of the Health Passport is appropriate. The MCO must refer situations involving the possible abuse of the Health Passport system to HHSC and DFPS for their additional review. This report must include the following data elements:

1. The names of the users and user types that appear to that exceed the usage threshold within a specified date range.
2. The number of times each user accessed the system within a specified date range.
3. The date and time of each access.

Full Access Report — The MCO must submit this deliverable on a daily basis. The report contains detailed information on each Member associated to an excessive usage incident recorded in the Excessive Usage Report. This report is utilized to assist HHSC and DFPS in determining the appropriateness of a user’s use of the Health Passport system. The report must include the following data elements:

1. The name of each Member accessed.
2. The name of the user and user type that accessed each Member’s record.
3. Each area of that Member's record that was accessed during the incident.
8.1.12.4 Health Passport Mobile Accessibility

The MCO must develop and maintain accessibility and secure viewing of Health Passport EHRs on users' mobile devices. At a minimum, this mobile accessibility must meet requirements for usability, security, availability, and downtime described in items 1-6 of the minimum system functions and features listed in Section 8.1.12.1, "Required Features and Data Elements." The mobile accessibility must be implemented by the Operational Start Date. At a minimum, the mobile access must be capable of displaying all data items listed in Section 8.1.12.1 "Required Features and Data Elements."

8.1.12.5 Health Passport Review Requirements

The MCO must develop and maintain a process to review, at least once every three months, a statistically valid sample of the Health Passports of Members currently enrolled in Service Management to determine if the Member’s Health Passport displays the data items required by Section 8.1.12.1, including the HCSP. If the MCO determines that the HCSP has not been completed, is missing data, or is not updated, the MCO must add or correct the HCSP within 30 Days. If the Service Manager is unable to speak to the Member or Medical Consenter in person or by telephone about completing or revising the HCSP after three attempts on different Days, the Service Manager must escalate the issue to the regional DFPS well-being specialist within 14 Days after the third attempt to speak to the Member or Medical Consenter.

8.1.13 Services for Members with Special Healthcare Needs (MSHCN)

8.1.13.1 Identification

The MCO must develop and maintain a system and procedures for identifying Members with Special Health Care Needs (MSHCN). HHSC has designated Members in the following groups as MSHCN:

1. Members with Severe Emotional Disturbance (SED);
2. Members with disabilities or Chronic (or Complex Conditions, including high-cost catastrophic cases);
3. Members with high-risk pregnancies;
4. ECI program participants;
5. Dual Eligibles;
6. Members enrolled in HHSC hospice services; and
7. Medically Dependent Children's Program (MDCP) recipients.

The MCO must use data obtained through its Service Management screening process, or other methods such as codes in the Enrollment Files, claims data, and medical history data, to identify Members who qualify as MSHCN. The MCO must contact a Member identified as MSHCN, as well as DFPS Staff, Caregivers, and Medical Consenters to inform them that the Member meets the MCO's MSHCN criteria and has conditions requiring special services described in Sections 8.1.13.2, 8.1.13.3, 8.1.13.4 and 8.1.14. The MCO’s screening process and other mechanisms to evaluate MSHCN must use appropriate healthcare professionals.

Except in designated foster care redesign areas, DFPS contracts with Youth for Tomorrow to identify service levels for the STAR Health population for the purposes of determining placement. DFPS will provide this information to the MCO in the event this information is helpful in designing HCSPs for Members.
The MCO must provide information to the HHSC Administrative Services Contractor that identifies Members assessed to be MSHCN by the MCO. The information must be provided to HHSC as specified in the Joint Interface Plan (JIP) found in the UMCM Chapter 7. The information must be updated with newly identified MSHCN by the 10th Day of each month.

In the event that a MSHCN is disenrolled from the MCO and enrolled in another health plan, such as in STAR, STAR+PLUS, STAR Kids, CHIP, or commercial insurance, the MCO must provide the receiving health plan with information concerning the results of the MCO’s identification and assessment of that Member’s needs, to prevent duplication of those activities.

Once the MCO has identified a Member as MSHCN, it must have effective systems in place to ensure the provision of Covered Services to meet the special, preventive, Community-Based Services, LTSS, primary Acute Care, and specialty health care needs appropriate for treatment of the Member’s condition. The MCO must provide Service Management to MSHCN, including the development of a Healthcare Service Plan and ensuring access to a multidisciplinary team when necessary, as described in Section 8.1.14.

To ensure Continuity of Care, if a MSHCN is transitioning from another health plan, the MCO must contact the Member’s prior health plan and request information regarding the Member’s needs, current medical necessity determinations, authorized care and treatment plans. To ensure Continuity of Care for a MSHCN receiving services authorized in a treatment plan by their prior health plan, the Service Manager will authorize the Member to continue with his or her provider, and allow an OON authorization to ensure the Member’s condition remains stable and services are consistent to meet the Member’s needs. The OON authorization will continue until the authorized treatment plan is completed or the MCO can provide comparable services to transition the Member to a Provider who will be able to meet the Member’s complex needs.

The MCO must have Network PCPs and specialty care Providers that have demonstrated experience with MSHCN, including SED, in pediatric specialty centers such as Children’s Hospitals, teaching Hospitals, and tertiary care centers, and in community mental health centers or other venues for treatment of SED.

The MCO must provide access to PCPs and specialty care Providers with experience serving MSHCN, including SED and Members who have experienced trauma, Abuse or Neglect. Such Providers must be board-qualified or board-eligible in their specialty. The MCO may request exceptions from HHSC for approval of traditional Providers who are not board-qualified or board-eligible but who otherwise meet the MCO’s Credentialing requirements.

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. The MCO must also provide MSHCN with access to non-primary care physician specialists as PCPs, as required by 28 Tex. Admin. Code § 11.900 and Section 8.1.4.2.

The MCO must provide information and education in its Member handbook and Provider manual about treatment planning available for MHSCN, including the availability of Service Management.

**8.1.13.2 Access to Care and Service Management**

The MCO must provide Service Management to 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). The MCO Service Managers must identify Members who may benefit from Service Management, conduct a screening and provide Service Management when appropriate. The MCO must contact the identified Member, Caregiver, DFPS Staff or Medical Consenter to communicate the benefits of Service Management and encourage the Member’s participation in Service Management. Service Management is not solely for MSHCN. PCPs, PCP Teams, Caregivers, Medical Consenters, and DFPS Staff can request Service Manager assistance at any time to coordinate healthcare planning and the integrated delivery of all Covered Services. Service Management includes coordination of services and authorizations to prevent duplication for clients who require THSteps - Comprehensive Care Program Services, such as coordination between Private Duty Nursing and PPECC providers.

The MCO must identify to the Member, Medical Consenter, and DFPS Caseworker, a single Service Manager to be the main point of contact for Members, Medical Consenters, and DFPS staff. The single identified Service Manager is responsible for coordinating with other MCO staff, including other Service Managers, and Discharge planning teams, to ensure integrated physical and Behavioral Health care and minimize disruption of services for the Member currently enrolled in Service Management.

To ensure Continuity of Care for MSHCN receiving services authorized in a treatment plan, transition plan, or Individual Service Plan (ISP) by their prior health plan, the MCO and Service Managers will work with the Member’s current PCP and specialists to ensure the Member’s condition remains stable and services are consistent to meet the Members ongoing needs. The Service Manager will authorize the transitioning Member’s OON providers to continue with the current treatment plan authorized by the Member’s prior health plan until the initial HCSP is completed or the MCO can provide comparable services to transition the Member to a Provider who will be able to meet the Member’s complex needs.

For Dual Eligible Members, the Service Manager must work with the Member’s PCP to coordinate all Covered Services and any applicable Non-capitated Services, regardless of whether the PCP is in the MCO’s Network. Dual Eligible Members receive most Acute Care services through Medicare, rather than Medicaid. Service Managers must coordinate Medicare and Medicaid services for Dual Eligible Members.

The MCO will complete Service Management screenings for all new Members to establish the degree to which Service Management is needed. During this telephonic screening, the MCO must ensure that the Medical Consenter is aware that Members in category 1 of the Target Population age 3 through 17 must receive the Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 days of receipt on the DNF. The MCO must assist in scheduling this assessment with a BH Provider that is trained and certified in the administration of the CANS assessment tool.

The MCO must complete an initial HCSP within 45 Days after receipt of the Member on the DNF for each new Member whose screening indicates a need for Service Management. The MCO must ensure the initial HCSP includes recommended services indicated on the results page of the Texas Comprehensive CANS 2.0 (child welfare) assessment. The MCO must offer Service Management or Service Coordination to the Member or the Member’s Caregiver if the results of the Service Management screening or the Texas Comprehensive CANS 2.0 (child welfare) assessment indicate a need for either of these services. The MCO must not remove Members from Service Management unless requested by the Member or Medical Consenter.

The MCO will complete a new Service Management screening each time a Member moves to a new placement. If the screening indicates the need for Service Management, an HCSP must be
completed or updated by the MCO within 30 Days of notification of the Member's move to a new placement.

The MCO must develop HCSPs for MSHCN using Person-Centered Planning. The MCO must develop a process by which Members' HCSPs are reviewed and updated on a regular basis. The MCO must ensure the HCSP includes the components of a Person-Centered service plan described in 42 C.F.R. § 441.301(c)(1) and (2). The MCO must develop and implement the HCSP with and ensure that it is understandable to the Member or the Member's Medical Consenter. The MCO must revise the HCSP within 10 Business Days after the Member's health condition changes or a Member, Medical Consenter or DFPS staff requests a revision to the HCSP. Telephone call attempts to update the HCSP must be made over a minimum of seven Business Days. The MCO must update the HCSP each time an annual Texas Comprehensive CANS 2.0 (child welfare) assessment is completed. The HCSP for Members with an SED must include a contingency crisis plan.

The HCSP must include, but is not limited to, the following:

1. the Member's history;
2. the Member's service preferences;
3. short and long-term needs, personal preferences, and outcomes for the Member and Member's Medical Consenter;
4. the Member's natural strengths and supports, such as the Member's abilities or family members;
5. a summary of the Member's current medical and social needs and concerns including:
   a. Behavioral Health Services needs, including Substance Use Disorder treatment needs that meet the guidance outlined in UMCM Chapter 16;
   b. physical, occupational, speech, or other specialized therapy services needs;
   c. durable medical equipment and medical supplies needs;
   d. needed nursing services, including Home Health Skilled Nursing, Private Duty Nursing, and nursing services offered through a Prescribed Pediatric Extended Care Center;
   e. prescription drugs, including psychotropic medications needs; and
   f. transportation needs;
6. a list of Covered Services required for the Member, and the frequency of those services;
7. a description of who will provide the Member's services; and
8. a list of services that are not Covered Services, community supports, and other resources that the Member already receives or that would be beneficial to the Member.

The MCO must provide information and education in its Member handbook and Provider manual explaining how Members, Caregivers, and Medical Consenters may access Service Management or request a PCP Team. The MCO is responsible for providing Service Management to assist in developing an HCSP for Members enrolled in Service Management,
and to facilitate access to clinical treatment and services recommended by the PCP Team or the results of the Texas Comprehensive CANS 2.0 (child welfare) and approved by the DFPS Caseworker, Member, or their Medical Consenter. A refusal to utilize Service Management and the development of a HCSP for a Member must be authorized by the DFPS caseworker and documented in the Member’s file and Health Passport.

Service Managers who provide assistance to MDCP Members must be trained in the following:

1. The full MDCP service array and program requirements;
2. Provider requirements for each service described in Section 8.2, "Additional Requirements Regarding the Medically Dependent Children Program (MDCP);
3. The three service delivery options described in Section 8.1.41, "Service Delivery Options"; and
4. 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 home and community-based Long-Term Services and Supports using 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 Manager training requirements. Service Managers must also receive an HHSC-approved or HHSC-offered Person-Centered training refresher course every two years.

For all MDCP Members, the HCSP must include the MDCP plan of care and meet all additional requirements in Section 8.2, "Additional Requirements Regarding the Medically Dependent Children Program (MDCP) and subsections.

Service Managers will work with the PCP Team to avoid separate and fragmented evaluations, HCSPs and treatment. The MCO’s Service Management process and procedures for assisting Members must include how the Service Manager will:

1. work with DFPS staff, SSCC staff, ICC Vendor staff, Members, Medical Consenters, PCPs, specialists, other Providers and DM staff, as appropriate, to ensure that the Member’s medical and BH needs are coordinated;
2. ensure that the initial and all annual Texas Comprehensive Child Adolescent Needs and Strengths Assessments 2.0 (CANS) have been completed timely, and the results and recommendations shared with Members, DFPS Staff, Medical Consenters, and PCP Teams and included in the Member’s HCSP;
3. identify Members who are suspected of having a SED and arrange for an assessment by a comprehensive provider using CANS or other appropriate standardized clinical instruments;
4. work with the Member, DFPS Staff, Caregiver and Medical Consenter to assist them in accessing Non-capitated Services;
5. prepare and present specialty care recommendations to the PCPs and specialists or PCP Teams to consider including in the Member’s HCSP;
6. participate in Hospital pre-admission planning for non-emergency hospitalizations and discharge planning;
7. evaluate and report Member’s clinical progress and adherence to the HCSP and include this information in the Health Passport after discussing with the PCP or PCP Team and other parties involved in the healthcare planning process;
8. provide information, and involvement from MCO staff, as requested by DFPS Staff to facilitate development of the DFPS Case Plan and coordination with DFPS Case Management Services, including participation in DFPS Family Group Conferences (FGCs), where professionals share information, concerns, and resources with the family and assist the family in the development of a Service Plan;
9. encourage BH Providers to use EBPs and promising practices and confirm that BH Providers and PCPs are sharing information as required in Section 8.1.17.4, “Coordination between the BH Provider and the PCP;”
10. serve as a Member Advocate as indicated in Section 8.1.33.10, "Member Advocates;”
11. outreach to Members transitioning into Target Population categories 3-4, refer to the Transitioning Youth Program (TYP) and develop Transition Plans, as needed;
12. for MDCP Members, the development of an MDCP plan of service as described in Section 8.2;
13. ensuring that services such as Private Duty Nursing and PPECC are coordinated to prevent duplication between home health agencies, PPECCs, therapy providers, and other Comprehensive Care Program (CCP) providers; and
14. provide other clinical Service Management functions as required to meet Member’s healthcare needs.

If a Member is admitted to an inpatient psychiatric hospital, the MCO must notify the Member’s PCP and BH Provider within 24 hours of MCO notice of Member admission.

The MCO Service Managers may request and review DFPS case plans, safety plans and permanency plans during the HCSP development and monitoring process.

**8.1.13.3 Transition Planning**

The MCO must employ Transition Specialists who are responsible for assisting Members and their Service Managers or 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.

Transition planning services must be provided using a team approach and in coordination with the assigned Service Manager. Transition Specialists must be employed by the MCO and wholly dedicated to counseling and educating Members, Medical Consenters, and others in their support system about resources for transitioning to adulthood.

For Members receiving Community Based Services, transition planning must begin when 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 healthcare services;
5. regularly update the HCSP with goals related to the Member's transition;
6. inform the Member and Medical Consenter of LTSS programs offered, such as CLASS, DBMD, TxHmL, and HCS, and assist with application to those programs;
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, transition planning must begin no later than the Member’s 17th birthday. Transition planning for these Members must include activities 1-5 listed above.
Transition Specialists must be trained on other Medicaid managed care programs and maintain current information on local and state resources to assist Members and Medical Consenters during the transition process.

The MCO will coordinate with DFPS Transitioning Services staff and with DFPS contracted Transition Centers listed at https://www.dfps.state.tx.us/txyouth/contacts/transition.asp to develop workflows and processes that will ensure outreach to this population is successful.

8.1.13.4 Discharge Planning

The MCO may authorize a Discharge planner to perform the Service Management requirements described in Section 8.1.13.2 while a Member is receiving inpatient services. While a Member is receiving inpatient services, the Discharge planner or Service Manager performing Discharge planning must also:

- Begin the Discharge planning process at Member admission;
- Call Providers to verify provider availability and schedule appointments after Discharge;
- Work with the Member, Medical Consenter, PCP, and other Providers to determine what assessments, including LMHA and CFC assessments, the Member will need after Discharge;
- Facilitate outreach and scheduling for services, such as targeted case management, rehabilitative services, and group psychotherapy, to be provided to the Member after the seven Day follow-up required by Section 8.1.17.5;
- Create a plan to ensure the Member will have access to necessary medication without interruption after Discharge;
- As necessary, hold conference calls with the Medical Consenter and Provider to schedule appointments to be held after Discharge;
- For a Member receiving inpatient psychiatric services, provide education to the Member, Medical Consenter and DFPS staff on how to access crisis services through MCO programs and the LMHA; and
- Provide education to the Member, Medical Consenter, and relevant DFPS staff on services that are available after Discharge. These services may include YES waiver services, Mental Health Rehabilitative Services, Telemedicine and Telehealth services, crisis services, skilled nursing, Disease Management, and medication refills.

8.1.13.5 Service Management and the of Telecommunications

MCOs must adhere to provisions for services by Telecommunication located in UMCM Chapter 16 and Subchapter R of 1 Tex. Admin. Code § 353.

8.1.14 Service Coordination

The MCO must implement a systematic administrative process to coordinate access to services, including Non-capitated Services, and information at the request of a Member, DFPS Staff, Caregiver, Medical Consenter, or PCP. The MCO must also coordinate with DFPS Case Management Services, whose function is to enlist the involvement of community organizations that may not be providing Covered Services but are otherwise important resources to help Members in maintaining health and well-being.
The MCO’s Service Coordination process and procedures for assisting Members, Caregivers and Medical Consenters must include how the MCO will:

1. facilitate access to primary, dental and specialty care and support services, including assisting Members, Caregivers and Medical Consenters with locating Providers and scheduling appointments as necessary;
2. expedite the scheduling of assessments used to determine residential placements as requested by DFPS, and as required in Section 8.1.11, “Coordination with the Department of Family and Protective Services." (The MCO must give top priority to this function in its Service Coordination operations);
3. clarify and provide access to information regarding the PA process;
4. clarify Program requirements and processes, including the Member Appeals process and how the MCO will provide assistance with navigating this process;
5. educate the MCO’s staff that when medical information is required by DFPS or is necessary for court hearings, and the Provider has not timely responded to a DFPS request or a court’s subpoena or request for medical information, the MCO’s Provider Relations Representatives must timely contact the Provider in question to encourage him or her to provide the requested information, and remind the Provider of his or her legal obligations to produce this information, including those obligations arising out of the Network Provider Contract with the MCO;
6. coordinate with DFPS Case Management Services, which facilitate referrals and access to services provided by other agencies and community resources;
7. assist Members, Caregivers and Medical Consenters with other coordination needs as needed;
8. coordinate the sharing of health information between Providers and other Programs, such as ECI;
9. ensure coordination with and referral to DSHS Case Management;
10. ensure Members with transportation needs for medical appointments receive assistance through the HHSC’s Medical Transportation Program;
11. share information with DFPS Forensic Assessment Centers; and
12. represent the MCO at meetings with Community Resource Coordination Groups (CRCGs).

The MCO will contact all Members, Caregivers, and Medical Consenters upon enrollment to notify them of the availability of Service Coordination and its functions. The MCO will provide additional outreach about the availability of Service Coordination (such as additional phone calls or mailings) to Caregivers and Medical Consenters of Members identified by DFPS as having special healthcare needs, to parents of children in their own home, and to Caregivers and Medical Consenters of Members in relative placements. The MCO will also encourage Caregivers and Medical Consenters to use Service Coordination services.

Members, DFPS Staff, Caregivers, Medical Consenters, or PCPs may request Service Coordination from the MCO. A Service Coordinator will contact the Member, DFPS Staff, Caregiver, Medical Consenter, or PCP by the next Business Day upon receipt of a request for Service Coordination.

The MCO will maintain an adequate number of Service Management and Service Coordination personnel and management having expertise in physical health, BH, and the STAR Health population to meet the needs of the population, as measured by the timely completion of assessments and HCSPs and successful coordination of services as required by Section 8.1.13.2, “Coordination Between the BH Provider and the PCP.” The MCO will continue to assess the staff’s ability to complete these functions in a timely nature and will take corrective action as necessary.
The MCO’s Service Management and Coordination model will offer specialized teams having additional expertise to assist those experiencing acute episodes or severe complex conditions.

The MCO will maintain a sufficient number of regional offices in which Service Management and Service Coordination teams will be housed. 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.

In accordance with the requirements in **UMCM Chapter 16** the MCO must share and integrate care coordination and services authorization data internally and, if applicable, between the MCO and the third party or subsidiary contracted with the MCO to manage Behavioral Health Services. MCOs must implement joint rounds for physical health and Behavioral Health Services Network Providers or implement another effective means for sharing clinical information. MCOs must, to the extent feasible, co-locate physical health and Behavioral Health care coordination staff and ensure warm call transfers between physical health and Behavioral Health care coordination staff.

### 8.1.15 Health Home Services

The MCO must provide Health Home Services. The MCOs must include a designated Provider to serve as the health home. The designated Provider must meet the qualifications as established by the U.S. Secretary of HHS. The designated Provider may be a Provider operating with a team of health professionals, or a health team selected by the enrollee. The Health Home Services must be part of a person-based approach and holistically address the needs of persons with multiple Chronic (or Complex) Conditions or a single serious and persistent mental or health condition.

Health home services must include:

1. Member self-management education;
2. Provider education;
3. EBPs and minimum 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 the continuum 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. care 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. use of health information technology to link services, as feasible and appropriate.

The health home services requirements do not apply to Dual Eligible Members.
8.1.15.1 Health Home Services and Participating Providers

HHSC encourages MCOs to develop provider incentive programs for designated Providers who meet the requirements for Member-centered health homes found in Texas Government Code § 533.0029.

At a minimum, 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 a Service Plan;
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 make efforts to 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 the HHSC-approved implementation plan.

8.1.16 Disease Management (DM)

The MCO must provide, or arrange to have provided to Members, comprehensive DM services consistent with state statutes and regulations. Such DM services must be part of a person-based approach to DM and holistically address the needs of Members with multiple Chronic (or Complex) Conditions. The MCO must develop and implement DM services that relate to Chronic (or Complex) Conditions that are prevalent in Members. The MCO must have DM Programs that address Members with Chronic (or Complex) Conditions. The MCO must evaluate the priority needs of the STAR Health population on a regular basis with the goal of determining the relevancy and impact of additional or alternative DM programs. HHSC will not identify the Members with Chronic (or Complex) Conditions. The MCO must implement policies and procedures to ensure that Members that require DM services are identified and enrolled in a DM program.

The MCO must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of Members at risk for or diagnosed with Chronic (or Complex) Conditions identified the MCO as candidates for DM. The MCO must ensure that all Members identified for DM are enrolled into a DM Program with the opportunity to opt out of these services within 30 days while still maintaining access to all other Covered Services. A refusal to utilize Disease Management for a Member must be authorized by the DFPS caseworker.

The DM Program(s) must include:

1. Member self-management or Caregiver and Medical Consenter care management education;
2. provider education;
3. EBPs and minimum standards of care;
4. standardized protocols and participation criteria;
5. physician-directed or physician-supervised care;
6. a continuum of interventions to address individualized need;
7. mechanisms to modify or change interventions that are not proven effective; and
8. 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 their 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 UMCM Chapter 9.

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 UMCM Chapter 9.

8.1.16.1 Special Populations

The MCO is required to have a specialized program for targeting, outreach, education and intervention for Members who have excessive utilization patterns that indicate typical DM approaches are not effective. For the purposes of this contract, this group of Members is called “super-utilizers.” The MCO must have the following infrastructure in place to address super-utilizers’ needs, using, at a minimum, the following criteria:

1. Methodology for identification of super-utilizers on an ongoing basis, based on cost, utilization of the ER, utilization of inpatient or pharmacy, services, physical and Behavioral Health comorbidities, or other specified basis;
2. resources dedicated to ongoing targeting and identification of super-utilizers such as staff, specialized analytical tools, etc.;
3. staff resources for effective outreach and education of Providers and super-utilizers;
4. specialized intervention strategies for super-utilizers. 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; and
5. evaluation process to determine effectiveness of super-utilizer program. As part of the annual evaluation of effectiveness, the MCO should include a description or example of an intervention it found effective. It can be a Member case study with a description of the interventions and improvements or a specific project with demonstrated effectiveness.

Upon request, MCOs must demonstrate to HHSC their methodologies for identification and intervention strategies for this population, to include the MCO’s resources to support this effort. On an ad hoc basis, the MCO must provide a plan for management of super-utilizers including the criteria listed above. HHSC will evaluate the plan and provide feedback to the MCO. Upon HHSC’s approval of the plan, each MCO will be retrospectively evaluated on their execution of the written plan, as described in Section 8.1.16.3, “Disease Management Evaluation.” An MCO may reuse elements of the same plan as long as the submission reflects the current state of their special population program and is updated as necessary on evaluation methodologies and key findings.

The MCO is also required to have a specialized program for targeting and providing outreach, education and intervention for Members who are transitioning to adulthood. Members approaching age 18 will require additional education and supports to understand their rights and
responsibilities as adult Members, including actions they will need to take in order to stay connected to their benefits and services. Members approaching age 21 will require additional education and supports to understand the service and benefit changes that will occur following their 21st birthday.

The MCO must provide ongoing transition planning that includes:
1. health and wellness education,
2. assistance with self-management of their own healthcare services,
3. identifying adult healthcare providers, particularly for Members with Special Healthcare Needs,
4. transitioning Medicaid services and benefits from STAR Health to the STAR or STAR+PLUS Medicaid managed care models without a break in service, when applicable, and
5. ensuring the Member, the Member’s Medical Consenter, Caregiver, and DFPS are aware of available programs, services, and supports the Member may utilize to improve their well-being as an adult.

8.1.16.2 Disease Management (DM) Services 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 Managers 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 HCSP; and
3. for a Member enrolled in a DM Program, provide reports on changes in a Member’s health status to their PCP and Service Manager.

HHSC encourages MCOs to develop Provider incentive programs for designated Providers who meet the requirements for patient-centered medical homes found in Texas Government Code § 533.0029.

8.1.16.3 Disease Management (DM) Evaluation

HHSC or its EQRO will evaluate the MCO’s DM Program. The MCO must provide all information HHSC deems necessary for such evaluation.

HHSC or its EQRO will also evaluate DM as it relates to specialized populations identified in Section 8.1.16.1, “Special Populations.” These evaluations will be on a retrospective basis and will include an analysis of MCO Encounter Data and other relevant data (e.g., reports). Evaluations could also include interviews with MCO staff that oversee the program as well as identified Providers. Based on HHSC’s retrospective evaluation, MCOs may be required to submit a Corrective Action Plan if directed by HHSC.

It is HHSC’s intent to hold quarterly collaborative calls or webinars with MCO medical directors to discuss plan implementation, barriers, successful strategies, etc.

8.1.17 Behavioral Health (BH) Services and Network

The MCO must provide or arrange for the delivery of all Medically Necessary community-based, rehabilitative, and inpatient Hospital BH Services. BH Services include Covered Services for the treatment of mental, emotional, or clinical dependency disorders. As is allowed in Medicaid Fee-
for-Service, the MCO must cover up to three five-day extensions in a Psychiatric Hospital after treatment is completed if DFPS Staff is in the process of finalizing the Member’s placement. The MCO will encourage all contracted Psychiatric Hospitals that have psychiatric bed capacity to expand their inpatient BH service capacity. PA processes for BH Services must recognize the intensive or ongoing need for these services often present among the STAR Health population and should not be unnecessarily burdensome to Providers or Members. Therefore, the MCO will not require a PA for all outpatient medication management services, and a PA will not be required for the first ten outpatient BH sessions, to include the initial evaluation.

As allowed by 42 C.F.R. § 438.3(e), the MCO may provide certain HHSC-approved services in lieu of Behavioral Health Services as described in UMCM Chapter 16.

The MCO must comply with DFPS rules and licensing standards regarding the provision of Covered Services, including certain BH Services, to the STAR Health population. Information on these requirements is available at the DFPS website. The MCO also must comply with 28 Tex. Admin. Code Chapter 3, Subchapter HH, regarding standards for chemical dependency treatment, and understand that to comply with Texas Family Code § 266.012, the MCO must ensure each Member in category 1 of the Target Population age three and older receives a Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 Days of receipt of the DNF. Medicaid BH Services are described in further detail in the 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.

BH assessments must include a primary and secondary (if present) diagnosis using the Diagnostic and Statistical Manual (DSM) multi-axial classification. Because BH and Substance Use Disorder problems commonly occur in Members, the MCO must screen all such Members for both types of problems. Diagnostic information and outcome measurement information must be documented in the Member’s Health Passport.

The MCO must contractually require BH Providers to:

1. assess applicable Members using the Texas Comprehensive CANS 2.0 (child welfare) assessment tool within 30 Days of entering conservatorship, or refer to a provider who is trained and certified to perform this assessment;
2. evaluate each Member’s progress using a standardized outcome measurement instrument, to be provided by the MCO, quarterly at a minimum, and at termination of the HCSP, or as significant changes are made in the HCSP;
3. document the outcome measurement scores in the Health Passport;
4. function as a member of the PCP Team by coordinating with the PCP and Service Manager 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. assessment information;
3. brief narrative summary of clinical visits/progress;
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 at termination of the HCSP, or as significant changes are made in the treatment plan; and
7. any other relevant care information.

The BH Provider must also submit an initial and monthly or more frequently, if a Member’s medical condition indicates, narrative summary report of a Member’s BH status for inclusion in the Health Passport. This information will be available to the Member’s Providers, the Service Management Team, and DFPS staff.

The MCO must contractually require that PCPs use the Texas Health Steps BH forms, at a minimum, for the detection and treatment of, or referral for, any known or suspected BH problems and disorders. Members must be screened for BH problems, including possible Substance Use Disorder or chemical dependency. The PCP must submit completed Texas Health Steps screening and evaluation results to the MCO to include in the Health Passport.

Children and young adults in the STAR Health population often have been victims of severe physical and emotional trauma, including sexual abuse. The MCO must encourage Providers to use EBPs and promising practices that are demonstrated through research to be effective with these traumas, such as TF-CBT, PCIT, CPP, and TBRI, and to address risk factors and stressors that influence future Abuse, Neglect, and Exploitation. BH treatment may require family counseling, when family reunification is planned.

8.1.17.1 Behavioral Health (BH) Provider Network

Due to the significant BH needs of the STAR Health population, 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 children and young adults in the STAR Health population such as abuse, neglect, sexual offender behavior, and exposure to complex and multiple traumas, in order to meet the BH needs of the STAR Health population. To the extent available, the Network must include Providers that utilize EBPs and promising practices specific to the diagnoses of the STAR Health population. The Network must also include Providers that are trained and certified in the administration of the CANS assessment.

The MCO must continue to make efforts to train BH Providers in Parent Child Interaction Therapy (PCIT), according to the HHSC-approved implementation plan.

The MCO must include Significant Traditional Providers (STPs) of these benefits in its Network and provide such STPs with expedited credentialing. The MCO must enter into Provider Agreements with any willing STP of these benefits that meets the Medicaid enrollment requirements and MCO credentialing requirements and agrees to the MCO’s contract terms and rates.

The MCO must maintain a Provider education process to inform BH Providers in the MCO’s Network on how to refer Members for treatment.

Provider Network capacity and distribution must permit Members to have ready access to services as specified in Sections 8.1.3, “Access to Care,” and 8.1.4, “Provider Network.”

The Network must include psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; LCSWs; LMFTs; LPCs; QMHPs working under the authority of an LMHA and as defined in TAC Title 25, Part 1, Chapter 412; Licensed Adolescent
Chemical Dependency Treatment facilities; and LCDCs with experience treating adults and adolescents. The Network must include Providers who are trained in and knowledgeable about:

1. screening and treating co-occurring BH and Substance Use Disorders;
2. treating 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. eating disorders;
5. TF-CBT screening, treatment, and assessment;
6. the diagnosis and treatment of Intellectual or Developmental Disabilities (IDD);
7. treating young children;
8. treating children dually diagnosed with IDD and BH issues;
9. treating children with autism;
10. screening and treating children with Fetal Alcohol Syndrome (FAS) or related disorders; and
11. administration of the Texas Comprehensive CANS 2.0 (child welfare) assessment tool.

To best address the special needs of the STAR Health population and provide effective treatment, Network Providers must be culturally competent 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. The Network must also include clinicians and early intervention specialists who use EBPs for disorders common to the STAR Health population. To the extent possible, the diversity of the Network should reflect the cultural groups of children and young adults in the STAR Health population.

8.1.17.2 Self-referral for Behavioral Health (BH) Services

The MCO must permit Members, DFPS Staff, or Medical Consenters to participate in the selection of appropriate BH Providers. The MCO must allow Members or their Medical Consenters to self-refer to any Network BH Provider. If the Member has not been assessed as needing BH Services, the MCO must require an assessment to authorize treatment. The MCO policies and procedures, Provider manual, and Member handbook must clearly specify how the Member may self-refer for services.

8.1.17.3 Behavioral Health (BH) Hotline and Emergency Services

This Section discusses BH hotline functions pertaining to Member hotlines. BH Provider hotline requirements are referenced in Section 8.1.4.8, “Provider Hotlines.”

The MCO must operate a toll-free BH hotline to handle routine behavioral-health related calls. The MCO cannot impose maximum call duration limits and must allow that calls can be of sufficient length to provide adequate information to Members, DFPS Staff, Providers, Caregivers and Medical Consenters. Only those persons who can identify themselves through the caller verification process approved by HHSC may obtain personal health information through the BH Services hotline. Hotline services must meet Cultural Competency requirements and provide linguistic access to all Members, including interpretive services required for effective communication. Hotline staff must be trained regarding a) emergency prescription process and what steps to take to immediately address Members’ problems when pharmacies do not provide a 72-hour supply of emergency medicines; b) processes for obtaining services and how to address common problems; and c) triaging calls to the appropriate MCO staff person, warm transferring calls, and escalating issues.
The 24-hour BH hotline will attempt to respond immediately to problems concerning emergency medicines by means at its disposal, including explaining the rules to Members so that they understand their rights and, if need be, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy processes. Hotline staff must also be trained regarding the availability of and access to Substance Use Disorder treatment services, including information on self-referral.

The MCO must conduct ongoing quality assurance activities to ensure the following standards are met:

1. at least 80 percent of calls must be answered by toll-free line staff within 30 seconds measured from the time the call is placed in queue after selecting an option;
2. the call abandonment rate is seven percent or less; and
3. the average hold time is two minutes or less.

The MCO must monitor its performance against the BH Services hotline standards and submit performance reports summarizing call center performance as indicated in Section 8.1.26.2, “Reports,” and UMCM Chapter 5.

The MCO must have a BH Services hotline, answered by a live voice, staffed by trained personnel and available 24 hours per day, 7 days a week, toll-free throughout the state which addresses routine and crisis BH calls. The Hotline must be staffed by or have access to qualified BH professionals to assess emergencies. Clinicians staffing the BH Services Hotline must be available to accept emergency and crisis calls. The MCO may operate one Hotline to handle Behavioral Health calls (including emergency and crisis Behavioral Health calls) and other routine calls unrelated to Behavioral Health as long as requirements related to emergency and crisis calls are met. However, the MCO must submit hotline performance reports separately as required by UMCM Chapter 5. 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 may use mobile crisis teams to provide on-site emergency response services.

If HHSC determines that it will conduct onsite monitoring of the MCO’s BH Services Hotline functions, the MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) relating to such monitoring. For purposes of this section, “authorized reimbursable travel costs” may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

8.1.17.4 Coordination between the BH Provider and the PCP

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 MCO and BHO have shared, integrated data systems to facilitate Service Management, 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 Comprehensive CANS 2.0 (child welfare) assessment tool 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 shall 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 Service Coordinator and Service Manager in the coordination and sharing of health information and status. BH Providers may only provide physical Healthcare 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 Members’ 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 Texas Family Code § 266.007. This requirement must be specified in Provider Contracts, handbooks and manuals.

PCPs must screen Members for any BH condition and may treat Members within the appropriate scope of their practice and refer Members for treatment through the Provider Network.

The MCO must use evidence-based integrated healthcare practices. These practices include, for example, the use of an appropriate outcome measurement instrument to monitor effectiveness of medication and psychotherapy, and access to psychiatric consultation for the PCP and Service Manager. 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 Foster Care found at the DFPS website.

The MCO should seek to recruit PCPs and BH Providers who are located in the same office or clinic to facilitate access to treatment and services. The MCO will include in its trainings, Provider Materials and handbooks guidelines, policies and procedures related to physical and BH coordination of treatment and services. The MCO should seek to recruit providers who practice using the Medical Home Services Model and IPC Model. The MCO should actively promote these models, provide training in these models, and may differentially reimburse for these models as they have been shown to be more fiscally efficient and clinically effective in the early identification and treatment of BH problems.

MCO training for PCPs must include the use of valid screening and assessment instruments as well as the use of the Texas Health Steps Forms. 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 chemical dependency. 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 child or young adult has a developmental disability or is at risk for or has a serious emotional disturbance 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 training to Network PCPs on identifying and referring Members for BH assessments and for neuropsychological assessments to determine if Members have suffered trauma to the brain. The MCO will provide information on EBPs for BH problems commonly seen in primary care (e.g., depression and anxiety disorders). The MCO will encourage PCPs to contact MCO Service Managers 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.

The MCO shall require BH Providers to refer Members with known or suspected and untreated physical health problems or disorders to their PCP.

**8.1.17.5 Follow-up after Hospitalization for BH 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, within 24 hours, BH Providers contact Members who have missed appointments to reschedule appointments.

**8.1.17.6 Substance Use Disorder and Chemical Dependency Treatment Services**

The MCO must comply with 28 Tex. Admin. Code §§ 3.8001 et seq., regarding Utilization Review for Substance Use Disorder and Chemical Dependency Treatment. Substance Use Disorder and Chemical Dependency Treatment must conform to the standards set forth in 28 Tex. Admin. Code Chapter 3, Subchapter HH. Substance Use Disorder includes Substance Use Disorder and dependence as defined by the current DSM.

**8.1.17.6.1 Providers**

MCOs must follow provider requirements at Sections 8.1.3.2, and 8.1.4 for Substance Use Disorder outpatient and residential services, respectively. MCOs must maintain a Provider education process to inform Substance Use Disorder treatment Providers in the MCO’s Network on how to refer Members for treatment.

**8.1.17.6.2 Care Coordination**

The MCO must ensure care coordination is provided to Members with a Substance Use Disorder. The MCO must work with Providers, facilities, and Members to coordinate care for Members with a Substance Use Disorder and to ensure Members have access to the full continuum of Covered Services, including without limitation, 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 and DFPS, and their designees, for Members and Medical Consenters for Members requiring Non-Capitated Services. Non-Capitated Services include services that are not available for coverage under the Contract, State Plan, or waiver that are available under the Federal Substance Use Disorder and Prevention and Treatment block grant when provided by a 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 Out-of-Network providers who also provide related Non-capitated Services when the Covered Services are not available through Network Providers.

In accordance with UMCM Chapter 16, the MCO must share and integrate care coordination and service authorization data internally and, if applicable, between the MCO and the third party or subsidiary contracted with the MCO to manage Behavioral Health Services. MCOs must implement joint rounds for physical health and Behavioral Health Services Network Providers or implement another effective means for sharing clinical information. MCOs must, to the extent feasible, co-locate physical health and Behavioral Health care coordination staff and ensure warm call transfers between physical health and Behavioral Health care coordination staff. The MCO must also comply with the requirements in UMCM Chapter 16.

8.1.17.6.3 Requirements for Medication Assisted Treatment

The MCO must comply with Texas Human Resources Code §32.03115.

8.1.17.7 Court-ordered Services

The MCO is required to pay for Medicaid Covered Services ordered by a court pursuant to the statutory citations listed below. The MCO cannot deny, reduce, or controvert the court orders for Medicaid inpatient mental health Covered Services for Members birth through age 20, provided pursuant to:

1) a court order; or
2) as a condition of probation.

The MCO cannot deny, reduce, or controvert the court orders for Medicaid inpatient mental health Covered Services for Members of any age if the court-ordered services are delivered in an Acute Care Hospital.

The MCO may not limit Substance Use Disorder treatment or outpatient mental health services for Members of any age provided pursuant to:

1) a court order; or
2) a condition of probation.

The MCO cannot apply its own utilization management criteria through prior authorizations, concurrent reviews or retrospective reviews for such services.

Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Member who has been ordered to receive treatment pursuant to a court order can only Appeal the court order through the court system.

MCOs are required to have a mechanism to receive court order documents from providers at the time of an authorization request.
8.1.17.7.1 Psychiatric Services

The MCO must provide all Medicaid inpatient psychiatric Covered Services to Members and outpatient Covered Services to Members of any age who have been ordered to receive the services by:

1) a court of competent jurisdiction including services ordered pursuant to the Texas Health & Safety Code Chapters 573, Subchapters B and C, Texas Health and Safety Code Chapter 574, Subchapters A through G, Texas Family Code 55, Subchapter D or
2) as a condition of probation.

These requirements are not applicable when the Member is considered incarcerated, as defined in UMCM Chapter 16.

For STAR Health Members age 21 or older, 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 as allowed by 42 C.F.R. §438.6(e).

8.1.17.7.2 Substance Use Disorder Treatment Services

MCOs must provide Medicaid-covered Substance Use Disorder treatment services, including Substance Use Disorder residential treatment, required as a:

1) court order consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or
2) condition of probation.

These requirements are not applicable when the Member is considered incarcerated, as defined in UMCM Chapter 16.

8.1.17.8 Mental Health Rehabilitative Services and Mental Health Targeted Case Management Services

Mental Health Rehabilitative Services and Mental Health Targeted Case Management Services must be available to eligible STAR Health Members based on the appropriate standardized assessment (the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS) through a qualified Network of entities. Qualified entities can include both LMHAs and other entities, such as multi-specialty groups and clinic/group practices that employ providers of these services.

Mental Health Rehabilitative Services include training and services that help the Member maintain independence in the home and community, such as 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 in order to control acute symptoms that place the Member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting.

5. **Day program for acute needs** – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms of 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 Targeted Case Management in accordance with **UMCM Chapter 15**, including provider training requirements and the use of 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 Targeted Case Management use and are trained and certified to use the Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) tools for assessing a Member’s needs.

The MCO must ensure that it coordinates with providers of Targeted Case Management to ensure integration of behavioral and physical health needs of Members.

**8.1.17.9 Mental Health Parity**

The MCO must comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all related regulations, including 42 C.F.R. Part 438, Subpart K, and 45 C.F.R. §§146.136, 147.136, and 147.160. The MCO must work with HHSC to be in compliance with parity, and must provide HHSC with a non-quantitative treatment limitation assessment tool(s); survey(s); or corrective action plans related to compliance with MHPAEA; and statements of attestation stating compliance with MHPAEA and any other information as requested by HHSC. The information must be provided within the timeframe included in HHSC’s request.

**8.1.18 Dental Services and Dental Network**

The MCO must provide the delivery of all dental Medically Necessary Covered Services as described in the **TMPPM**. Dental services include, without limitation, periodontics, orthodontics, endodontics, pediatric dentistry, and other services included in the **TMPPM**. Dental services must comply with the Texas Health Steps Dental Policy and Procedures and American Academy of Pediatric Dentistry (AAPD) recommendations, and the Texas Medicaid Bulletins. The MCO must ensure the STAR Health population receives a Texas Health Steps dental exam within 60 Days of enrollment for Members six months of age and older. Members under six months of age at the time of enrollment must receive their initial Texas Health Steps dental checkup within 30 Days of becoming six months of age. The MCO must recruit and maintain an adequate dental Provider Network, including dentists for First Dental Home for children six months through 35 months and MSHCN. Dental services include, without limitation, periodontics, orthodontics, endodontics, pediatric dentistry, and other services included in the **TMPPM**.

The MCO must enroll, train, and support a statewide Network of dental Providers who understand and are responsive to the STAR Health population’s special health and dental care needs. The MCO must undertake an aggressive dentist recruitment strategy in collaboration with the Texas Dental Association (TDA), the Texas Academy of Pediatric Dentists (TAPD),
Texas Academy of General Dentistry, the Gulf State Dental Association, the Hispanic Dental Association, and any other interested dental provider organization to the extent these organizations are willing to commit to assistance in the dental provider outreach and recruiting effort.

Dentists providing emergency dental 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.

**8.1.18.1 First Dental Home**

The MCO must implement a “First Dental Home Initiative” that will enhance dental Providers’ ability to assist Members, Medical Consenters, and Caregivers in obtaining optimum oral healthcare. 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 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 six through 35 months of age may be seen for dental checkups by a certified First Dental Home Initiative Provider as frequently as every three months if Medically Necessary.

To become a First Dental Home Initiative Provider, the dentist must complete either the online module or an in-person training and submit registration information. The Texas Health Steps online First Dental Home Module is available at the DSHS website.

**8.1.18.2 Main Dental Home**

Establishment of a client’s Main Dental Home must begin no later than at six months of age and includes referrals to dental specialists when appropriate. A Main Dental Home must support an ongoing relationship with the Member that includes all aspects of oral healthcare delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Provider types that can serve as Main Dental Home Providers are FQHCs, RHCs, and individuals who are general dentists or pediatric dentists.

The MCO must require Main Dental Home Providers to provide Members with diagnostic and preventive services in accordance with the AAPD recommendations. The MCO must make best efforts to ensure that Main Dental Home Providers follow these periodicity dental requirements for children. Best efforts must include Provider education, Provider profiling, monitoring, and feedback activities.

**8.1.19 Vision Services and Vision Network**

The MCO must provide the delivery of all Medically Necessary Covered Services for vision as described in the TMPPM. The MCO must recruit and maintain an adequate vision network, including optometrists for MSHCN.

The MCO must enroll, train, and support a statewide Network of vision Providers who understand and are responsive to the STAR Health population’s special health and vision care needs. The MCO must undertake an aggressive recruitment strategy.
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.

8.1.20 Pharmacy Services

The MCO must provide pharmacy-dispensed prescriptions as a Covered Service. The MCO must ensure that such coverage meets the standards provided for by 42 U.S.C. § 1396r-8, as applied to Medicaid managed care in accordance with 42 C.F.R. § 438.3(s).

The MCO must submit pharmacy clinical guidelines and PA policies for review and approval during Readiness Review, then after the Operational Start Date prior to 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 provider regardless of Network participation. 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. The MCO must ensure that reasonable pharmacy provider reimbursement rates include a dispensing fee, administration fees (when applicable), and ingredient costs. 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 or its Subcontractor must disclose to HHSC the reimbursement rates and payment methodology used to develop the rates specific to the pharmacy provider during the contract negotiations between the PBM and pharmacy provider. The disclosure must be specific to Medicaid/CHIP and must not include rates or methodologies for the MCO’s or its Subcontractor's other lines of business. The MCO and its Subcontractors must not prohibit pharmacy providers from disclosing any information regarding the pharmacy provider agreement to HHSC.

The MCO or its Subcontractors must provide HHSC with all provider processes and procedures in a separate Texas Medicaid section specific to Medicaid and CHIP only.

The MCO must comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 for pharmacy services. The MCOs must demonstrate compliance for all covered outpatient drugs on the 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 fee-for-service edits or other prescription drug limitations applicable to managed care organizations or related to the HHSC’s preferred drug list and any other state-mandated prior authorization or clinical edit.

8.1.20.1 Formulary and Preferred Drug List (PDL)

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 preferred drug list (PDL) developed by HHSC. HHSC will maintain separate Medicaid and CHIP formularies, and a Medicaid PDL. The MCO must administer the PDL in a way that allows access to all non-preferred drugs that are on the formulary through a structured PA process.
The MCO must educate Network Providers about how to access HHSC’s formularies and the Medicaid PDL on HHSC’s website. In addition, the MCO must allow Network 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/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 Texas Insurance Code Chapter 1369, Subchapter J, the MCO must establish a process by which the MCO, the enrollee, 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 Texas Insurance 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 health-care 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.

8.1.20.2 Prior Authorization (PA) for Prescription Drugs and 72-Hour Emergency Supplies

The MCO must adopt prior authorization (PA) policies and procedures that are consistent with Section 8.1.8.1, “Compliance with State and Federal Prior Authorization Requirements.”

HHSC will identify both "required" and "optional" Clinical PAs on the Vendor Drug Program website. If the information about a Member’s medical condition meets the Clinical PA criteria, the claim or PA request may be approved. If a Member's medical condition does not meet the Clinical PA criteria, the claim or PA request may be denied. The MCO is responsible for managing Clinical PA denials through its appeal process.

The MCO must also adhere to HHSC VDP’s PDL for Medicaid drugs. Preferred drugs must adjudicate 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.

Any proposed MCO clinical criteria not listed on the Vendor Drug Program Website described above as a required or optional Clinical PA or listed in the Contract must be submitted to HHSC for review and approval following the process outlined in UMCM Chapter 3. 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 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 UMCM Chapter 3. 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 HHSC VDP’s Clinical PAs, the MCO can reference VDP’s Texas Medicaid formulary on Epocrates.

HHSC’s Medicaid PDL PA, Clinical PA, and other drug policies for the VDP are available on HHSC’s VDP website. HHSC’s website 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 MCOs.

The MCO may require a prescriber’s office to request a PA as a condition of coverage or pharmacy payment if the PA request is approved or denied within 24 hours of receipt.

For second generation antiviral drugs used to treat Hepatitis C, a 72-hour emergency rule should not be utilized. These medications require strict prior authorization procedure, however, the immediate dispensing is not required prior to confirming with the prescriber that the specific clinical criteria is met. 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 drug 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. 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. An emergency 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 MCO’s pharmacy website must provide information explaining how to obtain a 72 hour emergency supply of medication. The MCO must ensure through its Provider Contracts, Provider Contract oversight, and Provider education that pharmacies do not use 72-hour emergency supplies routinely and continuously. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.

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 Texas Government Code § 531.073(h).) This process must automatically evaluate whether a submitted pharmacy claim meets PA criteria for both PDL and Clinical PAs. (See UMCM, Chapter 2.2., Section V 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 8.1.4.8. “Provider Hotline.” 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 may 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 Services Administration (HRSA) 340B discount drug program, the MCO may impose Clinical PA requirements only. 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 8.1.33, “Member Complaint and Appeal System.”

If a Member transitions to a different Medicaid or CHIP MCO, the STAR Health 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 STAR Health MCO to respond with the requested information within 72-hours of the new MCO’s request.

8.1.20.3 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 webpage under “Contact Information.”

An MCO may restrict some compounded medications available through the pharmacy benefit. MCOs’ coverage of compounded medications must follow the same requirements as outlined in this section and must be listed on the Texas Medicaid formulary. MCOs may not reimburse pharmacies for compounding powders since these are not included on the Texas Medicaid formulary.

8.1.20.4 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 § 354.1923 (c). The MCO may reject a claim for a compounded mediation 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 $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 NDCs, quantities, and calculations.

8.1.20.5 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 Texas Government 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 outpatient drug claims, including Provider-administered drugs, must be exempt from such rebate agreements. The MCO must include rebateable National Drug Codes (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 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 timely support HHSC’s Medicaid rebate dispute resolution processes.

a. The MCO must allow HHSC or its designee to contact Network pharmacy Providers to verify information submitted on claims, and upon HHSC’s request, assist with this process.

b. The MCO must establish a single point of contact where the HHSC’s designee can send information or request clarification.

c. 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.

8.1.20.6 Drug Utilization Review (DUR) Program

The MCO must have a drug utilization review program (DUR) 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 and 42 C.F.R. part 456, subpart K. The MCO must submit an annual report to HHSC Vendor Drug Program (VDP) that provides a detailed description of its DUR program activities, as provided for under 42 C.F.R. § 438.3(s).

Prospective review should take place at the dispensing pharmacy’s 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 prescriber and contracted pharmacies for outlier activities. Retrospective reviews should also determine whether services were delivered as prescribed and consistent with the MCO’s payment policies and procedures.

8.1.20.7 Pharmacy Benefit Manager

The MCO must use a pharmacy benefit manager (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 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 such Subcontractors. These assurances and procedures must be submitted for HHSC’s review during Readiness Review (see Section 7, “Transition Phase Requirements”) then prior to initiating any PBM Subcontract after the Operational Start Date.

The MCO must ensure its subcontracted PBM follows all pharmacy-related Contract, UMCM, state, and federal law requirements related to the provision of pharmacy services.

The MCO must ensure its Material Subcontract with a PBM does not include language that permits:

- pharmacy provider rate reductions without HHSC notification of approval as required in under Section 8.1.4.9;
- reconciliation methodologies that include Medicaid or CHIP claims;
- mechanisms that facilitate "spread pricing," including provider reimbursement clawbacks or discounts, which is described below in this section; or
- PBM restrictions that are greater than those required by HHSC for Medicaid/CHIP participation.

Further, the MCO’s reimbursement methodology for the PBM must be based on the actual amount paid by the PBM to a pharmacy for dispensing and ingredient costs. However, this prohibition on the industry practice 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 UMCM Chapter 6.

Unless directed by HHSC, the MCO and its PBM are prohibited from implementing an aggregate reconciliation process after the point-of-sale transaction, such that the final cost of drugs for payors is changed or the price paid to pharmacy providers is changed. Such prohibition includes aggregate reconciliation processes for additional fees, contracted effective rate agreements, payment reductions, and the recoupments of funds based on financial performance measures. This prohibitive language does not apply to audit-related claim reviews, approved Alternative Payment Models, or Fraud, Waste, and Abuse investigations.

The MCO must ensure its subcontracted PBM does 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.

8.1.20.8 Financial Disclosures for Pharmacy Services

The MCO must disclose all 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 labeler, including formulary management, drug-switch programs, educational support, claims processing, payments, payment adjustments, overpayments, recoupments, pharmacy network fees, data sales fees, and any other fees. Article 9 of Attachment A "Audit and Financial Compliance, and Litigation Hold," provides
HHSC with the right to request and timely receive such information from the MCO and its Subcontractors 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.

8.1.20.9 Limitations Regarding Registered Sex Offenders

HHSC’s Medicaid formulary does not include sexual performance enhancing medications. If these medications are added to the Medicaid formulary, then MCO must comply with the requirements of Texas Government Code § 531.089 prohibiting the provision of sexual performance enhancing medication to persons required to register as sex offenders under Chapter 62, Texas Code of Criminal Procedure.

8.1.20.10 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 § 353.905 and § 354.1853 and include processes for notifying Network pharmacy Providers.

8.1.20.11 Maximum Allowable Cost (MAC) Requirements

The MCO must develop MAC prices and lists that comply with state and federal laws, including Texas Government 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 known 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 (a group of therapeutically related drugs that will be assigned the same price), MCOs and PBMs 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, MCOs and PBMs can only use A-rated drugs to set MAC prices. B-rated drugs cannot be used in MAC pricing calculation. MCOs and PBMs can include B-rated drugs in, but those B-rated drugs must be assigned the same price as the A-rated drugs.

The MCO cannot set a MAC on a drug that is both preferred on HHSC’s PDL and a brand name drug.

The MCO must provide a Network pharmacy the sources used to determine the MAC pricing at contract execution, renewal, and upon request. MCOs may not use as a pricing source provider performance standards, provider network performance standards, or effective rate agreements.

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 Service Area.

The MCO must provide HHSC a report regarding MAC price review and updates upon request in the manner and format by HHSC no later than 30 Days after the MCO receives the request.
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 UMCM.

The MCO or PBM, as applicable, must provide a process for each of its Network pharmacy providers to readily access the MAC list specific to that 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 network pharmacy to download a searchable file of the MAC list specific to that pharmacy from the MCO or PBM website. Alternatively, the MCO or PBM may allow a network pharmacy to view and search the MAC list specific to that pharmacy 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 9 of Attachment A, “Uniform Managed Care Contract Terms and Conditions” and sources used to determine the MAC pricing no later than 10 Days after the MCO receives the request. The MCO must implement a process that allows a Network pharmacy to readily access the pharmacy’s MAC price through a website. The MCO must submit the process for HHSC’s review and approval prior to implementation and modification. As described in Texas Government Code § 533.005(a-2), a MAC price list that is specific to a Network pharmacy is confidential for all other purposes.

The MCO must inform HHSC no later than 21 Days after implementing a MAC price list for drugs dispensed at retail pharmacies but not by mail.

8.1.20.12 Mail-Order and Delivery

The MCO may include mail-order pharmacies in its pharmacy Network, but cannot require Members to use a mail-order pharmacy except in its specialty pharmacy network when a drug is available only from a mail-order pharmacy.

The MCO cannot charge a Member who opts to use a mail order pharmacy 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, or through other methods approved by HHSC. Mail order delivery is not an appropriate substitute for delivery from a qualified community retail pharmacy unless requested by the Member. The MCO’s process must be approved by HHSC, submitted using HHSC’s template, and include all qualified community retail pharmacies identified by HHSC.

The MCO must implement a process to ensure that Medicaid and CHIP Members receive free outpatient pharmaceutical deliveries from community retail pharmacies in their Service Areas, or through other methods approved by HHSC. Mail order delivery is not an appropriate substitute for delivery from a qualified community retail pharmacy unless requested by the Member. The MCO’s process must be approved by HHSC, submitted using HHSC’s template, and include all qualified community retail pharmacies identified by HHSC.
8.1.20.13 Health Resources and Services Administration 340B Discount Drug Program

The MCO must use a shared-savings approach for reimbursing Network Providers that participate in the federal Health Resources and Services Administration’s (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 of the MCO's shared savings model for the reimbursement of 340B-purchased drugs, 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 cannot require a Network Provider to submit its actual acquisition cost (AAC) on outpatient drugs and biological products purchased through the 340B program, consistent with UMCM Chapter 2. In addition, the MCO cannot impose PA requirements based on non-preferred status (“PDL PAs”) for these drugs and products.

8.1.20.14 Pharmacy Claims and File Processing

The MCO must process claims in accordance with UMCM Chapter 2 and Texas Insurance Code § 843.339. 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 8.1.27, “Continuity of Care and Out-of-Network (OON) Providers,” regarding payment of OON pharmacy claims.

HHSC will provide the MCO or its designee with pharmacy interface files, including formulary, PDL, third party liability, master provider, and drug exception files. Due to the point-of-sale nature of outpatient pharmacy benefits, the MCO must ensure all applicable MIS systems including pharmacy claims adjudication systems are updated to include the data provided in the pharmacy interface files. The MCO must update MIS systems within two Business Days of the pharmacy interface files becoming available through HHSC’s file transfer process unless clarification is needed or data or file exceptions are identified. The MCO must notify HHSC within the same two Business Days if clarification or data/file exceptions are needed. Additionally, the MCO must be able to perform off-cycle formulary and PDL updates at HHSC’s request.

The MCO must ensure that all daily enrollment and eligibility files in the JIP are loaded into the pharmacy claims adjudication system within two calendar days of receipt.

8.1.20.15 Pharmacy Audits

The MCO and its PBM are prohibited from using extrapolation in pharmacy audits.

8.1.20.16 E-Prescribing

The MCO must provide the appropriate data to the national e-prescribing network, which at a minimum will support: eligibility confirmation, PDL benefit confirmation, identification of preferred drugs that can be used in place of non-preferred drugs (“alternative drugs”), medication history, and prescription routing.
8.1.21 Cancellation of Product Orders

If a Network Provider offers delivery services for covered products, such as DME, home health supplies, or outpatient drugs or biological products, then the MCO’s Provider Contract must require the Provider to reduce, cancel, or stop delivery at the Member’s or the Member’s authorized representative’s written or oral request. The Provider must maintain records documenting the request.

For automated refill orders for covered products, the MCO’s 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 § 291.34. The Member or Member’s Medical Consenter or Caregiver must have the option to withdraw from an automated refill delivery program at any time.

8.1.22 Financial Requirements for Covered Services

The MCO must pay for or reimburse Providers for all Medically Necessary Covered Services provided to all Members. The MCO is not liable for cost incurred in connection with Healthcare Services or NEMT Services rendered prior to the Member’s Effective Date of Coverage in the MCO. When Medicaid provider rates are increased as a result of a legislative appropriation, MCOs must increase provider rates as required by HHSC to the extent allowed by federal laws and regulations.

Medicaid is the payer of last resort for Covered Services, unless an exception applies under federal law or HHSC 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 of the value of Covered Services paid by the MCO. See Section 8.1.34, “Third Party Liability and Recovery, and Coordination of Benefits,” for additional information regarding coordination of benefits and recoveries from third parties.

8.1.23 Accounting and Financial Reporting Requirements

The MCO’s accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations (“FAR”), Generally Accepted Accounting Principles (GAAP), Attachment A, Article 9, “Audit and Financial Compliance,” and the cost principles contained in the Cost Principles Document in UMCM Chapter 6. HHSC will not recognize or pay services that cannot be properly substantiated by the MCO and verified by HHSC.

The MCO must maintain:
1. accounting records separate and apart from other corporate accounting records;
2. records for all claims payments, refunds and adjustment payments to Network Providers and OON providers, and capitation payments;
3. records on interest income and payments for administrative services or functions;
4. separate records for medical and administrative fees, charges, and payments; and
5. 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.

MCO will reimburse HHSC, if reimbursement is sought from the MCOs 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.

8.1.23.1 Financial Reporting Requirements

HHSC will require the MCO to 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 the 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 data submitted with respect to the required financial reports or filings that are in Portable Document Format (PDF), or similar file format such as Tagged Image File Format (TIF), must be generated in a text-searchable format.

Due dates, content, and formats for the following deliverables and reports may be referenced herein or in UMCM Chapter 5.

(a) **Audited Financial Statements**—The MCO must provide the annual audited financial statement, for each year covered under the Contract, no later than June 30. The MCO must provide the most recent annual financial statements, as required by the TDI for each year covered under the Contract, no later than March 1.

(b) **Affiliate Report**—The MCO must submit an Affiliate Report to HHSC if the information changes from the submission of the MCO’s proposal or the last report submission. The report must contain:
   1. a list of all Affiliates; and
   2. for HHSC’s prior review and approval, a schedule of all transactions with Affiliates that, under the provisions of the Contract, will be Allowable Expenses in the FSR for services provided to the MCO by the Affiliate. The schedule should include financial terms (such as pricing), a detailed description of the services to be provided, and an estimated aggregate amount that will be incurred by the MCO for each Affiliate’s services during each Rate Period of the Contract.

(c) **Employee Bonus or Incentive Payment Plan**—If an MCO intends to include employee bonus or incentive payments as allowable administrative expenses, the MCO must furnish a written Employee Bonus or Incentive Payments Plan to HHSC so it may determine whether such payments are allowable administrative expenses in accordance with UMCM Chapter 6. The written plan must include a description of the MCO’s criteria for establishing bonus and incentive payments, the methodology to calculate bonus and incentive payments, and the timing of bonus and incentive payments. The Employee Bonus or Incentive Payment Plan and description must be submitted to HHSC for approval no later than 30 Days after the Effective Date of the Contract and any Contract renewal. If the MCO substantively
revises the Employee Bonus or Incentive Payment Plan, the MCO must submit the revised plan to HHSC for prior review and approval.

(d) **Claims Lag Report**—The MCO must submit a Claims Lag Report as a Contract year-to-date report. The report must be submitted quarterly by the last day of the month following the reporting period. The report must be submitted to HHSC in a format specified by HHSC, or in a format approved by HHSC. The report format is contained in the **UMCM Chapter 5**. The report must at a minimum disclose the amount of incurred claims each month and the amount paid each month.

(e) **MCO Disclosure Statement**—The MCO must file:
1. an updated MCO Disclosure Statement by September 1 of each Contract Year; and
2. a “change notification” abbreviated version of the report, no later than 30 Days after any of the following events:
   a. entering into, renewing, modifying, or terminating a relationship with an affiliated party;
   b. a change in control, ownership, or affiliations; or
   c. a material change in, or need for addition to, the information previously disclosed.

The MCO Disclosure Statement will include, at a minimum, a listing of the MCO’s control, ownership, and any affiliations, and information regarding Affiliate transactions. Minor quarterly adjustments in stock holdings for publicly-traded corporations are excluded from the reporting requirements. The reporting format is included in the **UMCM Chapter 5**.

(f) **Financial Statistical Reports**—The MCO must file quarterly and SFY FSRs in the format, timeframe and per the instructions specified in the HHSC **UMCM Chapter 5**. The MCO must incorporate financial and statistical data of delegated Networks (e.g., IPAs, Limited Provider Networks), if any, in its FSRs. Administrative expenses reported in the FSRs must be reported in accordance with **UMCM Chapter 6**. Quarterly FSRs are due no later than 30 Days after the end of the quarter and must provide information for the current quarter and year-to-date information through the current quarter. The first annual FSR must reflect expenses incurred through the 90th Day after the end of the fiscal year. The first annual report must be filed on or before the 120th Day after the end of each fiscal year. Subsequent annual reports must reflect data completed through the 334th Day after the end of each fiscal year and must be filed on or before the 365th Day following the end of each fiscal year.

HHSC will post all FSRs on the HHSC website.

(g) **Historically Underutilized Business (HUB) Reports**—Upon contract award, the MCO must attend a post-award meeting in Austin, Texas, at a time specified by HHSC, to discuss the development and submission of a Client Services Historically Underutilized Business (HUB) Subcontracting Plan for inclusion, and the MCO’s good faith efforts to notify HUBs of subcontracting opportunities. The MCO must maintain its HUB Subcontracting Plan and submit monthly reports documenting the MCO’s HUB program efforts and accomplishments to the HHSC HUB Office. The report must include a narrative description of the MCO’s HUB program efforts and a financial report reflecting payments made to HUBs. MCOs must use the formats included in HHSC’s **UMCM Chapter 5** for the HUB monthly reports. The MCO must comply with HHSC’s standard Client Services HUB Subcontracting Plan requirements for all Subcontractors.

(h) **TDI Examination Report**—As applicable, the MCO must furnish a copy of any TDI Examination Report, including the financial, market conduct, target exam, quality of care
components, and corrective action plans and responses, no later than ten Days after receipt
of the final report from TDI.

(i) **TDI Filings**—The MCO must furnish a copy of any TDI filings, including, without limitation,
annual figures for controlled risk-based capital, and quarterly financial statements, both as
applicable and required by TDI.

(j) **Registration Statement (also known as the “Form B”)**—If the MCO is a part of an
insurance holding company system, the MCO must submit to HHSC a complete Form B, and
all amendments to this form, and any other information filed by such insurer with the
insurance regulatory authority of its domiciliary jurisdiction.

(k) **Third Party Liability and Recovery (TPL/TPR) Reports**—The MCO must submit TPL/TPR
reports in accordance with the **UMCM Chapter 5**. MCOs must submit TPL/TPR reports
quarterly by MCO Program plan code. The reports must include total dollars cost avoided,
and total dollars recovered from third party payers through the MCOs coordination of benefits
efforts during the Quarter.

(l) **Report of Legal and Other Proceedings and Related Events**—The MCO must comply
with the **UMCM Chapter 5.8**, "Report of Legal and Other Proceedings," regarding the
disclosure of certain matters involving the MCO, its Affiliates, or its Material Subcontractors.
Reports are due both on an as-occurs basis and annually each September 1st. The as-
occurs report is due no later than 30 Days after the event that triggered the notification
requirement.

(m) **Filings with other entities, and other existing financial reports** — The MCO must submit
an electronic copy of the following reports or filings pertaining to the MCO, or its parent, or
its parent's parent:

1. **SEC Form 10-K.** For publicly-traded (stock-exchange-listed) for-profit corporations,
submit the most-recent annual SEC Form 10K filing.
2. **IRS Form 990.** For nonprofit entities, submit the most recent annual IRS Form 990 filing,
complete with any and all attachments or schedules. If a nonprofit entity is exempt from
the IRS 990 filing requirement, demonstrate this and explain the nature of the
exemption.
3. If the MCO is a nonprofit entity that is a component or subsidiary of a County Hospital
District, or otherwise an entity of a government, then submit the annual financial
statements as prepared under the relevant rules or statutes governing annual financial
reporting and disclosure for the MCO and/or its parent, including all attachments,
schedules, and supplements.
4. **Annual Report.** The MCO must submit this report if it is different than or supplementary
to the audited financial statements or Form 10-K required herein, and if it is distributed to
either shareholders, customers, employees, owner(s), parent, bank or creditor(s),
donors, the community, or to any regulatory body or constituents, or is otherwise
externally distributed or posted.
5. **Bond or debt rating analysis.** If the MCO or its ultimate parent has been the subject of
any bond rating analysis, ratings affirmation, write-up, or related report, such as by AM
Best, Fitch Ratings, Moody’s, Standard & Poor, etc., submit the most recent complete
detailed report from each rating entity that has produced such a report.

All of the above such reports or filings are due to HHSC no later than 30 Days after such
report is filed or otherwise initially distributed. Each report should include all exhibits,
attachments, notes, supplemental data, management letters, auditor letters, etc., and any
updates, revisions, clarifications, or supplemental filings. If the reporting entity has a regular
required due date for any of the above reports, and receives an extension on the filing
deadline, then the MCO should notify HHSC of any such extension and the estimated
revised filing date.

n) **Medical Loss Ratio (MLR) Report** - The MCO must submit an annual MLR Report in
accordance with the specific requirements as stated in **UMCM Chapter 5**. The first
report will apply to the rating period commencing September 1, 2017. The Deliverable
will be due as specified in **UMCM Chapter 5**.

### 8.1.24 Management Information System (MIS) Requirements

The MCO must maintain an MIS that supports all functions of the MCO’s processes and
procedures for the flow and use of MCO data. If the MCO subcontracts a MIS function, the
Subcontractor’s MIS must comply with the requirements of this section. The MCO must have
hardware, software, and a network and communications system with the capability and capacity
to handle and operate all MIS subsystems for the following operational and administrative areas:

1. Enrollment/eligibility subsystem;
2. Provider subsystem;
3. Encounter/claims processing subsystem;
4. financial subsystem;
5. Utilization/Quality Improvement subsystem;
6. reporting subsystem;
7. interface subsystem;
8. TPR subsystem;
9. Health Passport subsystem and
10. Information Management Protecting Adults and Children in Texas (IMPACT)
subsystem, the DFPS system that will transmit to and receive data from the
MCO).

The MIS must enable the MCO to meet the Contract requirements, including all applicable state
and federal laws, rules, and regulations. The MIS must have the capacity and capability to
capture and utilize various data elements required for MCO administration.

The MCO must have a system that can be adapted to changes in business practices or policies
within the timeframes negotiated by the Parties. The MCO is expected to cover the cost of such
systems modifications over the life of the Contract.

MCOs 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 United States Postal Service (USPS). MCOs must validate addresses to the
master Provider file as it implements with the new Provider enrollment system.

The MCO is required to participate in the HHSC Systems Work Group.

The MCO must provide HHSC prior written notice, generally at least 180 Days, of Major
Systems Changes and implementations, including any changes relating to Material
Subcontractors, in accordance with the requirements of this Contract. Refer to **Attachment A,
Article 12**, “Remedies and Disputes,” and **Attachment B-3**, “Deliverables/Liquidated Damages
Matrix,” for additional information regarding remedies and damages. Refer to **Section 7.3.7**,
“Operations Readiness,” and **Section 8.1.1.1**, “Additional Readiness Reviews and Monitoring
Efforts,” for additional information regarding MCO Readiness Reviews. Refer to **Attachment A,**
Section 4.09(c), “Subcontractors and Agreements with Third Parties,” for information regarding Readiness Reviews of the MCO’s Material Subcontractors.

The MCO must notify HHSC of Major Systems Changes in writing. The notification must detail the following.

- The aspects of the system that will be changed and date of implementation
- How these changes will affect the Provider and Member community, if applicable
- The communication channels that will be used to notify these communities, if applicable
- A contingency plan in the event of downtime of system(s)

Major Systems Changes are subject to HHSC desk review and onsite review of the MCO’s facilities as necessary to test readiness and functionality prior to implementation. Prior to HHSC approval of the Major Systems Change, the MCO may not implement any changes to its operating systems. Failure to comply will result in contractual remedies, including damages. HHSC retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

If HHSC determines that it will conduct an onsite review, the MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) related to such monitoring. For purposes of this section, “authorized reimbursable travel costs” include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement. This provision does not limit HHSC’s ability to collect other costs as damages in accordance with Attachment A, Section 12.02(e), “Damages.”

The MCO must provide HHSC any updates to the MCO’s organizational chart relating to MIS and the description of MIS responsibilities at least 30 Days prior to the effective date of the change. The MCO must provide HHSC with the names of official points of contact for MIS issues on an ongoing basis.

If for any reason an MCO does not fully meet the MIS requirements, then the MCO must, upon request by HHSC, either correct such deficiency or submit to HHSC a Corrective Action Plan and risk mitigation plan to address such deficiency as requested by HHSC. Immediately upon identifying a deficiency, HHSC may impose remedies according to the severity of the deficiency including liquidated damages. The MCO’s MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan. Refer to Attachment A, “STAR Health Contract Terms,” for additional information.

In accordance with UMCM Chapter 16, the MCO must share and integrate service authorization data among all relevant MCO employees, including both physical and Behavioral Health staff, or, if applicable, between the MCO and the third party or subsidiary contracted with the MCO to manage Behavioral Health Services.

8.1.24.1 Encounter Data

The MCO must provide complete and accurate Encounter Data for all Covered Services, including Value-added Services. Encounter Data is subject to the requirements in 42 C.F.R. § 438.242 and § 438.818. The data will be submitted by the MCO in accordance with HHSC’s required format and required data elements for Medicaid MCOs. Encounter Data must follow the format and data elements as described in the most current version of HIPAA-compliant 837
Companion Guides, NCPDP format (pharmacy), and Encounters Submission Guidelines. HHSC will specify the method of transmission, and the submission schedule, in the UMCM Chapter 5.0. Minimally, the MCO must submit monthly Encounter Data transmissions, and include all Encounter Data and Encounter Data adjustments processed by the MCO within the preceding month. In addition, pharmacy Encounter Data must be submitted no later than 25 Days after the date of adjudication and include all Encounter Data and Encounter Data adjustments processed by the MCO. Encounter Data quality validation must incorporate assessment standards developed jointly by the MCO and HHSC. The MCO must submit complete and accurate Encounter Data not later than the 30th Day after the last Day of the month in which the claim was adjudicated. The MCO must make original records available for inspection by HHSC and its agents for validation purposes. The MCO must correct and return Encounter Data that do not meet quality standards within a time period specified by HHSC.

For reporting Encounters and Fee-for-Service claims 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 as directed by HHSC for both Encounter Data and Fee-for-Service claims submissions, as applicable.

The MCO must report Texas Health Steps medical and dental checkups data in a manner required for the reports to courts of law, including the number and percent of Members who receive all of their Texas Health Steps medical and dental checkups when due.

HHSC will use the Encounter Data to run the Quarterly Encounter Reconciliation Report, which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Vision 21 Data Warehouse. This report is based on querying the Vision 21 Data Warehouse 60 Days after the last day of the quarter. The MCO may be subject to liquidated damages as specified in Attachment B-3.

The MCO’s Provider Contracts must require Network Providers to comply with the requirements of Texas Government Code § 531.024161, regarding reimbursement of claims based on orders or referrals by supervising Providers.

8.1.24.1.1 NEMT Services Encounter Data Submission

The MCO must provide complete and accurate Encounter Data for all applicable NEMT Services provided to Members. Encounter Data must follow the format and data elements as described in the 837P Companion Guides, Encounter Submission Guidelines, MT88 MCO Companion Guide, or comparable format as determined by HHSC. HHSC will specify the method of transmission. The MCO must submit to HHSC Encounter Data and Encounter Data adjustments processed by the MCO. Encounter Data quality validation must incorporate assessment standards developed jointly by the MCO and HHSC. The MCO must submit complete and accurate Encounter Data no later than the 30th Day after the last Day of the month in which each claim was Adjudicated. The MCO must make original records available to HHSC upon request. Encounter Data that does not meet quality standards must be corrected and returned within a time period specified by HHSC.

For reporting claims processed by the MCO and submitted on the prescribed Encounter 837P format or comparable format as determined by HHSC, the MCO must use the HCPCS, provider identifiers, and other codes as directed by HHSC. Any exceptions will be considered on a case-by-case basis after HHSC receives written notice from the MCO requesting an exception. The MCO must:
1. Implement and maintain policies and procedures to support Encounter Data reporting and submission and provide copies for HHSC review prior to implementation of the NEMT Services carve-in;
2. Establish quality control procedures and edits to allow for the detection and correction of errors prior to submission of Encounter Data to HHSC or its designee;
3. Ensure the paid amount on Encounter Data is the amount paid to the provider of the NEMT Services;
4. Have a system in place for verifying and ensuring that only approved NEMT Services are rendered and, as applicable, paid to NEMT Services providers;
5. Review its quality control procedures at least on a quarterly basis to mitigate issues with the submission of Encounter Data; and
6. Have a computer processing and reporting system that is capable of following or tracing the Encounter record within its system using the unique authorization number assigned to each of the NEMT Services.

**8.1.24.2 MCO Deliverables related to MIS Requirements**

The MCO must submit the following documents and corresponding checklists for HHSC’s review and approval:

1. Disaster Recovery Plan;
2. Business Continuity Plan; and

The Disaster Recovery Plan and the Business Continuity Plan may be combined into one document. The Disaster Recovery Plan must include an inclement weather plan to minimize any disruption to NEMT Services during weather that does not constitute a disaster but could impact travel.

Additionally, if the MCO modifies the following documents, it must submit the revised documents and corresponding checklists for HHSC’s review and approval:

1. Joint Interface Plan;
2. Risk Management Plan; and

The MCO must submit plans and checklists to HHSC according to the format and schedule identified the UMCM Chapter 5. Additionally, if a Systems Readiness Review is triggered by one of the events described in Section 8.1.24, “Management Information Systems (MIS) Requirements,” the MCO must submit all of the plans identified in this section in accordance with an HHSC-approved timeline.

The MCO must follow all applicable JIPs and all required file submissions for HHSC’s Administrative Services Contractor, EQRO and HHSC Medicaid Claims Administrator. The JIPs can be accessed through the UMCM Chapter 7.

**8.1.24.3 System-wide Functions**

The MCO’s MIS system must include key business processing functions and features, which must apply across all subsystems as follows:

1. Process electronic data transmission or media to add, delete or modify membership records with accurate begin and end dates;
2. track Covered Services received by Members through the system, 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 the contractor designated by HHSC 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 a system or subsystem failure;
6. employ industry standard medical billing taxonomies (procedure codes, 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. relate and extract data elements to produce report formats provided within the UMCM Chapter 5 or otherwise required by HHSC;
12. ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS; and
13. maintain and cross-reference all Member-related information with the most current Medicaid Provider number.

8.1.24.4 Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH Act) Compliance

The MCO’s MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA or the HITECH Act as amended or modified. The MCO must comply with HIPAA EDI requirements. MCO’s enrollment files must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 format and all claims and remittance transactions in the 837/835 format, with the exception of pharmacy services. Pharmacies may submit eligibility inquiries in the NCPDP E1 HIPAA-compliant format. Claim transactions for pharmacy services must be in the NCPDP B1/B2 HIPAA-compliant formats; all others must be in the 837/835 HIPAA-compliant format. The MCO must follow the rules for 5010 Compliancy and ICD-10 Compliancy which is located on the CMS website under Medicare and Coding.

The MCO must provide its Members or their Medical Consenters with a privacy notice as required by HIPAA or the HITECH Act, including 45 C.F.R. § 164.520. The MCO must provide HHSC with a copy of its privacy notice during Readiness Review and any changes to the notice prior to distribution.

8.1.24.5 Claims Processing Requirements

The MCO must process all provider claims and must pay all claims for Medically Necessary healthcare Covered Services that are filed within the timeframe specified by this section, and pharmacy claims that are filed in accordance with the timeframes specified in UMCM Chapter 2. 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 the UMCM Chapter 2. The MCO and its Subcontractors cannot directly or indirectly charge or hold a Member or provider responsible for claims adjudication or transaction fees.

The MCO must maintain an automated claims processing system that registers the date a claim is received by the MCO, the detail of each claim transaction (or action) at the time the transaction occurs, and that has the capability to report each claim transaction by date and type to include interest payments. This information must be at claim and line detail level, maintained online and in archived files, as appropriate, per contractual record retention requirements. All claims data must be easily sorted and produced in formats upon request by HHSC. All provider claims must be processed within 30 Days from the date of claim receipt by the MCO. All provider claims that are Clean Claims must be adjudicated within 30 Days from the date of claim receipt.

The MCO must offer its Providers the option of submitting and receiving claims information through electronic data interchange (EDI) that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims 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, Chapter 21, Subchapters C and T.

HHSC reserves the right to require the MCO to receive initial electronic claims through an HHSC-contracted vendor at a future date. This function will allow Providers to send claims to one location, which will then identify where the claim should be submitted. The MCO will be expected to have an interface that allows receipt of these electronic submissions. If HHSC implements this requirement, then the MCO must maintain a mechanism to receive claims in addition to the HHSC claims portal. Providers must be able to send claims directly to the MCO or its Subcontractor.

The MCO must provide a Provider portal that supports functionality to reduce administrative burden on Network Providers at no cost to the Providers. If the MCO and its Subcontractor or subsidiary maintains separate Provider portals for physical health and Behavioral Health Services Network Providers, the MCO must comply with the requirements in UMCM Chapter 16. The Provider portal functionality must include the following:

1. Client eligibility verification;
2. submission of electronic claims;
3. PA requests;
4. claims appeals and reconsiderations;
5. exchange of clinical data and other documentation necessary for PA and claim processing;
6. An online process, through the provider portal or Health Passport, for providers to access the following information on their patients with the members consent
   a. Screening and Assessment Instrument (SAI)
   b. Member SAI MDCP Review signature page (Form 2605), as applicable
   c. Individual Service Plan (ISP), as applicable

To the extent possible, the Provider portal should support both online and Batch Processing as applicable to the information being exchanged. To facilitate the exchange of clinical data and other relevant documentation, the Provider portal must provide a secure exchange of
information between the Provider and MCO, including, as applicable, a Subcontractor of the MCO.

The MCO is subject to remedies, including liquidated damages, if the MCO does not pay providers interest at an 18 percent annual rate, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 30-Day claims processing deadline. The MCO may negotiate Provider Contract terms that indicate that duplicate claims filed prior to the expiration of 31 Days would not be subject to the 18 percent interest payment if not processed within 30 Days. The MCO is subject to contractual remedies, including liquidated damages and interest, if the MCO does not process and adjudicate pharmacy claims in accordance with the procedures and the timeframes listed in UMCM Chapter 2.

The MCO may deny a claim submitted by a provider for failure to file in a timely manner as provided for in UMCM Chapter 2. The MCO must withhold all or part of payment for any claim submitted by a provider who is:

1. excluded or suspended from the Medicare, Medicaid, or CHIP programs for Fraud, Waste or Abuse;
2. on payment hold under the authority of HHSC or its authorized agent(s);
3. with debts, settlements, or pending payments due to HHSC, or the state or federal government;
4. for neonatal services provided on or after September 1, 2017, if submitted by a Hospital that does not have a neonatal level of care designation from HHSC; or
5. for maternal services provided on or after September 1, 2021, if submitted by a Hospital that does not have a maternal level of care designation from HHSC.

In accordance with Texas Health and Safety Code § 241.186, the restrictions on payment identified in items 4–5 above do not apply to emergency services that must be provided or reimbursed under state or federal law.

With the following exceptions, 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. This limitation does not apply in cases of provider Fraud, Waste, or Abuse that the MCO did not discover within the two-year period following receipt of a claim. In addition, the two-year limitation does not apply when the officials or entities identified in Attachment A, Section 9.02(c), “Access to records, books and documents,” conclude an examination, audit, or inspection of a provider more than two years after the MCO received the claim. Finally, the two-year limitation does not apply when HHSC has recovered a capitation from the MCO based on a Member’s ineligibility. If an exception to the two-year limitation applies, then the MCO may recoup related payments from providers.

If an additional 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 that 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.

The MCO’s Provider Contract must specify that program violations arising out of performance of the contract are subject to administrative enforcement by the HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.
The MCO must obtain recovery of payment from a liable third party and not from the provider unless the provider received payment from both the MCO and the liable third party.

The MCO is subject to remedies, including liquidated damages, if within 30 Days of receipt, the MCO does not adjudicate to a paid or denied status 98 percent of all Clean Claims. The MCO is subject to remedies, including liquidated damages, if within 90 days of receipt, the MCO does not adjudicate to a paid or denied status 99 percent of all Clean Claims. Claims paid or denied deficient for additional information must be adjudicated paid or denied by the 30th Day following the date the claim is pended or denied deficient, if reasonably requested information is not received prior to the expiration of 30 Days.

The MCO must adjudicate all Appealed claims to a paid or denied status within 30 Days of receipt of the appealed claim. The MCO is subject to remedies, including liquidated damages, if 98 percent of Appealed claims are not adjudicated to a paid or denied status within 30 Days of receipt of the Appealed claim.

The MCO may deny a claim for failure to file timely if a provider does not submit the claim to the MCO within 95 Days of the date of service or a pharmacy claim. If a provider files with the wrong health plan, or with the HHSC Administrative Services Contractor, and produces documentation verifying the initial timely claims filing within 95 Days of the date of service, the MCO must process the provider’s claim without denying for failure to timely file.

The MCO must send a remittance and status report or other remittance written communication that includes detailed information for each adjudicated, denied deficient and pended deficient claim to allow the Provider to easily identify the claim number, date of service, type of service, claim codes, Member’s name, and Member ID number.

The MCO must finalize all claims, including Appealed claims, within 24 months of the date of service.

The MCO is subject to the requirements related to coordination of benefits for secondary payors in the Texas Insurance Code § 843.349(e) and (f).

The MCO must notify HHSC of major claim system changes in writing no later than 180 Days prior to implementation. The MCO must provide an implementation plan and schedule of proposed changes. HHSC reserves the right to require a desk or on-site readiness review of the changes.

The MCO must inform all Network 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 make any policies affecting claims adjudication and claims coding and processing guidelines available to Providers for the applicable provider type. Providers must receive 90 Days’ notice prior to the MCO’s implementation of changes to these claims policies and guidelines, unless HHSC requires a different notice period.

### 8.1.24.5.1 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 claim(s) for the purpose of conducting any necessary research on the claim(s) or to adjust the claim(s), if appropriate, excluding Nursing Facility Daily/Unit rate claims.
MCO may initiate a Project at its own initiative. All claims included in a particular Project must be finalized within 60 Days of the Project being opened or within an agreed upon timeframe 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 time frame. MCO must maintain the agreement for 18 months from the conclusion of the Project and make the agreement available to HHSC upon request. MCOs shall not include Nursing Facility Daily/Unit rate claims as part of a Project. MCO will report monthly to HHSC the start and end date for all Projects using HHSC’s report template. For Nursing Facility Daily/Unit rate claims, please see UMCM Chapter 8.

8.1.24.6 National Correct Coding Initiative

The MCO must comply with the requirements of Section 6507 of PPACA (P.L. 11-148), regarding “Mandatory State Use of National Correct Coding Initiatives,” including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

8.1.25 Fraud, Waste, and Abuse

The MCO is subject to all state and federal laws, rules, and regulations relating to Fraud, Waste, and Abuse (FWA) in healthcare and the Medicaid 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.


2. The MCO must submit a written Fraud, Waste, and Abuse compliance plan to HHSC OIG for approval each year per 1 Texas Admin. Code 353.502. The plan must be submitted 90 Days prior to the start of the State Fiscal Year. See Section 7, “Transition Phase Requirements” for requirements regarding timeframes for submitting the original plan.

3. The MCO must require all employees who process Medicaid claims, including Subcontractors, to attend annual training as provided by HHSC per Texas Government Code § 531.105.

4. The MCO must perform pre-payment review for identified providers as directed by HHSC OIG.

5. 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 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.

6. For the purposes of NF and Hospital Utilization Reviews, this section also applies to HHSC requests.

7. With regard to NEMT Services, when monitoring Fraud, Waste, and Abuse, the MCO must consider whether appropriate medical documentation supports use of:
   a. other demand response transportation services in areas where public transportation services are an available option; and
   b. transportation to obtain care outside of the Member’s Service Area.

8. Failure to comply with any requirement of Sections 8.1.25 and 8.1.26.2(c) and (f) may subject the MCO to liquidated damages and/or administrative enforcement pursuant to 1 Tex. Admin. Code Chapter 371 Subchapter G, in addition to any other legal remedy.
8.1.25.1 Special Investigative Units

In order to facilitate cooperation with HHSC OIG, the MCO must establish and maintain a special investigative unit (SIU), either in-house or by contract with another entity, to investigate possible acts of Fraud, Waste, or Abuse 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 located in Texas and 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 §§ 353.501-353.505, and 1 Tex. Admin. Code §§ 370.501-370.505.

2. The MCO must maintain a full-time SIU manager dedicated solely to the Texas Medicaid program to direct oversight of the SIU and Fraud, Waste, and Abuse activities.

3. 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 contracts. The investigator must hold credentials such as a 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 Fraud, Waste and Abuse investigatory experience.

8.1.25.2 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), the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, the Office of the Attorney General, the Texas Department of Insurance (TDI), or other units of State government.

1. The 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 via 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 UMCM Chapter 18.

The most common requests include (and due dates) include:

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 – fifteen Business Days;
6. Provider profile, Utilization Review 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 for interpretations or clarifications of the MCO policy and procedure - five Business Days; and
9. The basis for providing specific authorized services, including Case-by-case services, Value-added Services, and Comprehensive Care Program (CCP) services provided through THSteps – as needed.
10. Other time-sensitive requests – as needed.

8.1.25.3 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 ten 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, 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, Chapter 371, Subchapter G or liquidated damages as specified in Attachment B-3.

8.1.25.4 Payment Holds and Settlements

1. 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 Network Provider is under investigation based upon credible allegations of Fraud, depending on the allegations at issue.

2. 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. 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.

3. The MCO must also report all of the following information to HHSC OIG after it suspends payments to the Provider: date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, amount of adjudicated Medicaid payments held, and, if applicable, 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 UMCM Chapter 5.5 and provide this information to HHSC OIG upon request.

4. The MCO must follow the requirements set forth in a settlement agreement involving a 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: Senior Case Analyst, 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.

5. For payment suspensions initiated by the MCO, the MCO must report the following information to HHSC OIG: the nature of the suspected fraud, basis for the suspension, date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, the amount of payments held, the percentage of the hold, and, if applicable, the good cause rationale for imposing a partial payment suspension.

6. MCOs must maintain all documents and claim 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 this Section 8.1.19 and all state and federal laws and regulations relating to Fraud, Waste, and Abuse in healthcare and the Medicaid and CHIP programs are subject to administrative enforcement by HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

8.1.25.5 Treatment of Recoveries by the MCO for Fraud, Waste and Abuse

Pursuant to 42 CFR 438.608(d)(1)(i), the MCO must comply with all state and federal laws pertaining to provider recoveries including Texas Government Code § 531.1131 and 1 Tex. Admin. Code, Part 15,§ 353.1454.

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 Fraud, Waste, and Abuse.

1. 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.

2. 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, Texas Medicaid Fraud Prevention Act, or similar laws. The recovery of an overpayment by an MCO from a Provider does not preclude the prosecution of nor recovery from a Provider under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws.

3. Upon discovery of Fraud, Waste or Abuse the MCO shall:
   a. Submit a referral using the fraud referral form through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS); and
   b. Proceed with recovery efforts per 1 Tex. Admin. Code § 353.505.

4. The MCO may retain recovery amounts pursuant to Texas Government Code § 531.1131(c) and (c-1).

5. Pursuant to Government 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:
   a. 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. 
      i. The prohibition described in this section 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.
      ii. 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.
   b. The improperly paid funds have already been recovered by HHSC OIG.

6. The MCO must report at least annually, or at the request of the HHSC OIG, to the status of their recoveries of overpayments in the manner specified by the HHSC OIG.
8.1.25.6 Additional Requirements

In accordance with Section 1902(a)(68) of the Social Security Act, Medicaid MCOs and their Subcontractors that receive or make 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, which 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 whistleblower protections under such laws, as described in Section 1902(a)(68)(A).

2. Include as part of such written policies, detailed provisions regarding the MCO's or Subcontractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

3. Include in any employee handbook a specific discussion of the laws described in Section 1902(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 fraud, waste, and abuse.

8.1.25.7 Lock-in Actions

HHSC OIG’s Lock-in Program (OIG-LP) 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 Lock-in Program MCO Policies and Procedures”, including how NEMT Services are delivered to Members subject to the OIG-LP. MCOs must submit documentation on an annual basis demonstrating how the MCO complies with "HHSC OIG Lock-In Program Policies and Procedure" requirements. The MCO must submit the information 90 Days prior to the start of the State Fiscal Year in conjunction with the Fraud, Waste, and Abuse compliance plan.

8.1.26 Reporting Requirements

The MCO must provide and must require its Subcontractors to provide at no cost to the Texas HHSC:

1. All information required under the Contract, including but not limited to, the reporting requirements or other information related to the performance of its responsibilities thereunder as reasonably requested by the HHSC.

2. Any information in its possession sufficient to permit HHSC to comply with the Federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. 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 timeframe and formats reasonably acceptable to both parties.

3. The MCO’s Chief Executive and Chief Financial Officers, or persons in equivalent positions, must certify that financial data, Encounter Data and other measurement data have been reviewed by the MCO and are true and accurate to the best of their knowledge after reasonable inquiry.
8.1.26.1 Performance Measurement

The MCO must provide to HHSC or its designee all information necessary to analyze the MCO’s provision of quality care to Members using measures to be determined by HHSC in consultation with the MCO.

8.1.26.2 Reports

The MCO must provide the following reports, in addition to the Financial Reports described in Section 8.1.23.1, “Financial Reports,” and those reporting requirements listed elsewhere in the Contract. The UMCM Chapter 5 will include a list of all required reports, and a description of the format, content, file layout and submission deadlines for each report. HHSC also retains the option to require additional reports or to change the reporting frequency for any report(s).

(a) **Claims Summary Report**—The MCO must submit one Claims Summary Report each month by Program to HHSC the text file layout located in UMCM Chapter 5.

(b) **Quality Assurance and Performance Improvement (QAPI) Program Annual Summary Report**—The MCO must submit a QAPI Program Annual Summary in a format and timeframe as specified in the UMCM Chapter 5.

(c) **Fraudulent Practices Referral** —Utilizing the HHSC OIG fraud referral form, through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS), the HHSC’s assigned officer or director must report and refer all possible acts of Fraud or Abuse to the HHSC OIG within 30 Business Days of receiving the reports of possible acts of Fraud, Waste, or Abuse from the HHSC’s Special Investigative Unit (SIU). This requirement applies to all referrals of possible acts of Fraud, Waste, and Abuse. Additional guidance is provided in UMCM Chapter 5.

Additional reports required by the HHSC OIG relating to Fraud, Waste, and Abuse are listed in the UMCM Chapter 5.

(d) **Provider Complaints, Member Complaints, and Member Appeals**—The MCO must submit monthly Complaints and Member Appeals reports by Program. The MCO must include in its reports complaints, including Initial Contact Complaint and appeals submitted to the MCO and/or any Subcontractor delegated to provide a service for the MCO. All Member or Provider complaints, including NEMT Services complaints, submitted orally or in writing (e.g. via email, call, letter, etc.) to the MCO and/or its Subcontractor must be included within the MCO’s complaint reports. An Inquiry must not be counted as a compliant on the MCO’s complaint reports. The MCO Member Appeal report must include all appeals received prior to and during the month, appeals resolved during the month, and pending appeals. The MCO must submit its Member and Provider complaints and its Member appeals using the text file layouts in UMCM Chapter 5. The MCO must ensure that as many pending complaints and appeals as possible are resolved prior to submitting the reports.

(e) **Provider Termination Report**—The MCO must submit one Provider Termination Report each quarter by Program that identifies all Network Providers and NEMT Services providers who cease to participate in the MCO’s Provider Network or transportation network either voluntarily or involuntarily. The text file layout located in UMCM Chapter 5, must be submitted no later than 30 Days after the end of the reporting quarter.
Hotline Reports—The MCO must submit a MCO Hotlines Report each month per Program and hotline type that includes the Member Services Hotline, the Behavioral Health Services Hotline, the Nurse Hotline, the NEMT Services call center if the MCO operates a separate call center for this purpose, and the Provider Hotline to measure the MCO's compliance in accordance with the performance standards set out in Sections 8.1.4.8 Provider Hotline, 8.1.5.6 Nurse and Member Hotline Requirements, and 8.1.17.3 Behavioral Health Hotline and Emergency Services using the text file layout located in UMCM Chapter 5. If the MCO does not use a separate call center for NEMT Services, NEMT data must be detailed in the Member Hotline monthly status report. NEMT Services call center data must also be reported with the “Where’s My Ride” line data broken out.

If the MCO is not meeting a hotline performance standard, HHSC may require the MCO to implement corrective actions until the hotline performance standards are met.

Medicaid Managed Care Texas Health Steps Medical Checkups Reports—The MCO must submit reports identifying the number of new Members and existing Members receiving Texas Health Steps medical checkups. The MCO must also document and report those Members refusing to obtain the medical checkups. For HHSC purposes only, the documentation must include the reason the Member refused the checkup or the reason the checkup was not received.

The definitions, timeframe, format, and details of the reports are contained and described in the UMCM Chapters 12. The MCO may utilize UMCM Chapter 12.6, “Annual Report Refusal Tracking Log,” for refusal reporting.

Other—The MCO must follow all applicable JIPs and all required file submissions for Medicaid’s Administrative Services Contractor, EQRO, Quality Vendor, and Medicaid Claims Administrator. The JIPs can be accessed through the UMCM Chapter 7.

Audit Reports—The MCO must comply with the requirements in UMCM Chapter 5.3.11, “Audit Reports,” regarding notification and submission of audit reports.

Frew Quarterly Monitoring Report—Each calendar year quarter, HHSC prepares a report for the court that addresses the status of the Consent Decree paragraphs of the Frew v. Smith lawsuit. The MCO must prepare responses to questions posed by HHSC on the Frew Quarterly Monitoring Report template. The timeframe, format, and details of the report are set forth in the UMCM Chapter 12.

PCP Enrollment in Texas Health Steps Report—The MCO must submit a quarterly PCP Enrollment in Texas Health Steps Report. The MCO must include in its reports the number of PCPs enrolled in Network, and the number and percent of Network PCPs that are enrolled as Texas Health Steps providers. All data should be reported as of the first day in the SFQ. The MCO must submit the PCP Enrollment in Texas Health Steps reports electronically on or before 30 Days following the end of the SFQ, using the format specified in the UMCM Chapter 5.

HHSC retains the option to request a listing of Network PCPs enrolled as Texas Health Steps providers at the time of report submission when the need for further review is identified.

Network Summary Report—The MCO must submit a quarterly Network Summary Report. The MCO must include in its reports the number of enrollees residing in each county in the State, and the number of contracted and unduplicated Providers, by type, who are currently
practicing in each county in the State. Provider types to be included in the report as well as the format to be used are specified in the UMCM Chapter 5. The MCO must submit the Network Summary reports electronically on or before 30 Days following the end of the SFQ.

(m) **Liaison Summary Report**—The MCO must submit a quarterly Liaison Summary Report. The MCO must include in its reports the number of issues or requests, by type, that are received from the DFPS Well-Being Specialists in each of seven regions of the State and worked by the MCO Liaisons, and any pertinent detail that describes the nature of such issues or requests. The MCO must submit the Liaison Summary reports electronically on or before 30 Days following the end of the SFQ, using the format specified in the UMCM Chapter 5.

(n) **Psychotropic Medication Utilization Review (PMUR) Report**—The MCO must submit a quarterly PMUR Report. The MCO must include in its reports the number of PMUR screenings triggered by each of the sources approved by HHSC and specified in the UMCM Chapter 5, the number of PMUR screenings completed, and the number that fall into each of the outcomes approved by HHSC and specified in the UMCM, as well as the percentages of each source and outcome appearing in the format specified in the UMCM. The MCO must submit the PMUR Reports electronically on or before 30 Days following the end of the SFQ.

(o) **Service Management Summary Report**—The MCO must submit a quarterly Service Management Summary Report. The MCO must include in its reports the total number of telephonic screenings to be completed for new Members enrolled within the reporting quarter, the total number that were successfully completed in the reporting quarter, and the number that resulted in the development of an HCSP. The MCO must also include in its reports the number of telephonic screenings and HCSPs that could not be completed due to a wrong contact number listed in the eligibility or enrollment file, a non-responsive Caregiver or Medical Consenter, refusal by the Medical Consenter to assist in completion of an HCSP, or hospitalization of the Member. The MCO must also include in its reports the number of telephonic screenings and HCSPs that were not completed within contractually required timeframes. The MCO must submit the Service Management Summary Reports electronically on or before 45 Days following the end of the SFQ, using the format specified in the UMCM Chapter 5.

(p) **Drug Utilization Review (DUR) Reports**—MCO must submit the DUR reports in accordance with the requirements of UMCM Chapter 5.

(q) **Perinatal Risk Reports**—The MCO must submit a quarterly perinatal risk report as described in UMCM Chapter 5. Quarterly reports are due 30 Days after the end of each quarter.

(r) **MCO Pharmacy Quarterly Report**—MCO must complete and submit an MCO Pharmacy Quarterly Report using the HHSC-provided template in UMCM Chapter 5. Reports must be submitted for each MCO and cannot be grouped by the Pharmacy Benefit Manager (PBM).

(s) **Critical Incidents and Abuse, Neglect, and Exploitation (ANE) Report**—Medicaid MCOs must submit quarterly reports that includes the number of Critical Incidents unrelated to ANE identified by the MCO or reported by Network Providers and ANE reports received from Adult Protective Services (APS) for Members receiving LTSS. Upon written notification from HHSC, MCOs for STAR Health MDCP must use the CIMS in lieu of the Critical Incidents and ANE Report.
(t) **Value Added Services (VAS) Utilization Report** - The MCO must submit a report of Member utilization of its value added services. The report must be submitted to HHSC using the VAS Utilization Report template in **UMCM Chapter 4** and according to the timeframes identified in **UMCM Chapter 5**.

(u) **LTSS Actions** - IF MCO provides LTSS under its capitation for STAR Health, MCO must complete and submit a quarterly report of suspension, termination, or reduction of a Member’s LTSS services, or of an adverse benefit determination relating to an LTSS service required by 42 CFR § 438.228, specified in **UMCM Chapter 5**.

(v) **MDCP PDN PPECC Authorization Report** - The MCO must file monthly MDCP PDN PPECC Authorization Reports in accordance with the appropriate chapter in the **UMCM**. Monthly reports are due 15 Days after the end of each month.

(w) **MDCP Waiver Performance Measure Data Report** - For Members in the STAR Health Medically Dependent Children Program (MDCP) waiver program, the MCOs must, through self-reported data, report on the following CMS assurances and sub-assurances listed below in numbers 1-4 , The qualified provider Deliverables identified below in numbers 1-3 must be provided annually. The service plan Deliverable identified below in number 4 must be provided in four quarterly and one annual report for each SFY, **UMCM Section 5.7.4** outlines specific measures to be reported.

1. The MCO demonstrates that it has designed and implemented an adequate system for assuring that all MDCP waiver services are provided by qualified providers.
2. The MCO verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing MDCP waiver services.
3. The MCO monitors non-licensed/non-certified providers to assure adherence to MDCP waiver requirements.
4. The MDCP Services are delivered in accordance with the ISP, including the type, scope, amount, duration and frequency specified in the ISP.

(x) **TPR Report for Pharmacy TPL** – MCOs must complete and submit a TPR Report for Pharmacy TPL using the HHSC-provided template in **UMCM Chapter 5.3.4**.

(y) **Network and Capacity Report** – The MCO must submit a quarterly report that includes all mail order pharmacies and 24-hour pharmacies in its Provider Network. The report must be submitted using the text file layout located in **UMCM Chapter 5** no later than days after the end of the reporting quarter.

(z) **Out-of-Network (OON) Utilization Reports** – The OON Utilization Report will provide an overview of each MCO’s out-of-network claims. The MCO must file quarterly OON Utilization Reports in the format and timeframe specified in **UMCM Chapter 5**.

(aa) **Long-Term Services and Supports Report** - Beginning April 2021, the STAR Health MCO must file quarterly Long-Term Services and Supports Reports, including the data specified in **UMCM Chapter 10.1.11**, “LTSS Quality Measures Template.” Quarterly reports are due 30 Days after the end of each quarter.

**8.1.27 Continuity of Care and Out-of-Network (OON) Providers**

The MCO must ensure continuity of care such that the care of newly enrolled Members and Members who disenroll from the MCO is not disrupted or interrupted. The MCO must ensure that the care to newly enrolled Members is not disrupted or interrupted for Members: (1) whose
health or BH condition has been treated by specialty care providers or (2) whose health could be placed in jeopardy if Medically Necessary Covered Services are not provided. This shall include contacting a Member’s former MCO to request information regarding the Member’s needs, current Medical Necessity determinations, authorized care, and Service Plans or ISPs.

The MCO must respond to requests from other MCOs for information, including but not limited to, information regarding the Member’s needs, current Medical Necessity determinations, authorized care, Service Plans or ISPs, or other documents pertinent to the health and well-being of a former Member.

Additionally, the MCO must comply with the requirements of 42 CFR §438.208(b) & (c)(2)-(4) related to coordination and continuity of care.

Upon notification from a Member or Provider of the existence of a prior authorization, the new MCO must ensure Members receiving services through a PA from either another 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 transition to a new MCO;
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 transitioning from FFS to managed care was receiving a service that did not require a prior authorization in FFS, but does require one by the new 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, or (2) until the MCO has evaluated and assessed the Member and issued or denied a new authorization.

The MCO must make every effort to outreach to and recruit providers providing services to Members, including individual BH providers providing services in RTCs.

The MCO must allow pregnant Members with 12 weeks or less remaining before the expected delivery date past the 24th week of pregnancy to remain under the care of the Member’s current OB/GYN through the Member’s delivery, immediate postpartum care, and the follow-up postpartum checkup, even if the provider is OON. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

The MCO must pay a Member’s existing OON providers for Medically Necessary Covered Services until the Member’s records, clinical information and care can be transferred to a Network Provider. Payment to OON providers must be made within the time period required for Network Providers. The MCO must comply with OON provider reimbursement rules as adopted by HHSC and found in 1 Tex. Admin. Code § 353.4.

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 for more than 90 Days after a Member enrolls in the MCO, or 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’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 of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.
The MCO must provide or pay OON providers who provide Medically Necessary 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.

The MCO must provide Members with timely and adequate access to OON 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 will not be obligated to provide a Member with access to OON services if such Covered Services become available from a Network Provider.

The MCO must ensure that each Member, DFPS Staff, Caregiver or Medical Consenter has access to a second opinion regarding the use of any Covered Service. A Member, DFPS Staff, Caregiver or Medical Consenter must be allowed access to a second opinion from a Network Provider or OON provider if a Network Provider is not available, at no cost to the Member, in accordance with 42 C.F.R. § 438.206(b)(3). The MCO may use single case agreements with Out-of-Network providers to facilitate a Member’s access to a second opinion.

The MCO is not required to include Members seeking a second opinion as part of its “Out-of-Network Utilization Reporting” requirements under UMCM Chapter 5.

The MCOs must allow a Member who is receiving Service Management in STAR Health to remain under the care of a Medicaid enrolled specialty provider from whom the Member is receiving care, 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 provider types located in UMCM Chapter 3.1, Attachment B. The MCO provider directories must be consistent with the specialty providers listed in UMCM Chapter 3.1. The MCO must comply with OON provider reimbursement rules as adopted by HHSC at 1 Tex. Admin. Code § 353.4(f) until one of the following events occurs:

- An alternate reimbursement agreement (including a single-case agreement in accordance with Section 8.1.27.1) is reached with the Member’s specialty provider,
- The Member or the Member’s LAR agree to select a Network specialty provider, or
- The Member is no longer enrolled in the MCO.

The MCOs is not required to include Members seeing an OON specialty provider as part of its Out-of-Network Utilization Reporting requirements under UMCM Chapter 5.

8.1.27.1 Single Case Agreements with Out-of-Network Speciality Providers

If a Member who is receiving Service Management wants to remain under the care of a Medicaid enrolled specialty provider that is not in the MCO’s Provider Network, the MCO must make a good-faith effort to negotiate a single-case agreement with the OON specialty provider using a simple, timely, and efficient process developed by the MCO. Until the MCO and the OON specialty provider enter into the single-case agreement (or one of the other bulleted events in Section 8.1.27 occurs), the MCO must reimburse the OON specialty provider in accordance with the applicable reimbursement methodology at 1 Tex. Admin. Code § 353.4(f).
8.1.27.2 Member Advisory Groups

The MCO must establish an advisory group consisting of Members, their authorized representatives or caregivers, and advocates. An advisory group must meet and conduct quarterly meetings in each Service Area in which the MCO operates. Membership in the Member advisory group(s) must include at least five Members or their authorized representatives or caregivers, attending each meeting, as well as advocates for Members. The MCO must maintain a record of Member advisory group meetings, including agendas and minutes, for at least three years. For MCOs offering long term services and supports (LTSS), the Member advisory group must include a reasonably representative sample of the LTSS Member population or advocates. For the LTSS Member population the advisory group must include at least three Members receiving LTSS through the MCO or their representative.

8.1.28 Provisions Related to Covered Services for Members

8.1.28.1 Emergency and Post-Stabilization Services

MCO Emergency Services and Post-Stabilization Care Services policies and procedures, Covered Services, claims adjudication methodology, and reimbursement performance must comply with all applicable state and federal laws, rules, and regulations including 42 C.F.R. § 438.114 and 1, Tex. Admin. Code, Chapter 353, Medicaid Managed Care. These requirements apply whether the provider is Network or Out-of-Network.

The MCO must pay for the professional, facility, and ancillary services that are related to the provision of Emergency Services needed to evaluate or stabilize an Emergency Medical Condition, and Emergency BH Condition, and Post-Stabilization Care Services 24 hours a day, 7 days a week, rendered by either the MCO’s Network or Out-of-Network providers.

The MCO cannot require a PA as a condition for payment for Emergency Services, including Emergency Detentions as defined under Chapter 573, Subchapter A of the Texas Health and Safety Code and Chapter 462, Subchapter C of the Texas Health and Safety Code. The MCO cannot limit what constitutes an Emergency Medical Condition or an Emergency BH Condition on the basis of lists of diagnoses or symptoms. The MCO cannot refuse to cover Emergency Services based on the emergency room provider, Hospital, or fiscal agent not notifying the Member’s PCP or the MCO of the Member’s screening and treatment within ten calendar days of presentation for Emergency Services. The MCO may 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.

Emergency Services must be provided in a Hospital-based emergency department that meets the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 C.F.R. §§ 489.20, 489.24, and 438.114(b)&(c)). 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's services and the Hospital's Emergency Services, including the emergency room and its ancillary services.

When the medical screening examination determines that 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 emergency physician must document these services in the Member's medical record. The MCO must reimburse for both
the physician's and Hospital's emergency stabilization services including the emergency room and its ancillary services.

The MCO must cover and pay for Post-Stabilization Care Services in the amount, duration, and scope required by 42 C.F.R. § 438.114(b)&(e) and 42 C.F.R. § 422.113(c).

8.1.28.2 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 the 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 that Members and their Medical Consenters have the right to choose any Medicaid participating family planning provider, whether the provider chosen by the Member and their Medical Consenter is in or outside the Provider Network. The MCO must provide Members and their Medical Consenters access to information about available providers of family planning services and the Member and their 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 a minimum, the full scope of services available under the Texas Medicaid program for family planning services. The MCO will reimburse family planning agencies the Medicaid Fee-for Service amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies and will reimburse OON family planning providers in accordance with HHSC’s administrative rules. The MCO cannot require a PA for family planning services whether rendered by a Network or Out-of-Network 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 cannot 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’s (including minor’s) confidentiality for family planning services.

8.1.28.3 Texas Health Steps (EPSDT) Medical and Dental

8.1.28.3.1 Medical Checkups

The MCO must develop effective methods to ensure that Members receive Texas Health Steps medical checkup services according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the TMPPM, which includes checkups from birth through age 20. Medical services, including Texas Health Steps exams, must be provided within 30 Days of placement for all Members. Texas Health Steps dental services must be provided to Members six months of age through the month of their 21st birthday. Members
six months of age and older must receive Texas Health Steps dental services within 60 Days of placement, when due and according to the AAPD recommendations. Members under six months of age at the time of placement must receive their initial Texas Health Steps dental checkup within 30 Days of becoming six months of age.

The MCO must arrange for Texas Health Steps medical checkup services for all eligible Members except when a Member’s Caregiver or Medical Consenter knowingly and voluntarily declines or refuses services after receiving sufficient information to make an informed decision. A refusal to obtain a Texas Health Steps checkup for the Member must be authorized by the DFPS Caseworker.

A checkup for an Existing Member from birth through 35 months of age is timely if received within 60 Days beyond the periodic due date based on the Member’s birth date. A Texas Health Steps medical checkup for an Existing Member age three years and older is due annually beginning on the child’s birthday and is considered timely if it occurs no later than 364 Days after the child’s birthday. For New Members birth through age 20, overdue or upcoming Texas Health Steps medical checkups should be offered as soon as practicable, but in no case later than 30 Days of placement for all Members. For purposes of this requirement, the terms “New Member” and “Existing Member” are defined in UMCM Chapter 12.

For the purposes of this contract section only, enrollment means the effective date received on the Daily Eligibility file.

For the purposes of this contract section only, 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. These effective methods should be reported through the Medicaid Managed Care Texas Health Steps Medical Checkups reports described in UMCM Chapter 12. As required by Government Code § 533.0054(b), if the MCO does not report these effective methods, the MCO is subject to remedies, including liquidated damages.

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 Texas Health Steps visits and other relevant screenings or assessments performed by the PCP to comply with this provision of the Family Code.

8.1.28.3.2 Oral Evaluation and Fluoride Varnish

The MCO must educate Providers on the availability of the Oral Evaluation and Fluoride Varnish (OEFV) Medicaid benefit that can be rendered and billed by certified Texas Health Steps providers when performed on the same day as the Texas Health Steps 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. The Provider education must include information about how to assist a Member with referral to a dentist to establish a dental home.

8.1.28.3.3 Lab

The MCO must require Providers to send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code. Providers must 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 Texas Health Steps medical checkup.

All laboratory specimens collected as a required component of a Texas Health Steps checkup (see TMPPM for age-specific requirements), must be submitted to the DSHS Laboratory Services Section or to a laboratory approved by the department under Texas Health & Safety Code Section 33.016 for analysis unless the TMPPM, Children’s Services Handbook provides otherwise. The MCO must educate Providers about Texas Health Steps Program requirements for submitting laboratory tests to the DSHS Laboratory Services Section.

8.1.28.3.4 Education/Outreach

The MCO must ensure that Members, Caregivers, and Medical Consenters are provided information and educational materials about Texas Health Steps services, and how and when Members should obtain the preventative medical checkups, or diagnostic and treatment services, including Texas Health Steps Comprehensive Care Program services, and how the Member can request advocacy and assistance from the MCO. The information should tell the Member, Caregiver and Medical Consenter how they can access medical and dental benefits and NEMT Services. The UMCM Chapter 3 includes required language for Texas Health Steps services, including medical, dental, and case management services. 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 Texas Health Steps exam within 30 Days of placement, as required by DFPS form 2085-B Designation of Medical Consenter, as soon as possible and inform them of outreach opportunities. The MCO must educate the Members, Caregivers, and Medical Consenters that they must schedule the Texas Health Steps appointments as soon as possible to ensure the exam is completed within 30 Days of placement.

Each month, the MCO must retrieve from the HHSC Administrative Services Contractor Bulletin Board System a list of Members who are due and overdue Texas Health Steps services. Using these lists and its own internally generated list, the MCO will contact such Members, Caregivers and Medical Consenters to obtain the service as soon as possible. The MCO outreach staff must ensure that Members, Caregivers and Medical Consenters have access to NEMT Services. The MCO outreach staff must coordinate with the Texas Health Steps call center, agencies or staff for any other Texas Health Steps coordination needs.

The MCO should 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 Texas Health Steps checkups. This coordination should include informing Head Start programs in the service area how to request scheduling assistance from the plan when a plan Member needs a Texas Health Steps checkup.

8.1.28.3.5 Training

The MCO must provide appropriate training to all Network Providers and Provider staff in the Provider’s area of practice regarding the scope of Texas Health Steps services. Training must include:

1. Texas Health Steps benefits (preventative care, diagnostic services, and treatment) and training on how to use the mandatory Texas Health Steps forms;
2. the periodicity schedule for Texas Health Steps medical and dental checkups and immunizations;
3. required components of Texas Health Steps medical and dental checkups, the importance of documenting all required components of the checkup in the medical record, and the necessity of documentation to support a complete checkup qualifying for reimbursement is provided;
4. providing or arranging for all required lab screening tests including lead screening at 12 and 24 months, the importance of documenting all lab screening and results for Texas Health Steps medical checkups;
5. Comprehensive Care Program (CCP) services available under the Texas Health Steps program to Members;
6. NEMT Services available to Members;
7. Services available through Case Management for Children and Pregnant Women and how to make referrals;
8. importance of updating contact information to ensure accurate Provider directories and the Medicaid Online Provider Lookup;
9. The process to submit missed appointment referrals (either to the Texas Health Steps Outreach and Informing Unit, or the MCO) and the assistance provided by the MCO for these referrals;
10. administrative issues such as claims filing (including the processes regarding claims appeals and recoupments) and services available to Members;
11. 72-hour emergency supply prescription policy and procedures;
12. outpatient prescription drug PA process;
13. how to access the Medicaid formulary and PDL on HHSC’s website;
14. how to use HHSC’s free subscription service for accessing the Medicaid formulary and PDL through the internet or hand-held devices;
15. scope of DME and other items commonly found in a pharmacy that are available for class Members; and
16. Providers’ obligation to identify and report a Critical Event or Incident such as Abuse or Neglect (CPS) to the state.

The MCO must include specific information in training materials (such as in the MCO's Provider Manual) pertaining to Attention Deficit Hyperactivity Disorder (ADHD) Covered Services for children including reimbursement for ADHD and availability of follow-up care for children who have been prescribed ADHD medications. Providers should be educated and trained to treat each Texas Health Steps visit as an opportunity for a comprehensive assessment of the Member.

The MCO will encourage Medicaid-enrolled pharmacies to also become Medicaid-enrolled DME Providers.

The MCO will implement an HHSC-approved process by which it will systematically outreach contracted PCPs for enrollment and participation in the Texas Health Steps program. The MCO must also require non-PCP Texas Health Steps providers to notify the Members’ PCP of the results of the Texas Health Steps exams and refer Members to the PCP for follow-up services recommended as a result of the Texas Health Steps screening. HHSC will monitor the MCO’s compliance with these requirements on a quarterly basis by comparing the MCO’s PCP Provider list with Texas Health Steps listing of enrolled providers.

The MCO must educate Providers about blood lead level reporting under Texas Health & Safety Code Chapter 88 and 25 Tex. Admin. Code Chapter 37, Subchapter Q; coordination with the Texas Childhood Lead Poisoning Prevention Program at DSHS; and appropriate follow-up testing and care, including the Centers for Disease Control and Prevention guidelines located
on the DSHS website, “Texas Childhood Lead Poisoning Prevention”, “Screening”. The MCO must educate Providers about Medicaid coverage for lead screening, follow-up testing, and environmental lead investigations, whether as Non-capitated Services or Covered Services.

8.1.28.3.6 Data Validation

An MCO must require all Texas Health Steps Providers 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.

HHSC or its designee will validate Encounter Data by comparing chart review data and Encounter Data for a random sample of Members. HHSC or its designee will conduct chart reviews to validate that all components of the Texas Health Steps checkups are performed when due and as reported, and that reported data are accurate and timely. Substantial deviation between reported and charted Encounter Data could result in the MCO or Network Providers being investigated for potential Fraud, Waste, and Abuse infractions without notice to the MCO or the Provider.

8.1.28.3.7 Texas Health Steps-Comprehensive Health Care Program

The MCO must prior authorize and provide medically necessary services listed in Section 1905(a) of the Social Security Act to Members age 20 and younger through the Texas Health Steps Comprehensive Care Program (CCP) in accordance with Section 1905(a) of the Social Security Act and the Omnibus Budget Reconciliation Act of 1989. The MCO must provide Texas Health Steps Comprehensive Care Program services in accordance with service limitations specified in the Texas Medicaid Provider Procedures Manual, Children’s Services Handbook, Chapter 2.

Services required by EPSDT, including Texas Health Steps Comprehensive Care Program services, are not considered Case-by-case Services or Value-added Services.

8.1.28.4 Perinatal Services

The MCO’s perinatal Healthcare 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 Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M.

The MCO must have a perinatal healthcare system in place that, at a minimum, provides the following services:

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 care;
4. transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
5. availability and accessibility of OB/GYNs, 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 should also educate Providers on the PA processes for these benefits and services.

On a monthly basis, HHSC will supply the MCO with a file containing birth record data. The MCO must use this file to identify reproductive-age Members with a previous preterm birth. The MCO must provide outreach to, education to, and care coordination for identified Members as described in this section to prevent preterm births. Care coordination may include Service Management under Section 8.1.13.2, "Access to Care and Service Management" and Member referrals to Providers to assess the need for the use of hydroxyprogesterone caproate. The MCO must report on use of the data file as specified Section 8.1.20.2, “Reports” and in UMCM Chapter 5.

The MCO must have a process to expedite scheduling a prenatal appointment for an obstetrical exam for a pregnant Member no later than two weeks after the MCO learns of her pregnancy.

The MCO must have procedures in place to contact and assist DFPS Staff, the Medical Consenter or the pregnant/delivering Member in selecting a PCP for her baby as soon as the baby is born.

The MCO must provide Medically Necessary Covered Services relating to the labor and delivery for its pregnant/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 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 state-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 must notify providers involved in the care of pregnant/delivering women and newborns (including OON providers and Hospitals) of the MCO’s PA requirements. The MCO cannot require a PA for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the emergency condition arises.

8.1.28.5 Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)

The MCO must provide STD services that include STD/HIV prevention, screening, counseling, diagnosis, and treatment. The MCO is responsible for implementing procedures to ensure that Members have prompt access to appropriate services for STDs, including HIV. The MCO must allow Members access to STD services and HIV diagnosis services without a PA or referral by a PCP.

The MCO must comply with Texas Family 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 STD/HIV treatment plan.
The MCO must make education available to Providers, Members, Caregivers and Medical Consenters, on the prevention, detection and effective treatment of STDs, including HIV.

The MCO must require Providers to report all confirmed cases of STDs, including HIV, to the local or regional health authority according to 25 Tex. Admin. Code §§ 97.131–97.134, using the required forms and procedures for reporting STDs. The MCO must require the Providers to coordinate with the HHSC regional health authority to ensure that Members with confirmed cases of syphilis, chancroid, gonorrhea, chlamydia and HIV receive risk reduction and partner elicitation/notification counseling, as appropriate.

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 that Providers have procedures in place to protect the confidentiality of Members provided STD/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 inform and require its Providers who provide STD/HIV services to comply with all state laws relating to communicable disease reporting requirements. 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 and counseling Members provided STD/HIV services. See also the Procurement Library for the DFPS policy related to acquired immune deficiency syndrome (AIDS) and AIDS prevention.

8.1.28.6 Tuberculosis (TB)

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 develop policies and procedures to ensure that all Members are screened for TB. The MCO must establish mechanisms to ensure all procedures required to screen Members for TB, and to form the basis for a diagnosis and proper prophylaxis and management of TB, are available to all Members, Caregivers and Medical Consenters, except services referenced in Section 8.1.28.8, “Medicaid Non-capitated Services.” The MCO must consult with the local TB control program to ensure that all services and treatments are in compliance with the guidelines recommended by the American Thoracic Society (ATS), 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. The MCO must provide access to Member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases upon request.

The MCO must coordinate with the local TB control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). The MCO must require, through contract provisions, that Providers report to DSHS or the local TB control program any Member who is non-compliant, drug resistant, or who is or may be posing a public health threat. The MCO must cooperate with the local TB control program in enforcing the control measures and quarantine procedures contained in Chapter 81 Texas Health and Safety Code Chapter 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 Healthcare System 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.

8.1.28.7 Objection to Provide 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. 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 will 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.

In order to meet the requirements of this section, the MCO must notify HHSC of grounds for and provide detail concerning its moral or religious objections and the specific services covered under the objection, no less than 120 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 will 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.

An 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 the HHSC.

8.1.28.8 Medicaid 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 Fee-for-Service basis, and FFCC Members may be eligible for some of these services. MCOs should refer to relevant chapters in the TMPPM for more information.

1. Texas Health Steps environmental lead investigation (ELI);
2. ECI Case Management;
3. ECI Specialized Skills Training;
4. Texas School Health and Related Services (SHARS);
5. HHSC Blind Children’s Vocational Discovery and Development Program;
6. Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation);
7. HHSC hospice services;
8. Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members; and

8.1.28.9 Referrals for Non-capitated Services

Although the MCO is not responsible for paying or reimbursing Non-capitated Services, the MCO is responsible for educating Members, Caregivers, Medical Consenters, and DFPS Staff.
about the availability of Non-capitated Services, and for providing appropriate referrals for Members, Caregivers, and Medical Consenters to obtain or access these services. The MCO is responsible for informing Providers that bills for all Non-capitated Services must be submitted to HHSC’s Claims Administrator for reimbursement.

8.1.28.10 Immunizations

The MCO must educate Providers on the Immunization Standard Requirements set forth in Tex. Health and Safety Code, Chapter 161; the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule; 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 Texas Health Steps checkup according to the ACIP routine immunization schedule. The MCO must also educate Providers that the screening Provider is responsible for administration of the immunization and should not refer children to Local Health Departments or other entities to receive immunizations and should not refer children to Local Health Departments 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 and Safety Code, Chapter 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. In addition, the MCO must work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac2 registry.

8.1.28.11 NEMT Services

NEMT Services should be part of the MCO’s overall strategy to affect positive Member outcomes. The MCO must assess, approve, arrange, coordinate, and ensure delivery of NEMT Services in accordance with the Contract and Chapter 16 of the UMCM. NEMT Services include the following:

1. Demand response transportation services, including Nonmedical Transportation (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 must be delivered using 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 MCO must coordinate NEMT Services that enable Members to obtain Medicaid-covered dental benefits in the Dental Program.

The MCO must require NEMT Services within the Member’s Service Area to be requested at least two Business Days in advance of the date of the requested trip. The MCO must require a request for a trip outside of the Member’s Service Area (i.e., a “long distance trip”) to be received at least five Business Days in advance of the trip. The MCO must make an exception to either of these requirements for transportation to access treatment for an Urgent Condition, transportation after hospital discharge, and transportation to a pharmacy to pick-up a prescription or obtain Healthcare Services provided by a pharmacy, such as DME items. These trips may be requested with less than 48 hours’ notice. Additional exceptions to these timeframe requirements may be granted at the MCO’s discretion. The MCO is not required to approve requests for NEMT Services made with less than three hours’ notice. The MCO must document actions taken in attempt to arrange the requested transportation.

The MCO must develop and maintain a database compliant with federal and state laws, rules, and regulations for tracking NEMT Services requests that is capable of interfacing with HHSC systems to provide electronic records in a prescribed media and format. At a minimum, the MCO must:

- Establish and maintain a computer system that complies with federal and state laws, rules, and regulations, including HIPAA.
- Maintain hardware, software, internet and communication equipment to support automated services necessary to carry out the requirements of the Contract using industry standard products.
- Maintain a reservation system capable of conducting NEMT Services reservations and confirmation of transactions.
- Track NEMT Services received by Members through the system, and accurately and fully maintain those service records as HIPAA-complaint Encounter transactions.
- Maintain a history of changes and adjustments and audit trails for current and retroactive data.
- Maintain a vehicle management platform capable of monitoring vehicle status including mileage, condition, and inspections routinely, including identification data for the vehicles including owner, plate number, and vehicle identification number.
- Maintain a driver management platform capable of monitoring driver status including trainings, driver’s license, criminal history checks, sex offender registry checks, motor vehicle reports from DPS, drug testing, and federal and state screening requirements.
- Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure.

**8.1.28.11.1 Approval of NEMT Services**

All NEMT Services provided to Members must be approved by the MCO. The MCO must have a process in place for modifying a Member’s approved, scheduled trip to add a stop, such as to the pharmacy, clinic, or other health care facility as ordered by an attending physician. The MCO must use an automated scheduling system to record, approve, and coordinate NEMT Services. This system must be capable of accommodating reservations for future trips as well as requests for same day trips and urgent trips.

At minimum, for any delivered NEMT Services, the MCO must be able to provide documentation of the following upon request:

- The name and Medicaid number of the Member using the service.
• The pickup and destination addresses, including a telephone number for the trip destination.
• Evidence that the NEMT Service was for an allowable purpose and in conjunction with a covered Healthcare Service.
• Evidence that the Member had no other means of transportation (this may be met through self-attestation).
• Information on any special transportation needs, such as use of a wheelchair.
• If applicable, the justification for providing NEMT Services outside of the Service Area.

Each MCO may determine the means by which this information is collected, including whether the information is collected prior to each NEMT service occurrence.

To avoid risk to Member health and safety, the MCO must determine the appropriateness of using a TNC while authorizing the transportation.

Separate from, and in addition to, the automated scheduling system, the MCO must provide an online reservation system for Members or Providers to request NEMT Services.

8.1.28.11.1.1 Out-of-State Travel Requests

The MCO must permit and provide out-of-state NEMT Services to Members for approved out-of-state Healthcare Services. If a Member must travel to another state to receive Healthcare Services, the MCO must not levy additional fees against the Member or HHSC.

8.1.28.11.1.2 Meals and Lodging

The MCO must provide the cost of meals and lodging for a Member, birth through age 20, if the costs are either:

a) directly associated with a long-distance trip to obtain Healthcare Services, or
b) necessary because a Member who is already outside his or her county of residence experiences an unplanned or urgent healthcare event that requires the Member to remain in the area overnight for treatment before the Member can return home.

Meals and lodging may be provided while en route to and from or while receiving a Healthcare Service. The MCO may approve meals or lodging or both. If the Member requires an NEMT Attendant, the cost of meals and lodging for the NEMT Attendant must also be covered, except if the NEMT Attendant is a service animal.

The MCO is responsible for making the appropriate arrangements, reservations, and otherwise coordinating the stay with the lodging facility.

Meal Per Diem: The per diem rate for meals is $25 per day per person. The MCO must approve meals for an additional NEMT Attendant when a health care provider documents the need for the NEMT Attendant.

Lodging: The MCO must approve expenses to cover the Member’s lodging for the night before a Healthcare Service if travel cannot be reasonably accomplished on the day of the appointment, or if a health care provider’s statement of need or equivalent documents the necessity to travel the night before a Healthcare Service. The MCO must approve expenses for lodging services the night after a Healthcare Service if:

1. Travel to the Member’s residence reasonably requires an additional day due to length or circumstances beyond the Members control; or
2. A health care provider’s statement of need or equivalent documents the necessity for additional lodging.

Lodging services are limited to the overnight stay and do not include any amenities or incidentals used during the Member’s stay, such as phone calls, room service, or laundry service. The Member may use amenities offered by charitable organizations, such as the
Ronald McDonald House, at no cost to the Member or HHSC. The MCO must approve lodging for an additional NEMT Attendant when a health care provider documents the need, such as for both parents to receive training on the use of medical equipment or delivery of complex care or to allow both parents to accompany a child not expected to survive the trip.

8.1.28.11.1.3 Individual Transportation Participants (ITPs)

ITP services reimburse a Member or his or her family member, friend, or neighbor for the mileage, as calculated by the MCO, incurred when driving the Member to a Healthcare Service. ITP services are available to Members of any age.

8.1.28.11.1.4 Advanced Funds

For Members age 20 and younger, the MCO must authorize advanced funds to be used to purchase gas, meals, or lodging prior to the trip if the Member requires these funds in advance to access necessary Healthcare Services. All other ITP requirements apply in these circumstances.

8.1.28.11.1.5 Nonmedical Transportation Services

The MCO must only approve a TNC to provide NMT Services. If a TNC does not operate in the area where the Member or the Healthcare Service is located, the MCO may not approve the use of NMT. Instead, the MCO must provide the requested transportation using another NEMT Service for the Member, including demand response transportation services with less than 48-hours' notice, if the trip is to access treatment for an Urgent Condition, transportation after hospital discharge, or transportation to a pharmacy.

8.1.28.11.1.6 NEMT Attendant Requirements

Members who need assistance while being transported may request an NEMT Attendant. The MCO may approve an NEMT Attendant for nonmedical reasons, such as to provide communication assistance to the Member, without a written statement from a healthcare provider. A written statement from the Member's primary healthcare provider is necessary for the MCO to approve an NEMT Attendant for medical reasons.

The NEMT Attendant must accompany the Member from the origin to the approved destination and on the return trip, including add-on trips. Except for parents or guardians, the MCO must document the need for the NEMT Attendant. If documentation states an NEMT Attendant is necessary, the trip may not proceed without an NEMT Attendant. If an NEMT Attendant is necessary but not present when the driver arrives to pick up the Member, the NEMT Service must be recorded as a Member “no-show” and rescheduled. The NEMT Attendant must remain at the location where Healthcare Services are being provided but may remain in the waiting room during the Member’s appointment. The NEMT Services provider must not require reimbursement from the NEMT Attendant.

Before the trip may commence, the NEMT Attendant must provide and install any necessary child safety seats.

8.1.28.11.2 Approval of Mass Transit NEMT Services

The MCO must not authorize mass transit if the Member’s health care provider has documented that the Member:

1. has a high-risk pregnancy;
2. is in the eighth month of pregnancy or later;
3. has high-risk cardiac conditions;
4. has severe breathing problems; or
5. requires life sustaining medical care.

NEMT Services for Members with these health concerns must be scheduled to minimize wait times and riding times.

8.1.28.11.3 NEMT Services Providers

8.1.28.11.3.1 Transportation Network

The MCO will establish and maintain a transportation network that meets NEMT Services needs for Members within the Service Area. In establishing its network, the MCO must consider the following factors: Member characteristics; historical service utilization data; geographic location of health care providers and Members, including distance, travel time, and available modes of transportation; and health care provider hours of operation that may be outside regular business hours, such as dialysis centers. The MCO’s transportation network must include a sufficient and reliable fleet of vehicles and various modes of transportation, including buses, sedans, vans, wheelchair accessible vehicles, and the personal cars of drivers who are part of a TNC’s network.

The MCO must ensure vehicles in its transportation network comply with all applicable state and federal laws, rules, and regulations, including Federal Motor Vehicle Safety Standards (49 C.F.R. Part 571) and Texas Transportation Code, Title 7, Chapter 547. MCOs must also ensure there are vehicles in their networks that comply with the ADA Accessibility Guidelines for Transportation Vehicles (36 C.F.R. Part 1192) in order to meet the needs of Members with special needs.

8.1.28.11.3.2 NEMT Services Provider Enrollment

The MCO must:

1. Comply with the provider selection requirements in 42 C.F.R. § 438.214 and the prohibitions against provider discrimination in 42 C.F.R. § 438.12, as applicable.
2. Ensure that NEMT Services providers are properly enrolled through the HHSC’s Claims Administrator and appear on PEMS or other system application designated by HHSC in order to be eligible for inclusion in the MT88 MCO Network File prior to providing NEMT Services.
3. Enroll NEMT Services providers that will be part of the MT88 MCO Network File through the MCO enrollment process and enter into a written agreement with each of those providers of NEMT Services. An executed copy of the written agreement must be provided to HHSC no later than 10 Business Days after execution.
4. Enter into a Data Use Agreement (DUA) with the NEMT Services provider and maintain a signed copy of that DUA.

NEMT Services providers may have an Atypical Provider Identifier (API) or NPI.

8.1.28.12 Case Management for Children and Pregnant Women Services

The MCO must provide Case Management for Children and Pregnant Women Services for Members in categories 3-6 of the Target Population. MCO efforts to provide these services include, but are not limited to, Member education, outreach, Service Management, Service Coordination, and case collaboration with and referrals to and from Case Management for Children and Pregnant Women services. The MCO is required to follow referral procedures as outlined in UMCM Chapter 16.
The MCO must reimburse Out-of-Network Case Management for Children and Pregnant Women providers in accordance with HHSC’s administrative rules regarding OON payment at 1 Tex. Admin. Code § 353.4.

The MCO must ensure Case Management for Children and Pregnant Women Providers have completed HHSC-approved training as required by Title 25, Part 1, Chapter 27, Subchapter C of the Texas Administrative Code.

The MCO must educate its Providers, including PCPs, Pediatric, and OB/GYN Providers, on the availability of Case Management for Children and Pregnant Women Services and how to provide referrals to Case Management for Children and Pregnant Women Providers.

Annually, all MCO Service Coordination and Service Management staff must complete the Texas Health Steps Online module titled: Case Management Services in Texas and maintain proof of completion.

8.1.29 Medicaid Significant Traditional Providers (STPs)

The MCO must seek participation in its Network from all STPs included on the list HHSC provided during Readiness Review. The MCO must also seek participation in its Network from healthcare providers on contract or subcontract with DFPS. DFPS residential providers often have healthcare providers on contract to provide Medicaid services to the Target Population. These healthcare providers on contract with DFPS residential providers are considered STPs.

HHSC defines STPs as any Provider currently serving STAR Health Members.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Service Area</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management for Children and Pregnant Women Providers</td>
<td>Statewide</td>
<td>September 1, 2025</td>
</tr>
</tbody>
</table>

The MCO must provide all types of STPs above the opportunity to participate in its Network on an ongoing basis. Upon the request of a Member or their Caregiver to contract with a particular healthcare provider, the MCO must make best efforts to recruit that provider into the Network. However, the STP provider must:

1. Agree to accept the MCO’s Provider reimbursement rate for the provider type
2. Meet the standard credentialing requirements of the MCO, provided that lack of board certification or accreditation by The Joint Commission (TJC) is not the sole grounds for exclusion from the Provider Network.

The MCO is not obligated to retain STPs in the Provider Network that the MCO has determined to be non-compliant with requirements in the Provider Contract. The MCO may terminate a Network Provider Contract with an STP after demonstrating, to the satisfaction of HHSC, good cause for the termination. Good cause may include evidence of provider fraud, waste, or abuse. The MCO must provide documentation on Providers terminated due to non-compliant, upon HHSC’s request.

Medicaid STP requirements apply statewide for providers of MDCP services through October 31, 2019. MDCP provider requirements are stated in Section 8.2 "Additional Requirements Regarding the Medically Dependent Children Program (MDCP)".

8-173
8.1.30 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

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 Medically Necessary Covered Services using the prospective payment methodology described in Sections 1902(bb) and 2107(e)(1) of the Social Security Act. Because the MCO is responsible for the full payment amount in effect on the date of service for RHCs, cost settlements (or “wrap payments”) will not apply.

When the MCO negotiates payment amounts with FQHCs for Medically Necessary 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. MCOs may elect to pay the FQHC wrap payment at the time of claim adjudication but 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 Healthcare Services at a time that is outside of regular business hours, the MCO must reimburse the FQHC, RHC, or public clinic for Medically Necessary 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, regular business hours has the meaning given to it in 1 Tex. Admin. Code § 353.2, as required by 1 Tex. Admin. Code § 353.407.

If a Member visits an Out-of-Network Indian Health Care Provider (IHCP) enrolled as an FQHC, for Medically Necessary Covered Services, the MCO must reimburse the OON IHCP a full encounter rate as if the provider were a Network Provider. This encounter rate is paid 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 FQHC’s Out-of-Network claim is subject to the same claim standards requirements as the MCO’s Network Providers.

8.1.31 MCO Internal Provider Complaints and Appeals Process

This section applies to NEMT Services providers unless stated otherwise.

8.1.31.1 Provider Complaints

The MCO must develop, implement, and maintain a system for tracking and resolving all Provider Complaints. Within this process, the MCO must fully and completely respond to each Complaint and establish a tracking mechanism to document the status and final disposition of each Provider Complaint. The MCO must provide information about the complaint and internal MCO appeal system to all Providers and subcontractors at the time they enter into a contract. The MCO must resolve Provider Complaints within 30 Days from the date the Complaint is received. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Provider Complaints are not resolved within 30 Days of receipt of the Complaint by the MCO. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Provider
Complaints are not resolved within 30 Days of receipt of the Complaint by the MCO (See Attachment A, “STAR Health Contract Terms,” and Attachment B-3, “Deliverables/Liquidated Damages Matrix.”

MCO must also resolve Provider Complaints received by HHSC no later than the due date indicated on HHSC’s notification form. HHSC will generally provide MCO ten Business Days to resolve such Complaints. If MCO cannot resolve a Complaint by the due date indicated on the notification form, it may submit a request to extend the deadline. HHSC may, in its reasonable discretion, grant a written extension if the MCO demonstrates good cause. Unless HHSC has granted a written extension as described above, the MCO is subject to remedies, including damages, if Provider Complaints are not resolved by the timeframes indicated in this section.

8.1.31.2 Provider Appeal of MCO Claims Determinations

The MCO must develop, implement, and maintain a system for tracking and resolving all Provider Appeals related to claims payment, as required by Texas Government Code § 533.005(a)(15). Within this process, the MCO must respond fully and completely to each provider’s claims payment Appeal and establish a tracking mechanism to document the status and final disposition of each provider’s claims payment Appeal.

In addition, the MCO’s process must comply with Texas Government Code § 533.005(a)(19). The MCO and Dental Contractor must provide information specified in 42 CFR § 438.10(g)(2)(xi) about the grievance and MCO appeal system to all Providers and subcontractors at the time they enter into a contract.

The MCO is subject to liquidated damages if at least 98 percent of Provider Appeals are not resolved within 30 Days of the MCO’s receipt.

The MCO must contract with non-network physicians to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a Provider Appeal. The physician resolving the dispute must not be an employee of the MCO’s Medicaid or CHIP business but may be an employee in the MCO’s Medicare or commercial lines of business. The determination of the physician resolving the dispute must be binding on the MCO and a Network Provider. The physician resolving the dispute must be licensed in the State of Texas and hold the same specialty or a related specialty as the appealing Provider. HHSC reserves the right to amend this process to include an independent review process established by HHSC for final determination on these disputes.

8.1.32 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 the right to a Medicaid Fair Hearing separate from the Appeals process for all Members.

The MCO must notify Members, DFPS Staff, and Medical Consenters of their right to request a copy of these rights and responsibilities. The Member handbook must include notification of Member, DFPS Staff, and Medical Consenter rights and responsibilities.

Members have additional rights and responsibilities that apply specifically to utilization of NEMT Services, which are outline in UMCM Section 3.15. Attachment P.
8.1.33 Member Complaint and Appeal System

The MCO must develop, implement, and maintain a Member Complaint and Appeal system that complies with the requirements in applicable federal and state laws, rules and regulations, including 42 C.F.R. § 431.200, 42 C.F.R. Part 438, Subpart F, “Grievance System,” and the provisions of 1 Tex. Admin. Code Chapter 357 relating to Medicaid MCOs.

The Complaint and Appeal system 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, and Medical Consenters, and must be reviewed and approved in writing by HHSC or its designee. Providers and Caregivers who are not Medical Consenters may file a Complaint or an Appeal on behalf of a Member if authorized by the Medical Consenter. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC’s approval at least 30 Days prior to the implementation.

For purposes of this section an “authorized representative” is any person or entity acting on behalf of the Member in compliance with State law and 42 C.F.R. § 438.402. A Provider may be an authorized representative.

8.1.33.1 MCO Internal Member Complaint Process

The MCO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members, DFPS Staff, or Medical Consenters. 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 MCO must resolve Complaints within 30 Days from the date the Complaint is received. The MCO is subject to remedies, including liquidated damages, if at least 98% of Member Complaints are not resolved within 30 Days of receipt of the Complaint by the MCO (See Attachment A, “STAR Health Contract Terms,” and Attachment B-3, “Deliverables/Liquidated Damages Matrix.”

MCO also must resolve Member Complaints received by HHSC no later than the due date indicated on HHSC’s notification form. HHSC will provide MCO up to 10 Business Days to resolve these Complaints, depending on the severity or urgency of the Complaint. HHSC may, in its reasonable discretion, grant a written extension if the MCO demonstrates good cause. Unless the HHSC has granted a written extension as described above, the MCO is subject to remedies, including damages if Member Complaints are not resolved by the timeframes indicated in this section.

The Complaint procedure must be the same for all Members, DFPS Staff, and Medical Consenters. Member, DFPS Staff, or Medical Consenter may file a Complaint either orally or in writing. The MCO must also inform Members, DFPS Staff, and Medical Consenters how to file a Complaint directly with HHSC, once the Member, DFPS Staff, or Medical Consenter has exhausted the MCO’s Complaint process.

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. Management, supervisory, and Quality Improvement staff must be involved in developing policies and procedures to address Complaints.

The MCO’s Complaint procedures must be provided to Members, DFPS Staff, and Medical Consenters in writing and through oral interpretive services. A written description of the MCO’s Complaint procedures must be available in Spanish and other Prevalent Languages for Major Population Groups identified by HHSC, at no more than a 6th-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 TeleTypeWriter/Telecommunications Device for the Deaf (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 internal MCO Complaint;
2. the date received;
3. the date of each review or, if applicable, review meeting;
4. resolution at each level of the internal MCO Complaint if applicable;
5. date of resolution at each level, if applicable; and
6. name of the covered person for whom the internal MCO Complaint was filed.

For Complaints that are received in person or by telephone, the MCO must provide Members, DFPS Staff, and Medical Consenters with written notice of resolution if the Complaint cannot be resolved within one working day of receipt. As the Texas Department of Insurance does not require the reporting of those issues to TDI (see 28 Tex. Admin. Code § 3.9202(2)), the MCOs shall report this subcategory of Complaints to HHSC as “Initial Contact Complaints.”

The MCO is prohibited from discriminating or taking punitive action against a Member, DFPS Staff, or Medical Consenter for making a Complaint or filing an Appeal.

The MCO will cooperate with HHSC or its designee to resolve all Member, DFPS Staff, or Medical Consenter Complaints. Such cooperation may include, but is not limited to, providing information or assistance to HHSC Complaint team members.

The MCO must provide designated Member Advocates to assist Members, DFPS Staff, and Medical Consenters in understanding and using the MCO’s Complaint system as described in Section 8.1.33, “Member Complaint and Appeal System.” The MCO’s Member Advocates must assist Members, DFPS Staff, and Medical Consenters in writing or filing a Complaint and monitoring the Complaint through the MCO’s Complaint process until the issue is resolved.

8.1.33.2 Intentionally Left Blank

8.1.33.3 Member MCO Internal Appeal Process

The MCO must develop, implement and maintain an Appeal process by which a Member or his or her representative, Medical Consenter or DFPS Staff can request a review of the MCO’s Adverse Benefit Determination. This procedure must comply with the state and federal laws, rules and regulations, including 42 C.F.R. § 431.200 and 42 C.F.R. Part 438, Subpart F,
“Grievance System.” The Appeal procedure must be the same for all Members, DFPS Staff, and Medical Consenters. When a Member, DFPS Staff, or Medical Consenter expresses orally or in writing any dissatisfaction or disagreement with an Adverse Benefit Determination, the MCO must regard the expression of dissatisfaction as a request to Appeal an Adverse Benefit Determination.

The provisions of Texas Insurance Code Chapter 4201, relating to an Appeal to an independent review organization, do not apply to a Medicaid recipient. Texas Medicaid is using the External Medical Review process provided in 42 C.F.R. 438.408(f)(1)(ii). Medicaid MCOs are still expected to comply with the other applicable requirements of the Texas Insurance Code, including Chapter 4201.

The MCO must have policies and procedures in place outlining the Medical Director’s role in an Appeal of an Adverse Benefit Determination. The Medical Director must have a significant role in monitoring, investigating and hearing 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 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 8.1.33.10, “Member Advocates,” to assist Members, DFPS Staff, and Medical Consenters in understanding and using the Appeal process. The MCO’s Member Advocates must assist Members, DFPS Staff, and Medical Consenters in writing or filing an Appeal and monitoring the Appeal through the MCO’s Appeal process until the issue is resolved.

Requirements regarding the MCO’s obligation to respond to each Member Appeal, and the timeframes associated with those responses, are identical to the requirements regarding Member Complaints in Section 8.1.33.1, “Member Complaint Process.”

During the 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 an opportunity, before and during the Appeal process, to examine the Member’s case file, including medical records and any other documents considered during the Appeal process. The MCO must include, as parties to the Appeal, the Member, DFPS Staff, and Medical Consenter, or the legal representative of a deceased Member’s estate. The MCO must also seek information and participation from the Caregiver when appropriate.

In accordance with 42 C.F.R. § 438.420, the MCO must continue the Member’s benefits currently being received by the Member, including the benefit that is the subject of the Appeal, if all of the following criteria are met:

1. The Member, DFPS Staff, or Medical Consenter files the Appeal timely as defined in this Contract;
2. the Appeal involves the termination, suspension, or reduction of a previously authorized service;
3. the services were ordered by an authorized Provider;
4. the period covered by the original authorization has not expired; and
5. the Member, DFPS Staff, or Medical Consenter 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 Appeal is pending, the benefits must be continued until one of the following occurs:

1. The Member, DFPS Staff, or Medical Consenter withdraws the Appeal or request for State Fair Hearing;
2. Ten Days pass after the MCO mails the notice resolving the Appeal against the Member, unless the Member, DFPS Staff, or Medical Consenter has requested a Fair Hearing with continuation of benefits; or
3. A state Fair Hearing officer issues a hearing decision adverse to the Member.

By execution of the Contract, the MCO agrees to waive its right under 42 C.F.R.§ 438.420(d), to recover costs from Members, HHSC, DFPS Staff, and Medical Consenters if the final resolution of the Appeal is adverse to the Member and upholds the MCO’s Adverse Benefit 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 Appeal was pending, the MCO is responsible for the payment of services.

If the MCO, IRO, or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the MCO must authorize or provide the disputed services as expeditiously as the Member’s health condition requires. If the IRO or a State Fair Hearing Officer reverses an MCO’s denial of a prior authorization 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.

8.1.33.4 Expedited MCO 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, 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 Member MCO Internal Appeals as set forth in Section 8.1.33.3, “Member MCO Internal Appeal Process,” except where differences are specifically noted. The MCO must accept oral or written requests for Expedited MCO Internal Appeals.

Members, DFPS Staff, and Medical Consenters must exhaust the Expedited MCO Internal Appeal process before making a request for an expedited State Fair Hearing/EMR. After the MCO receives the request for an Expedited MCO Internal Appeal, it must hear an approved request for a Member, DFPS Staff, or Medical Consenter to have an Expedited MCO Internal Appeal, and notify the Member, DFPS Staff, or Medical Consenter of the outcome of the Expedited MCO Internal Appeal within 72 hours, except that the MCO must complete 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, DFPS Staff, or Medical Consenter’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 8.1.33.6, “Notices of Adverse Benefit Determination and Disposition of Appeals for Members.” The MCO is responsible for notifying the Member, DFPS Staff, and Medical Consenter of the Member’s right to access an EMR and/or an expedited State Fair Hearing from HHSC. The MCO will be responsible for providing documentation to HHSC and to the Member, DFPS Staff, and Medical Consenter, indicating how the decision was made, prior to HHSC’s expedited 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 neither taken against a Provider who requests an expedited resolution or supports a Member’s, DFPS Staff’s, or Medical Consenter’s request. If the MCO denies a request for expedited resolution of an Appeal, it must:
1. transfer the Appeal to the timeframe for resolution; and
2. make a reasonable effort 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.

8.1.33.5 Access to State Fair Hearing and External Medical Review (EMR) for Medicaid Members

The MCO must inform Members, DFPS Staff, and Medical Consenters that they have the right to access the State Fair Hearing process, with or without an External Medical Review, only after exhausting the Internal MCO Appeal System provided by the MCO. 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 by an authorized representative such as DFPS Staff, or a Medical Consenter in the State Fair Hearing process.

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 MCO must provide the IRO the same set of records the MCO reviewed to determine service denial. EMRs will be conducted by Independent Review Organizations (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 is responsible for implementing the IRO EMR decisions of "overturned" or "partially overturned" within 72 hours of receiving the EMR decision from the IRO.

If a Member requests a State Fair Hearing, the MCO will complete and submit the request via 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 enter the request into TIERS, along with MCO Internal Appeal decision supporting documentation, and submit the request via TIERS to the HHSC Intake Team within three Days of the Member’s request for an EMR.
Within five Days of notification that the State Fair Hearing is set, the MCO will 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 in order to be able to speak and provide relevant information on the case attend all State Fair Hearings as scheduled.

8.1.33.5.1 Independent Review Organization (IRO) Reimbursement for External Medical Reviews (EMRs)

The MCO is responsible for all IRO costs for EMRs related to Adverse Benefit Determinations of medical necessity. The MCO must reimburse HHSC for such costs within the timeframes specified by HHSC. The MCO must not pass any IRO-related costs on to providers or Members. The MCO will reimburse the HHSC, at a rate calculated by HHSC, for an EMR HHSC assigns to the IRO which the Member subsequently withdraws prior to or on the 10-Day due date of the IRO EMR decision.

MCO will pay the IRO $300.00 if the Member withdraws a non-expedited EMR request within five Calendar Days from the date the IRO receives notice of the EMR request, provided the IRO has not rendered an EMR decision.

8.1.33.6 Notices of Adverse Benefit Determination and Disposition of Appeals for Members

The MCO must notify the Member, DFPS Staff, and Medical Consenter, in accordance with 1 Tex. Admin. Code Chapter 357, whenever the MCO takes an Adverse Benefit Determination. The notice must, at a minimum, include any information required by 1 Tex. Admin. Code Chapter 357 that relates to an MCO’s notice of Adverse Benefit Determination and any information required by 42 C.F.R. § 438.404, including:

1. The dates, types, and amount of service requested;
2. the Adverse Benefit Determination the MCO has taken or intends to take;
3. the reasons for the Adverse Benefit Determination (If the Adverse Benefit Determination taken is based upon a determination that the requested service is not medically necessary, the MCO must provide an explanation of the medical basis for the decision, application of policy or accepted standards of medical practice to the individuals medical circumstances, in its notice to the Member.);
4. the Member’s, DFPS Staff, and Medical Consenter’s right to access the MCO’s Appeal process;
5. the procedures by which the Member, DFPS Staff, and Medical Consenter may Appeal the MCO’s Adverse Benefit Determination;
6. the circumstances under which expedited resolution is available and how to request it.
7. the circumstances under which a Member may continue to receive benefits pending resolution of the Appeal and how to request that benefits be continued;
8. the date the Adverse Benefit Determination will be taken;
9. a reference to the MCO policies and procedures supporting the MCO’s Adverse Benefit Determination;
10. an address where written requests may be sent and a toll-free number that the Member, DFPS Staff, and Medical Consenter can call to request the assistance of a Member representative, file an Appeal, or request a State Fair Hearing;
11. an explanation that Members, DFPS Staff, and Medical Consenters may represent themselves, or be represented by a provider, legal counsel;
12. a statement that if the Member, DFPS Staff, and Medical Consenter wants a State Fair Hearing on the Adverse Benefit Determination, the Member, DFPS Staff, or Medical Consenter must make the request for a State Fair Hearing within 120 Days of the date on the notice or the right to request a hearing is waived;
13. a statement explaining that the MCO must make its decision within 30 Days from the date the Appeal is received by the MCO, or three Business Days in the case of an Expedited MCO Internal Appeal; and
14. a statement explaining that the hearing officer must make a final decision within 90 Days from the date a State Fair Hearing is requested.

8.1.33.7 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 15 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;
2. for denial of payment, at the time of any Adverse Benefit Determination affecting the claim; and
3. for standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R. § 438.210(d)(1).

If the MCO extends the timeframe in accordance with 42 C.F.R. § 438.210(d)(1), it must:
1. 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 a Complaint if he or she disagrees with that decision;
2. issue and carry out its determination as expeditiously as the Member’s health condition requires and no later than the date the extension expires;
3. for service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d), which constitutes a denial and is thus an Adverse Benefit Determination, on the date that the timeframes expire; and for expedited service authorization decisions, within the timeframes specified in 42 C.F.R. § 438.210(d).

The MCO must comply with all timeframes required in UMCM Chapter 3.21

8.1.33.8 Notice of Disposition of Appeal

In accordance with 42 C.F.R. § 438.408(e), the MCO must provide written notice of disposition of all Appeals including Expedited MCO Internal Appeals to the affected parties. The written resolution notice (e.g., approval, denial, etc.) must be sent to the Member and legal representative acting on behalf of the Member and must also be sent to a person acting on behalf of the Member to ensure the Member has an adequate opportunity to request a State Fair Hearing/EMR within ten Days if they choose to do so. The notice must include the results
and date of the Appeal resolution. For decisions not wholly in the Member’s favor, the notice must contain all of the following:

1. The right to request a State Fair Hearing/EMR;
2. how to request 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 Chapter 357 that relates to an MCO’s notice of disposition of an Appeal.

8.1.33.9 Timeframe for Notice of Resolution of Appeals

In accordance with 42 C.F.R. § 438.408, the MCO must provide written notice of 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 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 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 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.

8.1.33.10 Member Advocates

The MCO must provide Member Advocates to assist Members, DFPS Staff, and Medical Consenters. Member Advocates may be Service Managers, or other MCO staff as long as they meet Contract requirements for serving as Member Advocates. Member Advocates must be physically located within the State of Texas. 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. Covered Services available to them, including preventive services; and
5. availability of and access to Non-capitated Services.

Member Advocates must assist Members, DFPS Staff, and Medical Consenters in writing Complaints and are responsible for monitoring the Complaint through the MCO’s Complaint process.

Member Advocates are responsible for making recommendations to management on any changes needed to improve either the care provided, or the way care is delivered. Member Advocates are also responsible for identifying and referring Members, DFPS Staff, and Medical Consenters to community resources available to meet Members’ needs that are not available from the MCO as Covered Services.
8.1.33.11 NEMT Services Complaints and Appeals

All of the requirements found in this section 8.1.33, including its subsections, apply to NEMT Services, with the following exceptions:

1. The MCO Medical Director is not required to review Appeals in accordance with 8.1.33.3 related to NEMT Services, unless the MCO action being appealed is related to a medical issue.

2. No specific clinical expertise is required in accordance with 8.1.33.3 for reviewers of Appeals related to NEMT Services.

UMCM Chapters 3.21 and 3.22 do not apply to NEMT Services.

8.1.34 Third-Party Liability and Recovery and Coordination of Benefits

In the STAR Health program only, 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 will cost avoid and deny the claim for other insurance or, if the claim is already paid, pursue TPR.

The MCO is responsible for establishing and documenting a plan and process, referred to as the Third Party Liability Managed Care Organization Action Plan (TPL MCO Action Plan, in accordance with UMCM Chapter 5, 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]), service benefit plans, managed care organizations, Pharmacy Benefit Managers, 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 an individual 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), in accordance with UMCM Chapter 5, no later than September 1 for the upcoming state fiscal year for review and approval. MCOs 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 8.1.23.1, “Financial Reporting Requirements, Third Party Liability and Recovery (TPL/TPR) Reports” in accordance with UMCM Chapter 5.

The MCO must provide all TPR reports to OIG-TPR at the frequency stated in and in accordance with UMCM, Chapter 5.

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 obtain recovery of payment from a liable third party and not from the provider unless the provider received payment from both the MCO and the liable third party. The MCO shall provide to HHSC, on a monthly basis by the tenth Day of each month, a report indicating the claims where 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 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 UMCM Chapter 5. The MCOs are to 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 a HHSC-initiated recovery, the MCO must send the payment to OIG-TPR in the format prescribed in UMCM Chapter 5.

HHSC retains the responsibility to pursue, collect, and retain recoveries of all resources and insurances other than health insurance wherein payments have been made on behalf of a Member. These resources and other insurances include, but are not limited to: casualty insurance, liability insurance, estates, child support, and personal injury claims. The MCO must pay valid claims for Covered Services provided to MCO Members who have, or may have, resources and insurances other than health insurance. Since HHSC retains the right of recovery for such resources and insurances other than health insurance, the MCO is not permitted to cost avoid or seek recovery for such items. Should the MCO receive payment on a claim in which resources or insurances other than health insurance are utilized, the MCO must send the payment to OIG-TPR in the format prescribed in UMCM Chapter 5. Members with these other resources shall remain enrolled in the MCO.

8.1.34.1 Advance Directives

Federal and state law require MCOs and providers to maintain written policies and procedures for informing all Members 18 years of age and older about their rights to refuse, withhold or withdraw medical treatment and BH treatment through advance directives (see Social Security Act § 1902(a)(57) and § 1903(m)(1)(A). Also see the Procurement Library, DFPS Policy on Withdrawal of Life Support. The MCO’s policies and procedures must include written notification to Members 18 years of age and older and comply with provisions contained in 42 C.F.R. § 489, Subpart I, relating to advance directives for all Hospitals, critical access Hospitals, skilled nursing facilities, home health agencies, Providers of home healthcare, Providers of personal care services and hospices, as well as the following state laws, rules and regulations:

1. A Member’s right to self-determination in making healthcare decisions;
2. the Advance Directives Act, Texas Health & Safety Code Chapter 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; and

Chapter 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 BH treatment.

The MCO must maintain written policies for Providers to follow regarding receiving and
documenting consent from the DFPS individual authorized to provide medical consent prior to
implementing a Member’s advance directive. Those policies must include a clear and precise
statement of limitation if the Provider cannot or will not implement a Member’s advance
directive.

The MCO cannot require a Member to execute or issue an advance directive as a condition of
receiving Healthcare Services. The MCO cannot 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 Subcontractors to comply with
the requirements of state and federal law and DPFS policies 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 6th 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 6th 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.

8.1.35 Minimum Wage Requirements for Attendants

The MCO must ensure attendants are paid in accordance with 1 Tex. Admin. Code, § 355.7051, Base Wage for a Personal Attendant for any personal attendant who provides:

1. Personal Care Services (PCS);
2. CFC services (including PCS-CFC and acquisition, maintenance, and enhancement of
   skills); and
3. MDCP services (including Respite, Supported Employment and Employment
   Assistance).

8.1.36 Preadmission Screening and Resident Review (PASRR) Referring Entity
   Requirements

The MCO must follow any PASRR requirements when acting as a referring entity for Members
8.1.37 **Electronic Visit Verification (EVV)**

The MCO must comply with Title 1, Chapter 354, Subchapter O of the Texas Administrative Code and applicable chapters of the UMCM, including Chapter 8.7.

The MCO must require Providers, CDS employers, and Financial Management Services Agencies (FMSAs) to use an Electronic Visit Verification (EVV) System in accordance with the EVV requirements described in Title 1, Chapter 354, Subchapter O of the Texas Administrative Code.

The MCO must require Providers, CDS employers, and FMSAs to use EVV for home health care services in accordance with UMCM 8.7.1 Section VII.

8.1.38 **Community First Choice (CFC) Services**

Community First Choice (CFC) provides community-based LTSS to eligible Members with physical or cognitive disabilities, SPMI, or SED as an alternative to living in an institution. The MCO must make the array of services allowable under CFC available to Members who meet eligibility requirements.

The administration of CFC in managed care is governed by 1 Tex. Admin. Code, §§ 354.1360 et.seq.

Members with physical disabilities must meet the MN/LOC requirements for nursing facility care to be eligible for CFC services. The MCO must complete the MN/LOC Assessment Instrument, as amended or modified, and submit the form to HHSC’s Administrative Services Contractor (ASC). The MCO must also complete the assessment documentation and prepare a service plan identifying the needed CFC services and include it in the Member’s HCSP. 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 Member must be reassessed annually or if the child experiences a change in condition. A re-assessment must be completed and electronically submitted via the ASC’s portal in the specified format no later than 45 days prior to the annual service plan expiration date.

Members with cognitive disabilities must meet the institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF-IID) to be eligible for CFC services. The MCO must review and consider the assessment and service plan completed by the Local IDD Authority when determining eligibility and finalizing the service plan. The MCO must also include the CFC service plan in the Member’s HCSP. 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 IMD level of care, which is determined by receiving a CANS or ANSA with a level of care 4.

The MCO must coordinate with a provider of Mental Health Rehabilitative Services and Mental Health Targeted Case Management to determine whether the Member meets an IMD level of care. The MCO is also responsible for preparing a service plan identifying the needed CFC services and include it in the Member’s HCSP. 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 notify Members and their Medical Consenters of their eligibility determination. If the Member is eligible for CFC services, the MCO will notify the Member of the effective date of eligibility. If the Member is not eligible for CFC services, the MCO will provide the Member information on the right to appeal the determination, including access to HHSC’s Fair Hearing
process. The MCO is responsible for preparing any requested documentation regarding its assessments and service plans and attending the Fair Hearing.

As part of any assessment, the MCO must inform the Member and their Medical Consenter about service delivery options such as Consumer Directed Services (CDS).

The MCO must contract with Providers of CFC services to ensure access to these services for all qualified Members. CFC services must be provided in home and community based settings and comply with 42 CFR § 441.301(c)(4). At a minimum, these Providers must 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 Home and Community Support Services Agency (HCSSA) or certified as a Home and Community-based Services or Texas Home Living agency. The level of licensure required depends on the type of service delivered. Emergency Response Service Providers must be licensed by the Public Security Bureau of the Texas Department of Public Safety as an alarm systems company or by DSHS as a personal emergency response system provider.

### 8.1.39 Covered Community-Based Services

The MCO must ensure that Members needing Community-Based Services are identified and that services are referred and authorized in a timely manner. 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 Providers of Community-Based Services are appropriately licensed to deliver the service they provide. MDCP services must be provided in home and community based settings and comply with 42 CFR § 441.301(c)(4).

Community-Based Services may be necessary for preventative reasons to avoid more expensive hospitalizations, emergency room visits, or institutionalization. Community-Based Services must also be made available to Members to assure maintenance of the highest level of functioning possible in the least restrictive setting. A Member’s need for Community-Based Services to assist with activities of daily living and instrumental activities of daily living must be considered as important as needs related to a medical condition.

If the Member wishes to stay with the current MCO, the MCO must notify the Member of the date by which the Provider will no longer be in Network or eligible for reimbursement to serve the Member and assist the Member in locating and beginning services with a new Provider with minimal disruption in services.

This section only pertains to residential and employment provider termination as a cause for disenrollment (42 CFR § 438.56(d)(2)(iv); therefore, the requirement differs from those under Section 8.1.4.10 of the Contract.

### 8.1.39.1 This Section is Intentionally Left Blank

### 8.1.39.2 Home and Community Based Settings

The MCO must ensure that a setting in which any of the following STAR Health and MDCP home and community-based services are provided complies with 42 CFR §441.301(c)(4)-(5), and §441.530, as applicable:

1. PCS
There are three service delivery options available for STAR Health and MDCP Members for the delivery of certain covered services. These service delivery options are:

1. Consumer Directed Services (CDS) option;
2. Service Responsibility Option (SRO); and
3. Agency option

The MCO must provide information about the service delivery options in the Member Handbook, and the MCO service coordinator must present information about the three service delivery options to Members at the following times:

1. at initial assessment;
2. at annual reassessment or annual contact with the STAR Health Member; and
3. at the Member’s request.

The MCO must contract with Home and Community Support Services agencies (HCSSAs), certified Home and Community-based Services (HCS) or Texas Home Living (TxHmL) providers, and Financial Management Services Agencies (FMSAs) to ensure availability of all service delivery options. Network Providers must meet licensure and certification requirements as indicated in Section 8.1.4, Provider Network.

Regardless of which service delivery option(s) the Member selects, the Service Coordinator and the Member work together to develop the Member’s Service Plan (SP) or Individual Service Plan.

**8.1.40.1 Consumer Directed Services (CDS) Option**

In the CDS option, the Member or their Medical Consenter is the employer of record and retains control over the hiring, management, and termination of service providers. The Member or their Medical Consenter is responsible for ensuring that the employee or contracted service provider meets all applicable eligibility qualifications.

The Member or their Medical Consenter is required to receive Financial Management Services provided by a FMSA. The FMSA performs functions including processing payroll, withholding taxes, and filing tax-related reports to the Internal Revenue Service and the Texas Workforce Commission for services delivered through the CDS option. The FMSA is also responsible for providing training to the Member or their Medical Consenter on being an employer, verifying provider qualifications (including criminal history and registry checks), and approving the CDS budget.
The MCO must ensure the FMSA meets necessary qualifications to provide Financial Management Services, including completing the mandatory FMSA enrollment training provided by HHSC and meeting eligibility requirements for an HHSC FMSA contract.

The MCO must ensure that the CDS budget is calculated using HHSC rates for CDS services.

The MCO must offer the CDS option and make it available for the following STAR Health and MDCP covered services:

- CFC Personal Care Services and Habilitation
- PCS
- Respite
- Flexible Family Support Services
- Employment assistance
- Supported Employment
- Adaptive Aids
- Minor Home Modifications

8.1.40.2 Service Responsibility Option

In the service responsibility option (SRO), the Home and Community Support Services agency (HCSSA) or certified Home and Community-based Services (HCS) or Texas Home Living (TxHmL) Provider in the MCO Provider Network is the employer of record for the service provider. The Member or the Member’s legal guardian is actively involved in choosing and overseeing the service provider but is not the employer of record.

The Member selects their service provider from the HCSSA or certified HCS or TxHmL Provider’s employees. The Member retains the right to supervise and train the service provider, and to establish the schedule for service delivery. The Member may request a different personal attendant and the HCSSA or certified HCS or TxHmL Provider must honor the request as long as the new attendant is an employee of the agency. The HCSSA establishes the service provider’s payment rate, benefits, and conducts all administrative functions.

The MCO must offer SRO and make it available for the following STAR Health and MDCP Covered Services:

1. CFC Personal Assistance Services,
2. CFC Habilitation,
3. Personal Care Services, and
4. Respite

8.1.40.3 Agency Option

In the agency option, the MCO contracts with a Home and Community Support Services agency (HCSSA) or a certified Home and Community-based Services or Texas Home Living Provider for the delivery of services. The HCSSA is the employer of record for the service provider. The HCSSA or certified HCS or TxHmL Provider establishes the payment rate and benefits for the service providers and conducts all administrative functions. The agency option is the default service delivery option for all community-based LTSS.

The MCO must offer the agency option and make it available for all STAR Health and MDCP Covered Services.
8.1.41 Facility Based Care

A STAR Health Member who enters a community-based ICF/IID will remain a STAR Health Member.

The MCO will not be responsible for the cost of care provided in an ICF/IID. The MCO will not maintain ICFs/IID in its Provider Network and will not reimburse ICFs/IID for Covered Services.

The MCO must provide Service Coordination and any Covered Services that occur outside of the ICF/IID when a STAR Health Member is in an ICF/IID. Throughout the duration of the ICF/IID stay, the STAR Health MCO must coordinate with the Member and their Medical Consenter, and DFPS Staff to identify Community-Based Services and LTSS programs that may help the Member return to a placement in the community.

8.1.42 Prescribed Pediatric Extended Care

Prescribed Pediatric Extended Care services must be prescribed by a physician and are considered an alternative to Private Duty Nursing (PDN). However, PPECC services must not supplant a child's right to receive PDN per Texas Health and Safety Code § 248A.151. Service hours in a PPECC are intended to be a one-to-one replacement of PDN service hours, unless additional hours are medically necessary, in accordance with Texas Health and Safety Code § 248A.158. A Member who is eligible may receive both Private Duty Nursing and PPECC services. These services may be billed on the same day but cannot be received at or billed for at the same time in that day.

MCOs must ensure that Network PPECCs adhere to licensing requirements contained in 40 Texas Health and Safety Code, Chapter 248A - Prescribed Pediatric Extended Care Centers, and 26 Tex. Admin. Code, Chapter 550, "Licensing Standards for Prescribed Pediatric Extended Care Centers". MCOs and Network PPECCs must also adhere to Medicaid program rules contained in 1 Tex. Admin. Code, §§ 363.201 - 363.217.

Pursuant to Texas Health and Safety Code § 248A.151, admission to a PPECC must be voluntary and based on the preference of the Member or their Medical Consenter. The MCO must ensure continuity of PPECC services in accordance with the authorization timeframes established in Section 8.1.27, "Continuity of Care and Out-of-Network (OON) Providers." The MCO must also coordinate care and authorizations between PPECs and the Member's other providers, including home health agencies, to ensure that the Member's PPECC plan of care does not include an overlap or duplication of Medically Necessary Covered Services, including, but not limited to, PDN, PCS, Home Health Skilled Nursing, Home Health Aide services, and therapies. Members eligible for PPECC services will be classified as MSHCN as described in Section 8.1.13. The MCO must offer Service Management and develop an HCSP, as appropriate.

The cost of service must not be a factor in determining the most appropriate setting for an eligible Member to receive skilled nursing services. PPECC services are limited to no more than 12 hours a day and may not be rendered overnight. Therapy services (occupational, speech, physical, and respiratory) rendered in a PPECC may be provided by (1) therapists employed by or contracted with the PPECC or (2) by credentialed Network therapists not employed by or contracted with the PPECC. Therapy services must be authorized and billed separately from PPECC services, and the MCO’s claims systems must accommodate PPECCs as a place of service for therapy services.

8.1.42.1 Prior Authorization for PPECC Services

All PPECC services must be prior authorized. All prior authorization requests must contain documentation of medical necessity including a physician order and PPECC plan of care.
MCOs may choose to utilize prior authorization forms used in fee-for-service 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 prior authorization form.

An initial authorization for PPECC services may last 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.

8.1.43 Medicaid Wrap-Around Services

The MCO must supplement Medicare coverage for Dual Eligible Members by covering certain Medicaid Wrap-Around Services as described below.

The MCO must cover Medicaid Wrap-Around Services for outpatient drugs, biological products, certain limited home health supplies (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 Attachment A, Section 10.16, “Supplemental Payments for Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products.” Refer to UMCM Chapter 2 for additional information regarding the claims processing requirements for these Medicaid Wrap-Around Services.

The MCO must supplement the Medicare coverage for STAR Health members by providing Long-term Services and Supports as Medicaid Wrap-Around Services, including:

- Community First Choice (CFC) services for qualified members, as specified in Section 8.1.38, Community First Choice Services;
- Medically Dependent Children Program (MDCP) services for qualified members, as specified in Section 8.2., Additional Requirements Regarding the Medically Dependent Children Program (MDCP);
- Personal Care Services (PCS);
- Prescribed Pediatric Extended Care Centers (PPECC); and
- Private Duty Nursing (PDN).

When an authorization request for a Medicaid Wrap-Around Service that is not covered by Medicare is submitted to an MCO, the MCO must not require a Provider to submit a Medicare denial or explanation of benefits. Refer to UMCM Chapter 2 for additional information regarding the claims processing requirements for these Medicaid Wrap-Around Services.

MCOs must inform Providers and Members that all other Medicaid Wrap-Around Services than described herein are adjudicated and reimbursed by HHSC’s claims administrator and provide information about that process.

8.1.44 Carve-in Readiness

MCOs must participate in Readiness Review dictated by HHSC for the expansion of Medicaid managed care to populations currently served by the fee-for-service system.

8.1.45 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 that are internal, man-made, or natural, the MCO must
ensure the care of Members in compliance with the MCO’s continuity of Member care emergency response plan (COMCER plan), particularly the care of Members whose health or Behavioral Health 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 Section 16.1.13 of the UMCM Chapter 16.1.

The MCO must have a COMCER plan based on a risk assessment for each of the Service Areas in which Services are provided under the Contract, using an “all hazards” approach to respond. An “all hazards” approach focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies, man-made emergencies or natural disasters. As part of the plan, the MCO must describe the method to ensure that Members are able to see Out-of-Network providers if Members have a permanent address in FEMA or State of Texas Governor-declared disaster areas, or areas in which internal, man-made, or natural disasters have occurred and are unable to access Covered Services from Network Providers. The MCO must also describe the method it will use to ensure that prior authorizations 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. 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, man-made, or natural. The continuity of operations business 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 that is internal, 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 Texas Health and Safety Code § 483.047(b-1) as a justification for rejecting a claim provided the pharmacy or pharmacist meets Texas Health and Safety Code § 483.047(b-1)’s requirements.

### 8.1.46 CMS Interoperability and Patient Access

Effective January 1, 2021, MCOs are required by federal law to implement and maintain a Patient Access Application Programming Interface (API) and a Provider Directory API using the required Health Level 7 Fast Healthcare Interoperability Resources-based standards.

The MCO must comply with the Patient Access API requirements in 42 C.F.R. § 438.242(b)(5) and the Provider Directory API requirements in 42 C.F.R. § 438.242(b)(6), including the provider directory information specified in 42 C.F.R. § 438.10(h)(1) and (2). More detailed information regarding the federal compliance requirements can be found in the CMS Interoperability and Patient Access Final Rule in the May 1, 2020 issue of the Federal Register (85 FR 25510-01).
Additional guidance can also be found in the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program in the May 1, 2020 issue of the Federal Register.

8.1.46.1 Payer-to-Payer Data Exchange

Effective January 1, 2022, the MCO must comply with an individual's request to have the individual's health data transferred from payer to payer.

The rule finalizes the requirements in 42 C.F.R. § 438.62(b)(1)(vi) and (vii) for the creation of a process for the electronic exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 C.F.R. § 170.213.

8.2 Additional Requirements Regarding the Medically Dependent Children Program (MDCP)

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 support services 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 support Caregivers and Medical Consenters in providing a stable placement in a home-like setting for children and young adults who are medically dependent.

8.2.1 Program Eligibility and Assessment

MDCP provides 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 (NF). Total enrollment in MDCP is limited to the number of individuals and the amount of state funding approved by the Texas Legislature except as otherwise provided in 40 Tex. Admin. Code § 51.211(b)–(c).

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 Screening and Assessment Instrument (SAI) and MDCP module. A medical necessity determination must be authorized through HHSC or its designee.

If a Member is considered by HHSC for MDCP entry, the MCO must schedule and complete the required elements of the SAI within 30 Days of notice from HHSC. Once the SAI and MDCP module are complete, the MCO must submit the results of the assessment to the HHSC Administrative Services Contractor (ASC) 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 before the Member's ISP expires. The MCO must administer the SAI reassessment approved by HHSC by pre-populating specific HHSC-approved information collected during the assessment from the previous year. The MCO must ensure all pre-populated information is verified for accuracy at the time of the reassessment. The MCO must
not pre-populate the SAI without previously having completed the full SAI with the Member. 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 MCO must ensure reassessments occur before the Member’s medical necessity determination expires. The MCO must administer a SAI reassessment approved by HHSC by pre-populating specific HHSC-approved information collected during the assessment from the previous year. The MCO must ensure any pre-populated information is verified for accuracy at the time of the reassessment. The MCO must not pre-populate the SAI without previously completing the full SAI. The reassessment must be submitted to the HHSC ASC no later than 30 Days before the Member’s ISP expires to ensure that the HHSC ASC has sufficient time to process the Member’s medical necessity determination so the Member does not experience a lapse in MDCP program eligibility.

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 MCDP services with the Member, Caregiver and Medical Consenter within 14 Days of receipt of placement change information on the DNF. All re-assessments related to a change in condition must be completed within 30 Days of notification from the Member or 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 required elements of the ISP, as directed by HHSC, must be completed and submitted to the TMHP 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. A medical necessity determination will expire 120 Days after it is approved by the HHSC ASC if MDCP services have not begun.

The MCO must coordinate with the Member and their Medical Consenter to update the Member’s HCSP with the MDCP plan of care.

Following completion of an SAI, the MCO must review the information populated in the assessment with the Member or Member’s Medical Consenter for verification and make edits, as appropriate, prior to submitting to the HHSC Administrative Service Contactor. The Service Manager must notify the Member or Member’s Medical Consenter that the SAI will be available on the Member’s portal or Health Passport and offer a copy of the completed SAI. The MCO must provide the Member or Member’s Medical Consenter with a printed or electronic copy of the SAI within seven Days of the request.

Prior to November 1, 2016, HHSC will provide the MCO with a file on each MDCP Member, including when each Member is due for their next annual reassessment. The MCO must prioritize MDCP reassessments to ensure they occur on schedule. The MCO must continue to provide all services included in the Member’s existing MDCP plan of care 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 HCSP is complete. If an MDCP Member is disenrolled from STAR Health and enrolls in the STAR Kids program prior to annual reassessment, the MCO must provide the STAR Kids MCO with the results from the previous SAI assessment.

### 8.2.2 Service Management Requirements for MDCP Members

A registered nurse (RN), advance practice nurse (APRN), physician assistant (PA) social worker (MSW, LCSW, or LBSW), or LVN (with a minimum of one year previous experience with case
management with pediatric clients) must administer the SAI MDCP module. The MDCP modules may not be administered by any contracted entity providing direct services to the Member. An RN or APRN must administer the SAI NCAM and MDCP module, if needed.

Any MCO staff, or MCO-contracted staff, administering the STAR Kids SAI must take the STAR Kids SAI training module required by HHSC before administering the SAI. All MCO staff, or MCO-contracted staff administering the MDCP portion of the STAR Kids SAI must not only have completed the HHSC-approved STAR Kids SAI training, but also must be certified through the state-approved RUG training found at the Texas State University website under Continuing Education.

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 it in the Member's HCSP. 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 their cost limit. The MCO must also develop a process to track each Member's MDCP-related expenditures on a monthly basis and provide an update on the progress to the Member and their Medical Consenter no less than once per month.

The MCO must ensure that the Service Manager for an MDCP Member follow up with the Member and their Medical Consenter, either in person or by telephone, to ensure that necessary services are in place and document the visit in the Member's file. The MCO must ensure that the Service Manager for an MDCP Member continue to make monthly in person or by telephone contact with the Member and their 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 HCSP.

For all MDCP Members, the MCO must consult with the Member and their 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 MDCP Member's HCSP must include the components of a person-centered service plan 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 Manager in the STAR Health program reviews the information gathered in the Screening and Assessment Instrument (SAI) with the Medical Consenter. The Service Manager 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 Manager must document the refusal; the Service Manager 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 the TMHP 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 the TMHP portal through the final medical
necessity determination and must follow the guidelines stated in the UMCM Chapter 16.2, STAR Health MDCP Policy Section VII(A).

8.2.3 MDCP Provider Requirements

The MCO must provide MDCP Covered Services to eligible Members. (See Attachment B-2, “Covered Services”) 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 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. Registered nurses and licensed vocational nurses must have current licenses under Texas Occupations Code Chapter 301. Child Day Care Facilities must be licensed by HHSC.

Children with special healthcare needs must receive 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 Home and Community Support Services Agency (HCCSA) licensed by HHSC under 40 Tex. Admin. Code Chapter 97, skilled care must be performed by a registered nurse (RN) or licensed vocational nurse (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. The HCCSA must employ a Respite attendant who meets the following requirements:

1. is at least 18 years of age;
2. has a high school diploma, certificate of high school equivalency (General Educational Development (GED) credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks;
3. is trained in CPR and first aid;
4. can pass criminal history checks;
5. is not on the Employee Misconduct Registry or Nurse Aide Registry list;
6. is familiar with the individual’s specific tasks;
7. is not on the state and federal lists of excluded individuals and entities; and
8. is not the individual’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 (40 Tex. Admin. Code Chapters 745, 749, 750), the Provider of the Respite service component must be at least 18 years of age and have a high school diploma or certificate of high school equivalency (GED credentials). The host family must not provide services in its residence to more than four persons unrelated to the individual at one time. The host family may not be the foster family that is receiving payment from DFPS for the residential care of the child. 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 individual. 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 Chapter 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 Texas Occupations Code Chapter 301.

For out-of-home Respite delivered by Special Care Facilities licensed by HHSC under 26 Tex. Admin. Code Chapter 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 Texas Occupations Code, Chapter 301.

For out-of-home Respite delivered by a Hospital licensed by DSHS under 25 Tex. Admin. Code Chapter 133 and participating in Medicare under 42 C.F.R. Part 482, 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 Texas Occupations Code Chapter 301.

For out-of-home Respite delivered by a Nursing Facility licensed by HHSC under 40 Tex. Admin. Code Chapter 19, 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 Chapter 265, Subchapter B, 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 Texas Occupations Code Chapter 301. These camps must be accredited by the American Camping Association.

Supported Employment and Employment Assistance: HCCSAs providing Supported Employment or Employment Assistance are licensed by HHSC. The Provider of supported employment services must meet all of the criteria in one of 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's 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 Financial Management Services Agencies (FMSAs), are procured through an open enrollment process and are required to hold a Medicaid provider agreement with the
State. Through a delegation arrangement, HHSC executes a contract with the required elements of a Medicaid provider agreement on behalf of HHSC.

An FMSA must comply with the requirements for delivery of Financial Management Services, including attending a HHSC mandatory 3-Day training session. Topics covered in the training session include: contracting requirements and procedures; FMSA responsibilities; consumer/employer responsibilities; HHSC case manager/service coordinators responsibilities; enrollment, transfer, suspension and termination of the CDS option; employer budgets; reporting abuse, neglect and exploitation allegations; oversight of CDS; contract compliance and financial monitoring. The required training materials include the definition and responsibilities of a vendor fiscal/employer agent in accordance with IRS Revenue Procedure 70-6, 1970-1 C.B. 420 and an explanation of fiscal employer agent based on Section 3504 of the IRS code and state tax (unemployment) requirements as a Vendor Fiscal/Employer Agent. The training also covers IRS Forms SS-4 and 2678. The rules for the CDS option, located at 40 Tex. Admin. Code Chapter 41, require FMSAs to act as vendor fiscal/employer agents along with describing responsibilities such as the revocation of IRS Form 2678 if the individual terminates the CDS option or transfers to another FMSA.

The FMSA must not be the individual’s spouse, Caregiver, Medical Consenter, legal guardian, or the spouse of the individual’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. 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 & 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.

### 8.2.4 Continuity of Care Requirements for MDCP 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 in the care of enrolled Members who are Medically Fragile and those whose physical or behavioral health could be placed in jeopardy if Medically Necessary Covered Services are disrupted, compromised, or interrupted.

The MCO must continue to provide all services included in an MDCP Member’s existing plan of care 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 HCSP is updated to include the MDCP plan of care. 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 Prior Authorization, the MCO must ensure Members receiving services through a Prior Authorization 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 prior authorization, or
3. until the MCO has appropriately evaluated and administered the STAR Health MDCP Screening and Assessment Process and issued or denied a new authorization.

MCOs must allow Members to continue seeing their existing MDCP service Providers, including Out of Network providers, for a period of 180 Days after the transition to a new MCO.
## DOCUMENT HISTORY LOG

<table>
<thead>
<tr>
<th>STATUS</th>
<th>DOCUMENT REVISION</th>
<th>EFFECTIVE DATE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>2.0</td>
<td>July 1, 2015</td>
<td>Initial version of Attachment B-1, RFP Section 9, “Turnover Requirements” that includes all modifications negotiated by the Parties.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.1</td>
<td>September 1, 2015</td>
<td>Section 9.2 is modified to align with the LD Matrix and to add language that the MCOs need to include third-party software information in the MCOs' transition plan. Section 9.3 is modified to add clarification regarding HHSC's potential need for MCO's third party software for contract turnover. Section 9.4 is modified to require an update of the Turnover Plan 12 months prior to the end of the Contract Period.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.2</td>
<td>March 1, 2016</td>
<td>Section 9.4 is modified to clarify the requirements.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.3</td>
<td>September 1, 2016</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.4</td>
<td>March 1, 2017</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.5</td>
<td>September 1, 2017</td>
<td>Section 9.5 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.6</td>
<td>March 1, 2018</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.7</td>
<td>September 1, 2018</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.8</td>
<td>January 1, 2019</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
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<tr>
<td>Revision</td>
<td>2.9</td>
<td>March 1, 2019</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.10</td>
<td>September 1, 2019</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
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<td>Revision</td>
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<td>2.11</td>
<td>March 1, 2020</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
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<td>2.12</td>
<td>September 1, 2020</td>
<td>Section 9.1 is modified to clarify language to include expectations required of contracted MCO.</td>
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<td>2.13</td>
<td>March 1, 2021</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
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<td>2.14</td>
<td>June 1, 2021</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
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<td>2.15</td>
<td>September 1, 2021</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
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<td>2.16</td>
<td>March 1, 2022</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
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<td>2.17</td>
<td>September 1, 2022</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
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<td>2.18</td>
<td>March 1, 2023</td>
<td>Contract amendment did not revise Attachment B-1, RFP Section 9, and “Turnover Requirements”.</td>
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</table>

1 Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.

2 Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.
Table of Contents

9 TURNOVER REQUIREMENTS ...........................................................................................................4

9.1 Introduction .............................................................................................................................4

9.2 Turnover Plan ..........................................................................................................................4

9.3 Transfer of Data and Information ............................................................................................4

9.4 Turnover Services .....................................................................................................................5

9.5 Post-Turnover Services ............................................................................................................5
9 TURNOVER REQUIREMENTS

9.1 Introduction

This section presents the Turnover Phase. The MCO is required to perform all required activities prior to, upon, and following termination, expiration, merger, or acquisition of the Contract in accordance with the HHSC-approved Turnover Plan.

9.2 Turnover Plan

Twelve months after the start of the Contract, the MCO must provide a Turnover Plan covering the turnover of the records and information maintained to either HHSC or a subsequent contractor. The Turnover Plan will be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan should also include information about third-party software used by the MCO in the performance of duties under the contract, including the manner in which the software is used and terms of the software license agreement, so that HHSC can determine if this software is needed to transition operations under Section 9.3 of the Contract. HHSC must approve the Turnover Plan.

9.3 Transfer of Data and Information

The MCO must transfer to HHSC or a subsequent contractor all data and information necessary to transition operations, including:

1. data and reference tables;
2. data entry software;
3. license agreements for third-party software and modifications if required by HHSC;
4. documentation relating to software and interfaces;
5. functional business process flows; and
6. operational information, including
   a. correspondence,
   b. documentation of ongoing or outstanding issues,
   c. operations support documentation, and
   d. operational information regarding Subcontractors.

For purposes of this provision, “documentation” means all operations, technical, and user manuals used in conjunction with the 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 documentation in the formats in which any documentation exists at the expiration or termination of the Contract.

In addition, the MCO must provide the following to HHSC.

1. The MCO must provide data, information, and services necessary and sufficient to enable HHSC to map all Program data from the MCO’s system(s) to the replacement system(s) of HHSC or a successor contractor, including a comprehensive data dictionary as defined by HHSC.
2. The MCO must provide all necessary data, information, and services in the format defined by HHSC and must be HIPAA-compliant.
3. The MCO must provide all of the data, information, and services mentioned in this section using its best efforts to ensure the efficient administration of the contract. The
data and information must be supplied in media and format specified by HHSC and according to the schedule approved by HHSC in the Turnover Plan. The data, information, and services provided as detailed in this section must be provided at no additional cost to HHSC.

HHSC or the subsequent contractor must receive and verify all relevant data and information must be received and verified. If HHSC determines that data or information are not accurate, complete, or HIPAA-compliant, HHSC reserves the right to hire an independent contractor to assist HHSC in obtaining and transferring all the required data and information and to ensure that all the data are HIPAA-compliant. The MCO is responsible for the reasonable cost of providing these services.

9.4 Turnover Services

Twelve (12) months prior to the end of the Contract Period, including any extensions, the MCO must update its Turnover Plan and submit it to HHSC. If HHSC terminates the Contract prior to the expiration of the Contract Period, then HHSC may require the MCO to submit an updated Turnover Plan sooner than twelve (12) months prior to the termination date. In these cases, HHSC’s notice of termination will include the date the Turnover Plan is due.

The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the Turnover tasks. The Turnover Plan describes MCO’s policies and procedures that guarantees:

1. the least disruption in the delivery of Healthcare Services to those Members who are enrolled with the MCO during the transition to a subsequent contractor or provider;
2. cooperation with HHSC and the subsequent contractor or provider in notifying Members of the transition, as requested and in the form required or approved by HHSC; and
3. cooperation with HHSC and the subsequent contractor or provider in transferring information to the subsequent contractor or provider, as requested and in the form required or approved by HHSC.

HHSC must approve the Turnover Plan, which must include the following at a minimum:

1. The MCO’s approach and schedule for the transfer of data, information, and services, as described in this Section;
2. the quality assurance process that the MCO will use to monitor Turnover activities; and
3. the MCO’s approach to training HHSC or a subsequent contractor’s staff in the operation of its business processes.

HHSC is not limited or restricted in the ability to require additional information from the MCO or modify the Turnover schedule as necessary.

9.5 Post-Turnover Services

Thirty 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. HHSC will not consider Turnover completed until HHSC approves the Turnover Plan.

If the MCO does not provide the required data, information, or services necessary for HHSC or the subsequent contractor to assume the operational activities successfully, the MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) to carry out inspection, audit, review, analysis, reproduction, and transfer functions at the location(s) of such records and attorneys’ fees and costs. Reimbursement by the MCO will
be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.
## DOCUMENT HISTORY LOG

<table>
<thead>
<tr>
<th>STATUS</th>
<th>DOCUMENT REVISION</th>
<th>EFFECTIVE DATE</th>
<th>DESCRIPTION</th>
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<tr>
<td>Baseline</td>
<td>2.0</td>
<td>July 1, 2015</td>
<td>Initial version of Attachment B-2, “STAR Health Covered Services” that includes all modifications negotiated by the Parties.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.1</td>
<td>September 1, 2015</td>
<td>&quot;Covered Services include the following&quot; is modified to add “Emergency and non-emergency” to Ambulance services, Mental Health Rehabilitative Services, Community First Choice services, and Mental Health Targeted Case Management and to remove the asterisk and related language for Behavioral Health Services.</td>
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<tr>
<td>Revision</td>
<td>2.2</td>
<td>March 1, 2016</td>
<td>Contract amendment did not revise Attachment B-2, “STAR Health Covered Services.”</td>
</tr>
<tr>
<td>Revision</td>
<td>2.3</td>
<td>September 1, 2016</td>
<td>&quot;Covered Services include the following:&quot; is modified to add Prescribed Pediatric Extended Care Centers (PPECC). &quot;Services included under the MCO capitation payment for MDCP” is added.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.4</td>
<td>March 1, 2017</td>
<td>Contract amendment did not revise Attachment B-2, “STAR Health Covered Services.”</td>
</tr>
<tr>
<td>Revision</td>
<td>2.5</td>
<td>September 1, 2017</td>
<td>The modified language better organizes the section of &quot;covered services&quot; to ensure all behavioral health services are grouped under the Behavioral Health Services heading by including Mental Health Rehabilitative Services and Mental Health Targeted Case Management services in the list of Behavioral Health Services. The modified language also correctly references the population eligible for covered services.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.6</td>
<td>March 1, 2018</td>
<td>Contract amendment did not revise Attachment B-2, “STAR Health Covered Services.”</td>
</tr>
<tr>
<td>Revision</td>
<td>2.7</td>
<td>September 1, 2018</td>
<td>Attachment B-2 is modified to comply with home health requirements in 42 C.F.R § 440.70.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.8</td>
<td>January 1, 2019</td>
<td>Contract amendment did not revise Attachment B-2, “STAR Health Covered Services.”</td>
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<tr>
<td>Revision</td>
<td>2.9</td>
<td>March 1, 2019</td>
<td>Contract amendment did not revise Attachment B-2, “STAR Health Covered Services.”</td>
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<tr>
<td>Revision</td>
<td>2.10</td>
<td>September 1, 2019</td>
<td>Global change for the phrase, &quot;substance abuse&quot; to &quot;substance use disorder.”</td>
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<td>Revision</td>
<td>Date</td>
<td>Description</td>
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<td>2.11</td>
<td>March 1, 2020</td>
<td>Contract amendment did not revise Attachment B-2, “STAR Health Covered Services.”</td>
<td></td>
</tr>
<tr>
<td>2.12</td>
<td>September 1, 2020</td>
<td>Global Change to correct the references to UMCM Chapter 16.</td>
<td></td>
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<tr>
<td>2.13</td>
<td>March 1, 2021</td>
<td>Attachment B-2 is modified to comply with SB 1177, 86th Legislature, amended Government Code § 533.005 updating contract requirements to include the provisions of this bill.</td>
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<tr>
<td>2.14</td>
<td>June 1, 2021</td>
<td>Global Changes for NEMT Carve-in:</td>
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<td></td>
<td>- House Bill (H.B.) 1576, 86th Legislature, Regular Session, 2019, makes the following changes to the delivery of Non-emergency Medical Transportation (NEMT) Services:</td>
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<td>- Increases opportunities for Transportation Network Companies (TNCs) to deliver NEMT Services.</td>
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<td>- Requires MCOs to provide NMT Services.</td>
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<td></td>
<td>- Moves the responsibility to provide NEMT Services from managed transportation organizations (MTOs) to managed care organizations (MCOs) for Members.</td>
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<td></td>
<td></td>
<td>This amendment implements changes to the following section:</td>
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<tr>
<td></td>
<td></td>
<td>“STAR Covered Services include Medically Necessary” is modified.</td>
<td></td>
</tr>
<tr>
<td>2.15</td>
<td>September 1, 2021</td>
<td>B-2 STAR Health Covered Services is modified to add an additional covered service: Financial Management Services.</td>
<td></td>
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<tr>
<td>2.16</td>
<td>March 1, 2022</td>
<td>Contract amendment did not revise Attachment B-2, “STAR Health Covered Services.”</td>
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<tr>
<td>2.17</td>
<td>September 1, 2022</td>
<td>STAR Health “Covered Services” is modified to comply with the legislative high-priority bill (SB 672).</td>
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<tr>
<td>2.18</td>
<td>March 1, 2023</td>
<td>Contract amendment did not revise Attachment B-2, “STAR Health Covered Services.”</td>
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3 Brief description of the changes to the document made in the revision.
COVERED SERVICES

The following is a non-exhaustive, high-level listing of Services included under the STAR Health Medicaid managed care program.

The MCO is responsible for providing a benefit package to Members that includes all Medically Necessary services covered under the traditional fee-for-service Medicaid program except for Non-capitated Services listed in Section 8.1.28.8. The MCO must coordinate care for Members for these Non-capitated Services so that Members have access to a full range of Medically Necessary Medicaid services. The MCO may elect to offer additional Value-added Services.

The MCO should refer to the current Texas Medicaid Provider Procedures Manual for a more inclusive listing of limitations and exclusions that apply to each Medicaid benefit category. These documents can be accessed online at: http://www.tmhp.com.

The services listed in this Attachment are subject to modification based on federal and state laws and regulations and HHSC policy updates.

Covered Services include the following.

1. Emergency and non-emergency ambulance services
2. Audiology services, including hearing aids, for adults and children
3. Behavioral Health Services, including:
   a. Inpatient mental health services. Inpatient psychiatric hospital services provided in a free standing psychiatric hospital to Members under age 21 are a covered Medicaid benefit and there is no day limitation for services.
   b. Outpatient mental health services, including Mental Health Rehabilitative Services and Mental Health Targeted Case Management
   c. Psychiatry services
   d. Mental Health Rehabilitative Services
   e. Mental Health Targeted Case Management
   f. Collaborative Care Model services
   g. Residential and outpatient substance use disorder treatment services, including:
      i. Assessment
      ii. Detoxification services
      iii. Counseling treatment
      iv. Medication assisted therapy
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. Community First Choice services, including:
   a. Personal Assistance Services
   b. Habilitation
   c. Emergency Response Services
   d. Support Consultation
9. Dental services, including:
   a. Diagnostic and preventive, including support of the First Dental Home strategic initiative for Texas Health Steps 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
i. Adjunctive general

10. Dialysis
11. Durable medical equipment and supplies
12. Early Childhood Intervention (ECI) services
13. Emergency Services
14. Family planning services
15. Financial Management Services
16. Home healthcare services provided in accordance with 42 C.F.R. § 440.70, and as directed by HHSC
17. Hospital services, including inpatient and outpatient
18. Laboratory
   a. Mastectomy, breast reconstruction, and related follow-up procedures, including:
   b. 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:
      i. all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
      ii. surgery and reconstruction on the other breast to produce symmetrical appearance;
      iii. treatment of physical complications from the mastectomy and treatment of lymphedemas; and
      iv. prophylactic mastectomy to prevent the development of breast cancer.
   v. external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
19. Medical checkups and Comprehensive Care Program (CCP) Services (for children birth through age 20) through the Texas Health Steps Program (EPSDT)
20. Non-emergency Medical Transportation Services, including:
   o Demand response transportation services, including Nonmedical Transportation prearranged rides, shared rides, and public transportation services;
   o Mass transit;
   o Individual transportation participant mileage reimbursement;
   o Meals;
   o Lodging;
   o Advanced funds; and
   o Commercial airline transportation services, including out of state travel.
21. Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
22. Optometry, glasses, and contact lenses
23. Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
24. Drugs and biologicals provided in an inpatient setting
25. Podiatry
26. Personal Care Services
27. Prenatal care
28. Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center

29. Prescribed Pediatric Extended Care Centers (PPECC)

30. Primary care services

31. Private Duty Nursing (for adult and child Members)

32. Radiology, imaging, and X-rays

33. Specialty physician services

34. Therapies: physical, occupational, and speech

35. Transplantation of organs and tissues

**Services included under the MCO capitation payment for MDCP:**

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.
**DOCUMENT HISTORY LOG**

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<th>EFFECTIVE DATE</th>
<th>DESCRIPTION³</th>
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<tr>
<td>Baseline</td>
<td>2.0</td>
<td>July 1, 2015</td>
<td>Initial version of Attachment B-3, “Deliverables/Liquidated Damages Matrix” that includes all modifications negotiated by the Parties.</td>
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</table>
| Revision | 2.1               | September 1, 2015 | Item 9 is modified to increase the LD from $250 to $1,000 per calendar day of noncompliance.  
Item 17 is modified to allow the MCO to reference the VDP formulary on Epocrates when the MCO’s clinical edits are the same as or less stringent than VDP’s.  
Item 17.1 is added.  
Item 18 is modified to conform to other contracts  
Item 25 is modified to the change the requirement from 30 days to 10 days  
Item 32 is modified to separate certain Pharmacy requirements from non-pharmacy requirements.  
Item 34 is modified to add pharmacy requirements.  
Item 35 is modified to increase the LD from $250 to $1,000 per calendar day of noncompliance.  
Item 35.1 is added.  
Item 35.2 is added.  
Item 35.3 is added.  
Item 36 is modified to increase the LD from $250 to $1,000 per calendar day of noncompliance.  
Item 39 is modified |
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<th>DOCUMENT REVISION²</th>
<th>EFFECTIVE DATE</th>
<th>DESCRIPTION³</th>
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</table>
| Revision | 2.2               | March 1, 2016  | Item 41 is modified.  
Item 44 is modified to change from six months to twelve months. |
| Revision | 2.3               | September 1, 2016 | Item 3.1 is added.  
Item 3.2 is added.  
Item 3.3 is added.  
Item 14 is modified.  
Item 14.1 is added.  
Item 17 is modified.  
Item 42.1 is added. |
| Revision | 2.4               | March 1, 2017  | Item 10 is modified to correct the Service/Component reference and to add "per county" to the Measurement Assessment and Liquidated Damages. |
| Revision | 2.5               | September 1, 2017 | Item 14.2 is added.  
Item 20.1 is added.  
Item 34.1 is added.  
Item 38 is modified to change the report from quarterly to monthly and to remove Service Areas from the measurement assessment.  
Item 42 is modified to apply LDs to any appeal timeframe. |
## DOCUMENT HISTORY LOG

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<th>EFFECTIVE DATE</th>
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<td>Revision</td>
<td>2.6</td>
<td>March 1, 2018</td>
<td>Changes were made throughout the attachment for consistency purposes. Item 18 is modified to remove instruct and add allow. Items 26, 27, 29, and 30 are modified to clarify the number of days of which the report is due. Item 36 is modified to replace Report with Referral and change from quarterly to monthly submission.</td>
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<tr>
<td>Revision</td>
<td>2.7</td>
<td>September 1, 2018</td>
<td>Items 34 and 41 were modified to revise the language for the new reporting requirements.</td>
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<tr>
<td>Revision</td>
<td>2.8</td>
<td>January 1, 2019</td>
<td>Contract amendment did not revise Attachment B-3, “Deliverables/Liquidated Damages Matrix.”</td>
</tr>
<tr>
<td>Revision</td>
<td>2.9</td>
<td>March 1, 2019</td>
<td>Contract amendment did not revise Attachment B-3, “Deliverables/Liquidated Damages Matrix.”</td>
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<tr>
<td>Revision</td>
<td>2.10</td>
<td>September 1, 2019</td>
<td>Contract amendment did not revise Attachment B-3, “Deliverables/Liquidated Damages Matrix.”</td>
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<tr>
<td>Revision</td>
<td>2.11</td>
<td>March 1, 2020</td>
<td>Contract amendment did not revise Attachment B-3, “Deliverables/Liquidated Damages Matrix.”</td>
</tr>
<tr>
<td>Revision</td>
<td>2.12</td>
<td>September 1, 2020</td>
<td>Attachment B-3, “Deliverables/Liquidated Damages Matrix” was reorganized for programming into TexConnect. Items were moved under categories and item numbers changed. The crosswalk and modifications for previous and current LD items are as follows: Items OR-1 to OR-3 were Items 5, 8, and 7 respectively. Items GA-1 to GA-4 were Items 1, 2, 4, and 2.1 respectively. Items GA-3 and GA-4 were modified to add monthly and annual to the reporting timeframes.</td>
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<td>Items PS-1 and PS-2 were in Item 3.1, and PS-3 and PS-4 were Items 3.2 and 3.3 respectively.</td>
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<td>Items MS-1 to MS-4 were in Item 3.</td>
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<td>Items CL-1 to SHCL-2 were Items 38, 41, 34.1, 33, and 34. Items CL-4 and CL-7 were in Item 33, and Items CL-5, CL-6, CL-8, CL-9, SHCL-1, and SHCL-2 were in Item 34. The performance standards for CL-2, CL-3, CL-5, CL-6, CL-8, CL-9, SHCL-1 and SHCL-2 were clarified. Items CL-2, CL-4 to CL-9, SHCL-1 and SHCL-2 were modified to change the reporting timeframe to monthly.</td>
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<td>Items ED-1 to ED-6 were the Items 20.1 and 32. Items ED-1 and ED-4 were in Item 20.1. Items ED-2, ED-3, ED-5, and ED-6 were in Item 32.</td>
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<td></td>
<td>Item HL-1 was in Items 12 and 15. Item HL-2 is a new item. Item HL-3 was in Items 15 and 16. Items HL-4 and HL-5 were in Items 12, 15, and 16. HL-6 and HL-7 were in Item 16. SHHL-1 was in Item 15. Call pickup rate and busy signal performance standards were removed, and the reporting time was modified to monthly. The liquidated damages amount for Item HL-7 was modified to match with the amount in the new Item HL-2.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Items CA-1 and CA-2 were in Item 40. Items CA-3, CA-4, and SHCA-1 were Items 42, 37, and 42.1 respectively. Items CA-1 to CA-3 were modified to change the reporting time to monthly.</td>
</tr>
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<td>Items PN-1 and PN-2 were Items 10 and 14.2 respectively. Items PN-3 to PN-5 were in Item 11. PN-6 is a new item.</td>
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<td></td>
<td>Items MM-1 to MM-3 were Items 14, 14.1, and 13 respectively. Item MM-3 was modified to clarify performance standard.</td>
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<td>Items MI-1 and MI-2 were Items 31 and 6 respectively.</td>
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<td>Items FR-1 to FR-4 were Items 21, 22, 24, and 29 respectively. Items FR-5, FR-11, and FR-12 were in Item 30. Items FR-6 to FR-10 were Items 23, 25, 26, 27, and 28 respectively. Items FR-4 and FR-6 were modified to update deliverable due date information.</td>
</tr>
</tbody>
</table>
Items IG-1 to IG-3 were Items 9, 35.4, and 35 respectively. Items IG-4 and IG-5 were in Item 36. Items IG-6 to IG-8 were Items 35.1, 35.3, and 35.2 respectively. Items SHFW-1 and SHFW-2 were in Item 39. Items TO-1 to TO-3 were Items 45, 44, and 43 respectively. Items PH-1, PH-2, and PH-5 were Items 17, 17.1, and 19 respectively. Items PH-3 and PH-4 were in Item 18. Items PH-6 to PH-11 are new items. Items PH-1, PH-2, and PH-5 were modified to clarify the performance standard, and Item PH-2 was modified to change the liquidated damage information. In addition, the previous Item 20 was removed.

Item SHMD-1 was Item 42.2.

The following changes were made throughout the amendment for consistency among columns:

- Capitalized defined terms.
- Modified Service/Component column to remove “RFP” reference, update contract amendment sections as applicable, and change UMCM chapter reference to section heading level.
- Modified the Measurement Assessment and Liquidated Damages columns to match criteria assessed.

<table>
<thead>
<tr>
<th>STATUS</th>
<th>DOCUMENT REVISION</th>
<th>EFFECTIVE DATE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>Revision</td>
<td>2.13</td>
<td>March 1, 2021</td>
<td>Contract amendment did not revise Attachment B-3, “Deliverables/Liquidated Damages Matrix.”</td>
</tr>
<tr>
<td>Revision</td>
<td>2.14</td>
<td>June 1, 2021</td>
<td>Contract amendment did not revise Attachment B-3, “Deliverables/Liquidated Damages Matrix.”</td>
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<tr>
<td>Revision</td>
<td>2.15</td>
<td>September 1, 2021</td>
<td>CL-10 is added to establish a new performance measure.</td>
</tr>
<tr>
<td>Revision</td>
<td>2.16</td>
<td>March 1, 2022</td>
<td>CL-1 is modified to remove assessment by “per claim type.”</td>
</tr>
<tr>
<td>STATUS¹</td>
<td>DOCUMENT REVISION²</td>
<td>EFFECTIVE DATE</td>
<td>DESCRIPTION³</td>
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<tr>
<td>CL-10 is modified to capitalize “Day” in the measurement assessment and reference for UMCM.</td>
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<tr>
<td>ED-6 is modified to remove the repetitive, “in the initial quarter,” in the Liquidated Damages column.</td>
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<tr>
<td>HL-1, HL-2, HL-3, and HL-4 are modified to add the contract reference for the NEMT call center.</td>
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<tr>
<td>SHHL-2 is added to establish a new performance measure.</td>
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<tr>
<td>PH-3 and PH-4 are combined, and PH-4 is marked as “Reserved.”</td>
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<tr>
<td>PH-8 is modified to remove the call center requirement sentence from the performance standard and add “Medicaid” for consistency with other contracts.</td>
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<tr>
<td>PH-9 is modified to revise Medicaid reference for consistency with other contracts.</td>
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<tr>
<td>PH-10 is modified to remove the sentence for allowing Network pharmacies to challenge a MAC price from the performance standard.</td>
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<tr>
<td>Revision</td>
<td>2.17</td>
<td>September 1, 2022</td>
<td>CL-5 is modified to add “Nonemergency Medical Transportation (NEMT) Services” to the performance standard as a claim type.</td>
</tr>
<tr>
<td>CL-6 is modified to add “Nonemergency Medical Transportation (NEMT) Services” to the performance standard as a claim type.</td>
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<tr>
<td>FR-5 is modified to align language across all contracts.</td>
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<tr>
<td>SHHL-2 is modified to remove “per hotline” and “per Program” from the Measurement Assessment and Liquidated Damages columns as only one hotline is addressed in the performance standard and this contract only applies to one Program.</td>
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<tr>
<td>PH-7 is deleted</td>
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<tr>
<td>PH-11 is deleted.</td>
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<tr>
<td>PN-2 is modified updated current language to support a more comprehensive approach to APMs.</td>
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<tr>
<td>Revision</td>
<td>2.18</td>
<td>March 1, 2023</td>
<td>CL-5 and CL-6 are modified to change the performance standard language for the claims LDs, per leadership request.</td>
</tr>
</tbody>
</table>

1 Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.
2 Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
3 Brief description of the changes to the document made in the revision.
# Deliverables/Liquidated Damages Matrix

<table>
<thead>
<tr>
<th>#</th>
<th>Service/Component</th>
<th>Performance Standard</th>
<th>Measurement Period</th>
<th>Measurement Assessment</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Operations Readiness (OR)</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| OR-1 | Contract Attachment B-1, §7.2 Transition Phase Schedule and Tasks  
Contract Attachment B-1, §7.2.1 Transition Phase and Planning  
Contract Attachment B-1, §8 Operations Phase Requirements and General Scope of Work | The MCO must be operational no later than the agreed upon Operational Start Date. HHSC, or its agent, will determine when the MCO is considered to be operational based on the requirements in Sections 7 and 8 of Attachment B-1. | Operational Start Date | Each Day of noncompliance. | HHSC may assess up to $10,000 per Day of noncompliance, for each Day beyond the Operational Start Date that the MCO is not operational until the Day that the MCO is operational, including all systems. |

1 Derived from the Contract, General Terms & Conditions, or HHSC’s Uniform Managed Care Manual.
2 Standard specified in the Contract. Note: 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.
3 Period during which HHSC will evaluate service for purposes of tailored remedies.
4 Measure against which HHSC will apply remedies.
<table>
<thead>
<tr>
<th>#</th>
<th>Service/ Component¹</th>
<th>Performance Standard²</th>
<th>Measurement Period³</th>
<th>Measurement Assessment⁴</th>
<th>Liquidated Damages</th>
</tr>
</thead>
</table>
| OR-2 | Contract Attachment B-1, §7.2.5 System Readiness Review | The MCO must submit to HHSC or to the designated Readiness Review Contractor the following plans for review, no later than 120 Days prior to the Operational Start Date:  
  - Disaster Recovery Plan;  
  - Business Continuity Plan;  
  - Security Plan;  
  - Joint Interface Plan;  
  - Risk Management Plan; and  
  - Systems Quality Assurance Plan. | Transition Phase | Each Day of noncompliance, per report. | HHSC may assess up to $1,000 per Day of noncompliance and per report for each Day a Deliverable is not submitted or is late, inaccurate, or incomplete. |
| OR-3 | Contract Attachment B-1, §7.2.7 Operations Readiness | Final versions of the Provider Directory must be submitted to the HHSC Administrative Services Contractor no later than 95 Days prior to the Operational Start Date. | Transition Phase | Each Day of noncompliance, per directory. | HHSC may assess up to $1,000 per Day of noncompliance and per directory for each Day the directory is not submitted or is late, inaccurate, or incomplete. |

**General/ Administrative (GA)**

| GA-1 | General Requirement: Failure to Perform an Administrative Service  
Contract Attachment A, “STAR Health Contract Terms and Conditions” | The MCO fails to timely perform an MCO Administrative Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure either: (1) results in actual harm to a Member or places a Member at risk of imminent harm, | Ongoing | Per Day, per each incident of noncompliance. | HHSC may assess up to $5,000 per Day for each incident of noncompliance. |
<table>
<thead>
<tr>
<th>#</th>
<th>Service/Component(^1)</th>
<th>Performance Standard(^2)</th>
<th>Measurement Period(^3)</th>
<th>Measurement Assessment(^4)</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Contract Attachment B-1, §§ 6, 7, 8, and 9</td>
<td>or (2) materially affects HHSC’s ability to administer the Program.</td>
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</tr>
<tr>
<td>GA-2</td>
<td>General Requirement: Failure to Provide a Covered Service Contract Attachment A, “STAR Health Contract Terms and Conditions” Contract Attachment B-1, §§ 6, 7, 8, and 9</td>
<td>The MCO fails to timely provide an MCO Covered Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure results in actual harm to a Member or places a Member at risk of imminent harm.</td>
<td>Ongoing</td>
<td>Each Day of noncompliance, per each incident of noncompliance.</td>
<td>HHSC may assess up to $7,500 per Day of noncompliance for each incident of noncompliance.</td>
</tr>
<tr>
<td>GA-3</td>
<td>Contract Attachment B-1, §§ 6, 7, 8, and 9 UMCM</td>
<td>All reports and Deliverables as specified in Sections 6, 7, 8, and 9 of Attachment B-1 must be submitted according to the timeframes and requirements stated in the Contract (including all attachments) and the UMCM. (Specific reports or Deliverables listed separately in this matrix are subject to the specified liquidated damages.)</td>
<td>Transition Phase and Operations Phase</td>
<td>Per each Day of noncompliance.</td>
<td>HHSC may assess up to $250 per Day of noncompliance if the monthly, quarterly, or annual report/Deliverable is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
<tr>
<td>#</td>
<td>Service/Component</td>
<td>Performance Standard</td>
<td>Measurement Period</td>
<td>Measurement Assessment</td>
<td>Liquidated Damages</td>
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<tr>
<td>GA-4</td>
<td>Contract Attachment B-1, §§ 6, 7, 8, and 9 UMCM</td>
<td>All reports as specified in Sections 6, 7, 8, and 9 of Attachment B-1 must be submitted according to the requirements stated in the Contract (including all attachments) and the UMCM.</td>
<td>Transition Phase and Operations Phase</td>
<td>Per incident of noncompliance.</td>
<td>HHSC may assess up to $1,000 per incident of noncompliance if either the monthly, quarterly, or annual report is not submitted in the format/template required by HHSC.</td>
</tr>
</tbody>
</table>

**Privacy/ Security (PS)**

<p>| PS-1 | Contract Attachment A, &quot; STAR Health Contract Terms and Conditions,&quot; Section 7.06 HIPAA and Article 11 Disclosure &amp; Confidentiality of Information | The MCO must meet all privacy standards under applicable state or federal law, rule, regulation and HHSC contract requirement. | Transition Phase and Quarterly during Operations Phase | Per quarterly reporting period, per violation. | HHSC may assess up to $5,000 per quarterly reporting period for each privacy violation of applicable federal or state law or the HHSC privacy standards in the Contract. |
| PS-2 | Contract Attachment A, &quot; STAR Health Contract Terms and Conditions,&quot; Section 7.06 HIPAA and Article 11 Disclosure &amp; Confidentiality of Information | The MCO must meet all security standards under applicable state or federal law, rule, regulation and HHSC contract requirement. | Transition Phase and Quarterly during Operations Phase | Per quarterly reporting period, per violation. | HHSC may assess up to $1,000 per quarterly reporting period for each security violation of security requirements under federal or state law or the HHSC security standards in the Contract. |
| PS-3 | Contract Attachment A, &quot; STAR Health Contract Terms and Conditions,&quot; Section 7.06 HIPAA and | The MCO must meet all confidentiality standards under applicable state or federal law, | Transition Phase and Quarterly during | Per quarterly reporting period, per privacy/security | HHSC may assess up to $5,000 per quarterly reporting period for each breach by MCO scenario as required by HHSC. |</p>
<table>
<thead>
<tr>
<th>#</th>
<th>Service/ Component¹</th>
<th>Performance Standard²</th>
<th>Measurement Period³</th>
<th>Measurement Assessment⁴</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS-4</td>
<td>Contract Attachment A, “STAR Health Contract Terms and Conditions,” Section 7.06 HIPAA and Article 11 Disclosure &amp; Confidentiality of Information</td>
<td>The MCO must meet the privacy breach notification and/or breach response standard required by applicable federal and state law and HHSC contract requirements.</td>
<td>Transition Phase and Quarterly during Operations Phase</td>
<td>Per Day, per violation of breach notification and/or response standards of an actual or suspected privacy breach which may or actually requires notification to HHSC, an individual, the press and/or a federal regulatory body, or may require appropriate mitigation and/or remediation activity.</td>
<td>HHSC may assess up to $1,000 per Day for each MCO violation of breach notice, breach response standard for each violation and/or for each privacy violation impacting an individual according to applicable federal or state breach notification law or the HHSC breach notification and response standards in the Contract.</td>
</tr>
</tbody>
</table>

**Material Subcontractors (MS)**

<p>| MS-1 | Contract Attachment A, “STAR Health Contract Terms and Conditions,” Section 4.09 Subcontractors and Agreements with Third Parties | Unless otherwise provided in this Contract, the MCO must provide HHSC with written notice no later than three Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Subcontract. | Transition Phase, Quarterly during the Operations Phase | Each Day of noncompliance. | HHSC may assess up to $5,000 per Day of noncompliance. |</p>
<table>
<thead>
<tr>
<th>#</th>
<th>Service/Component</th>
<th>Performance Standard</th>
<th>Measurement Period</th>
<th>Measurement Assessment</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS-2</td>
<td>Contract Attachment A, “STAR Health Contract Terms and Conditions,” Section 4.09 Subcontractors and Agreements with Third Parties</td>
<td>Unless otherwise provided in this Contract, the MCO must provide HHSC with written notice no later than 180 Days prior to the termination date of a Material Subcontract for MIS systems operation or reporting.</td>
<td>Transition Phase, Quarterly during the Operations Phase</td>
<td>Each Day of noncompliance.</td>
<td>HHSC may assess up to $5,000 per Day of noncompliance.</td>
</tr>
<tr>
<td>MS-3</td>
<td>Contract Attachment A, “STAR Health Contract Terms and Conditions,” Section 4.09 Subcontractors and Agreements with Third Parties</td>
<td>Unless otherwise provided in this Contract, the MCO must provide HHSC with written notice no later than 90 Days prior to the termination date of a Material Subcontract for non-MIS MCO Administrative Services.</td>
<td>Transition Phase, Quarterly during the Operations Phase</td>
<td>Each Day of noncompliance.</td>
<td>HHSC may assess up to $5,000 per Day of noncompliance.</td>
</tr>
<tr>
<td>MS-4</td>
<td>Contract Attachment A, “STAR Health Contract Terms and Conditions,” Section 4.09 Subcontractors and Agreements with Third Parties</td>
<td>Unless otherwise provided in this Contract, the MCO must provide HHSC with written notice no later than 30 Days prior to the termination date of any other Material Subcontract.</td>
<td>Transition Phase, Quarterly during the Operations Phase</td>
<td>Each Day of noncompliance.</td>
<td>HHSC may assess up to $5,000 per Day of noncompliance.</td>
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</table>

**Claims (CL)**

<table>
<thead>
<tr>
<th>#</th>
<th>Service/Component</th>
<th>Performance Standard</th>
<th>Measurement Period</th>
<th>Measurement Assessment</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL-1</td>
<td>Contract Attachment B-1, §8.1.26.2 Reports UMCM Chapter 5</td>
<td>Claims Summary Report: The MCO must submit monthly Claims Summary Reports to HHSC by the last Day of each phase.</td>
<td>Operations Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.</td>
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<tr>
<td>#</td>
<td>Service/Component</td>
<td>Performance Standard</td>
<td>Measurement Period</td>
<td>Measurement Assessment</td>
<td>Liquidated Damages</td>
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<td>month following the reporting period.</td>
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<tr>
<td>CL-2</td>
<td>Contract Attachment B-1, §8.1.31.2 Provider Appeal of MCO Claims Determinations UMCM Chapter 2</td>
<td>The MCO must resolve at least 98% of appealed claims within 30 Days from the date the appealed claim is filed with the MCO.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per month, per claim type.</td>
<td>For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO’s monthly performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO’s monthly performance percentages fall below the performance standards.</td>
</tr>
<tr>
<td>CL-3</td>
<td>Contract Attachment B-1, §8.1.24.5.1 Claims Project UMCM Chapters 2 and 5</td>
<td>The MCO must complete all claims projects within 60 Days of the claims project’s start date unless the MCO enters into a written agreement with the Provider before the initial expiration of the 60 Days to establish the claims project’s agreed upon timeframe. MCOs may not include Nursing Facility Daily/Unit Rate claims as part of the claims project.</td>
<td>Operations Phase</td>
<td>Per incident of noncompliance.</td>
<td>HHSC may assess up to $5,000 per incident of noncompliance. A claim’s project incident of noncompliance is considered any claims project not completed within 60 Days of the claims project’s start date or any claims project that includes Nursing Facility Daily/Unit Rate claims.</td>
</tr>
<tr>
<td>CL-4</td>
<td>Contract Attachment B-1, §8.1.24.5</td>
<td>For a Clean Claim not adjudicated within 30 Days of receipt by the MCO, the MCO must pay the</td>
<td>Operations Phase</td>
<td>Per month, per claim.</td>
<td>HHSC may assess up to $1,000 per month and per claim if the MCO fails to pay interest timely.</td>
</tr>
<tr>
<td>#</td>
<td>Service/Component¹</td>
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<tr>
<td>CL-5</td>
<td>Claims Processing Requirements UMCM Chapter 2</td>
<td>provider interest at 18% per annum, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 30-Day claims processing deadline. Interest owed to the provider must be paid on the same date as the claim.</td>
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<tr>
<td>CL-6</td>
<td>Contract Attachment B-1, §8.1.24.5 Claims Processing Requirements UMCM Chapter 2</td>
<td>The MCO must comply with the claims processing requirements and standards as described in Section 8.1.24.5 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 98% of Clean Claims within 30 Days of the claim being submitted to the MCO.</td>
<td>Operations Phase</td>
<td>Per month, per claim type.</td>
<td>For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO’s monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO’s monthly claims performance percentages fall below the performance standards.</td>
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<td>the claim being submitted to the MCO.</td>
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<td>type that an MCO’s monthly claims performance percentages fall below the performance standards.</td>
</tr>
<tr>
<td>CL-7</td>
<td>Contract Attachment B-1, §8.1.24.5 Claims Processing Requirements Contract Attachment B-1, §8.1.20.14 Pharmacy Claims and File Processing UMCM Chapter 2</td>
<td>For a Clean Claim for outpatient pharmacy benefits not adjudicated within (1) 18 Days after receipt by the MCO if submitted electronically or (2) 21 Days after receipt by the MCO if submitted non-electronically, the MCO must pay the provider interest at 18% per annum, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 18-Day or 21-Day claims processing deadline. Interest owed to the provider must be paid on the same date as the claim.</td>
<td>Operations Phase</td>
<td>Per month, per claim.</td>
<td>HHSC may assess up to $1,000 per month and per claim if the MCO fails to pay interest timely.</td>
</tr>
<tr>
<td>CL-8</td>
<td>Contract Attachment B-1, §8.1.24.5 Claims Processing Requirements Contract Attachment B-1, §8.1.20.14 Pharmacy Claims and File Processing UMCM Chapter 2</td>
<td>The MCO must comply with the claims processing requirements and standards as described in Sections 8.1.24.5 and 8.1.20.14 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 98% of electronic pharmacy Clean Claims within 18 Days of the claim being submitted to the MCO.</td>
<td>Operations Phase</td>
<td>Per month.</td>
<td>For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month that an MCO’s monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month that an MCO’s monthly claims performance percentages fall below the performance standards.</td>
</tr>
<tr>
<td>#</td>
<td>Service/ Component&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Performance Standard&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Measurement Period&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Measurement Assessment&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Liquidated Damages</td>
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</tbody>
</table>
| CL-9 | Contract Attachment B-1, §8.1.24.5 Claims Processing Requirements  
Contract Attachment B-1, §8.1.20.14 Pharmacy Claims and File Processing  
UMCM Chapter 2 | The MCO must comply with the claims processing requirements and standards as described in Sections 8.1.24.5 and 8.1.20.14 of Attachment B-1 and in UMCM Chapter 2.  
The MCO must pay or deny 98% of non-electronic pharmacy Clean Claims within 21 Days of the claim being submitted to the MCO. | Operations Phase | Per month. | For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month that an MCO’s monthly claims performance percentages fall below the performance standards.  
For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month that an MCO’s monthly claims performance percentages fall below the performance standards. |
| CL-10 | Contract Attachment B-1, § 8.1.24.5 Claims Processing Requirements  
Contract Attachment B-1, § 8.1.20.14 Pharmacy Claims and File Processing  
UMCM Chapter 2 | The MCO must comply with the claims processing requirements and standards as described in Sections 8.1.24.5 and 8.1.20.14 of Attachment B-1 and in UMCM Chapter 2.  
The MCO must ensure all applicable MIS systems (including pharmacy claims adjudication systems) are updated with data provided in the pharmacy interface files within two Business Days of the receipt from HHSC unless the MCO requests clarification or data or file exceptions from HHSC within the same Business Days. | Ongoing | Per Day, per incident of noncompliance. | HHSC may assess up to $500 per Day, per each incident of noncompliance. |
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<thead>
<tr>
<th>#</th>
<th>Service/Component</th>
<th>Performance Standard</th>
<th>Measurement Period</th>
<th>Measurement Assessment</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHCL-1</td>
<td>Contract Attachment B-1, §8.1.24.5 Claims Processing Requirements UMCM Chapter 2</td>
<td>The MCO must comply with the claims processing requirements and standards as described in Section 8.1.24.5 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 98% of dental Clean Claims within 30 Days of the claim being submitted to the MCO.</td>
<td>Operations Phase</td>
<td>Per month.</td>
<td>For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month that an MCO’s monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month that an MCO’s monthly claims performance percentages fall below the performance standards.</td>
</tr>
<tr>
<td>SHCL-2</td>
<td>Contract Attachment B-1, §8.1.24.5 Claims Processing Requirements UMCM Chapter 2</td>
<td>The MCO must comply with the claims processing requirements and standards as described in Section 8.1.24.5 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 99% of dental Clean Claims within 90 Days of the claim being submitted to the MCO.</td>
<td>Operations Phase</td>
<td>Per month.</td>
<td>For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month that an MCO’s monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month that an MCO’s monthly claims performance percentages fall below the performance standards.</td>
</tr>
</tbody>
</table>

**Encounter Data (ED)**

<p>| ED-1 | Contract Attachment B-1, §8.1.24.1 Encounter Data | The MCO must submit complete and accurate non-pharmacy | Measured Quarterly during | Per Day, per incident of noncompliance. | For the initial quarter: HHSC may assess up to $500 per Day and per incident of noncompliance that the |</p>
<table>
<thead>
<tr>
<th>#</th>
<th>Service/ Component(^1)</th>
<th>Performance Standard(^2)</th>
<th>Measurement Period(^3)</th>
<th>Measurement Assessment(^4)</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Encounter Data transmissions in accordance with Section 8.1.24.1.</td>
<td>the Operations Phase</td>
<td></td>
<td>MCO fails to submit complete and accurate non-pharmacy Encounter Data in a quarter.</td>
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<td></td>
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<td>For each subsequent quarter: HHSC may assess up to $1,000 per Day and per incident of noncompliance for each quarter the MCO fails to submit complete and accurate non-pharmacy Encounter Data.</td>
</tr>
<tr>
<td>ED-2</td>
<td>Contract Attachment B-1, §8.1.24.1 Encounter Data</td>
<td>The MCO will be subject to liquidated damages if the Quarterly Encounter Reconciliation Report (which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Vision 21 Data Warehouse) includes more than a 2% variance for non-pharmacy Encounter Data.</td>
<td>Operations Phase</td>
<td>Per quarter, per incident of noncompliance.</td>
<td>HHSC may assess up to $2,500 per quarter and per incident of noncompliance if the MCO is not within the 2% variance for non-pharmacy Encounter Data.</td>
</tr>
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<td></td>
<td>HHSC may assess up to $5,000 per quarter and per incident of noncompliance for each additional quarter that the MCO is not within the 2% variance for non-pharmacy Encounter Data.</td>
</tr>
<tr>
<td>ED-3</td>
<td>Contract Attachment B-1, §8.1.24.1 Encounter Data</td>
<td>The MCO must submit non-pharmacy Encounter Data transmissions and include all Encounter Data and Encounter Data adjustments processed by the MCO on a monthly basis, not later than the 30th Day after the last Day of the month in which the claim(s) are adjudicated.</td>
<td>Quarterly during Operations Phase</td>
<td>Per month, per incident of noncompliance.</td>
<td>For the initial quarter: HHSC may assess up to $2,500 per month and per incident of noncompliance if the MCO fails to submit monthly non-pharmacy Encounter Data in a quarter.</td>
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<td>For each subsequent quarter: HHSC may assess up to $5,000 per month and per incident of noncompliance for each additional quarter that the MCO is not within the 2% variance for non-pharmacy Encounter Data.</td>
</tr>
<tr>
<td>#</td>
<td>Service/ Component&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Performance Standard&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Measurement Period&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Measurement Assessment&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Liquidated Damages</td>
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<td>The MCO must submit complete and accurate pharmacy Encounter Data transmissions in accordance with Section 8.1.24.1.</td>
<td>Measured Quarterly during Operations Phase</td>
<td>Per Day, per incident of noncompliance.</td>
<td>For the initial quarter: HHSC may assess up to $1,000 per Day and per incident of noncompliance that the MCO fails to submit complete and accurate pharmacy Encounter Data in a quarter. For each subsequent quarter: HHSC may assess up to $2,000 per Day and per incident of noncompliance for each quarter the MCO fails to submit complete and accurate pharmacy Encounter Data.</td>
</tr>
<tr>
<td>ED-4</td>
<td>Contract Attachment B-1, §8.1.24.1 Encounter Data</td>
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<td>The MCO will be subject to liquidated damages if the Quarterly Encounter Reconciliation Report (which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Vision 21 Data Warehouse) includes more than a 2% variance for pharmacy Encounter Data.</td>
<td>Operations Phase</td>
<td>Per quarter, per incident of noncompliance</td>
<td>HHSC may assess up to $2,500 per quarter and per incident of noncompliance that the MCO is not within the 2% variance for pharmacy Encounter Data. HHSC may assess up to $5,000 per quarter and per incident of noncompliance for each additional quarter that the MCO is not within the 2% variance for pharmacy Encounter Data.</td>
</tr>
<tr>
<td>ED-5</td>
<td>Contract Attachment B-1, §8.1.24.1 Encounter Data</td>
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<td>#</td>
<td>Service/Component¹</td>
<td>Performance Standard²</td>
<td>Measurement Period³</td>
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<tr>
<td>ED-6</td>
<td>Contract Attachment B-1, §8.1.24.1 Encounter Data</td>
<td>Pharmacy Encounter Data must be submitted no later than 25 Days after the date of adjudication and include all Encounter Data and Encounter Data adjustments.</td>
<td>Operations Phase</td>
<td>Per quarter, per incident of noncompliance.</td>
<td>For the initial quarter: HHSC may assess up to $10,000 per quarter and per incident of noncompliance that the MCO fails to submit pharmacy Encounter Data in a timely manner. For each subsequent quarter: HHSC may assess up to $15,000 per quarter and per incident of noncompliance that the MCO fails to submit pharmacy Encounter Data in a timely manner.</td>
</tr>
</tbody>
</table>

**Hotlines (HL)**

| HL-1 | Contract Attachment B-1, §8.1.5.6 Nurse and Member Hotline Requirements  
Contract Attachment B-1, §8.1.5.6.1 NEMT Services Call Center Requirements  
Contract Attachment B-1, §8.1.4.8 Provider Hotline | The MCO must operate toll-free Member and Provider hotlines from 8 AM – 5 PM local time for all areas of the State, Monday through Friday, excluding State-approved holidays. | Operations Phase and Turnover Phase | Per month, per each incident of noncompliance, per hotline. | HHSC may assess up to $100 per month, per each incident of noncompliance, and per hotline for each hour, or portion thereof, that appropriately staffed hotlines are not operational.  
If the MCO’s failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan. |
<table>
<thead>
<tr>
<th>#</th>
<th>Service/Component</th>
<th>Performance Standard</th>
<th>Measurement Period</th>
<th>Measurement Assessment</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>HL-2</td>
<td>Contract Attachment B-1, §8.1.5.6 Nurse and Member Hotline Requirements</td>
<td>Call hold rate: At least 80% of calls must be answered by hotline staff within 30 seconds.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per each percentage point below the standard, per hotline, per monthly reporting period.</td>
<td>HHSC may assess up to $100 for each percentage point below the standard and per hotline that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated hotlines.</td>
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<tr>
<td></td>
<td>Contract Attachment B-1, §8.1.17.3 Behavioral Health (BH) Hotline and Emergency Services</td>
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<tr>
<td>HL-3</td>
<td>Contract Attachment B-1, §8.1.5.6 Nurse and Member Hotline Requirements</td>
<td>Call abandonment rate: The call abandonment rate must be 7% or less.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per each percentage point above the standard, per hotline, per monthly reporting period.</td>
<td>HHSC must assess up to $100 for each percentage point above the standard and per hotline that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated hotlines.</td>
</tr>
<tr>
<td></td>
<td>Contract Attachment B-1, §8.1.6.1 NEMT Services Call Center Requirements</td>
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<td>Contract Attachment B-1, §8.1.4.8 Provider Hotline</td>
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<td></td>
<td>Contract Attachment B-1, §8.1.17.3 Behavioral Health (BH) Hotline and Emergency Services</td>
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</table>
| HL-4 | Contract Attachment B-1, §8.1.5.6 Nurse and Member Hotline Requirements  
Contract Attachment B-1, §8.1.5.6.1 NEMT Services Call Center Requirements  
Contract Attachment B-1, §8.1.4.8 Provider Hotline  
Contract Attachment B-1, §8.1.17.3 Behavioral Health (BH) Hotline and Emergency Services | The average hold time must be two minutes or less.                                         | Operations Phase and Turnover Phase                                                      | Per month, per hotline for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time. | HHSC may assess up to $100 per month and per hotline for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time. |
| HL-5 | Contract Attachment B-1, §8.1.17.3 Behavioral Health (BH) Hotline and Emergency Services | The MCO must have a Behavioral Health Services Hotline, answered by a live voice, available 24 hours per Day, 7 Days a week, toll-free throughout the state which addresses routine and crisis behavioral health calls. | Operations Phase and Turnover Phase                                                      | Per month, per each incident of noncompliance.                                                | HHSC may assess up to $100 per month and per each incident of noncompliance for each hour, or portion thereof, that appropriately staffed hotlines are not operational. If the MCO’s failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan |

[^1]: HL-4  
[^2]: HL-5
<table>
<thead>
<tr>
<th>#</th>
<th>Service/ Component¹</th>
<th>Performance Standard²</th>
<th>Measurement Period³</th>
<th>Measurement Assessment⁴</th>
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</thead>
<tbody>
<tr>
<td>HL-6</td>
<td>Contract Attachment B-1, §8.1.17.3 Behavioral Health (BH) Hotline and Emergency Services</td>
<td>Crisis hotline staff must include or have access to qualified Behavioral Health Services' professionals to assess behavioral health emergencies.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per each incident of noncompliance.</td>
<td>HHSC may assess up to $1000 per each incident of noncompliance for each occurrence that HHSC identifies through its recurring monitoring processes that hotline staff were not qualified or did not have access to qualified professionals to assess behavioral health emergencies.</td>
</tr>
<tr>
<td>SHHL-1</td>
<td>Contract Attachment B-1, §8.1.5.6 Nurse and Member Hotline Requirements</td>
<td>The MCO must operate a toll-free Nurse Hotline that Providers, Members, DFPS Staff, Caregivers, and Medical Consenters can call 24 hours a Day, seven Days a week.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per month, per each incident of noncompliance.</td>
<td>HHSC may assess up to $100 per month and per each incident of noncompliance for each hour, or portion thereof, that appropriately staffed hotlines are not operational. If the MCO’s failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan.</td>
</tr>
<tr>
<td>SHHL-2</td>
<td>Contract Attachment B-1, §8.1.5.6.1 NEMT Services Call Center Requirements</td>
<td>The MCO must have a “Where’s My Ride” line and/or phone prompt that ensures the Members’ calls are answered by live operators 5:00 a.m. through 7:00 p.m. local time Monday through Saturday.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per month, per each incident of noncompliance.</td>
<td>HHSC may assess up to $100 per month and per each incident of noncompliance, for each hour, or portion thereof, that appropriately staffed hotlines are not operational. If the MCO’s failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the</td>
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<td>#</td>
<td>Service/ Component¹</td>
<td>Performance Standard²</td>
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<td>The MCO must resolve at least 98% of Member Complaints within 30 Days from the date the Complaint is received by the MCO.</td>
<td>Operations Phase</td>
<td>Per monthly reporting period.</td>
<td>MCO fails to implement its Disaster Recovery Plan.</td>
</tr>
<tr>
<td>CA-1</td>
<td>Contract Attachment B-1, §8.1.33 Member Complaint and Appeal System</td>
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<tr>
<td></td>
<td>Contract Attachment B-1, §8.1.33.1 MCO Internal Member Complaint Process</td>
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<tr>
<td>CA-2</td>
<td>Contract Attachment B-1, §8.1.31.1 Provider Complaints</td>
<td>The MCO must resolve at least 98% of Provider Complaints within 30 Days from the date the Complaint is received by the MCO.</td>
<td>Operations Phase</td>
<td>Per monthly reporting period.</td>
<td>HHSC may assess up to $250 per monthly reporting period if the MCO fails to meet the performance standard.</td>
</tr>
<tr>
<td>CA-3</td>
<td>Contract Attachment B-1, §8.1.33 Member Complaint and Appeal System</td>
<td>The MCO must resolve at least 98% of Member appeals within the specified timeframes for standard and expedited appeals.</td>
<td>Operations Phase</td>
<td>Per monthly reporting period.</td>
<td>HHSC may assess up to $500 per monthly reporting period if the MCO fails to meet the performance standard.</td>
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<td></td>
<td>Contract Attachment B-1, §8.1.33.3 Member MCO</td>
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</table>
| | Internal Appeal Process  
Contract Attachment B-1, §8.1.33.4  
Expedited MCO Internal Appeals | The MCO must resolve Member and Provider Complaints received by HHSC and referred to the MCO no later than the due date indicated on HHSC's notification form unless an extension is granted by HHSC. The MCO response must be submitted according to the timeframes and requirements stated within the MCO notification correspondence (letter, e-mail, etc.). | Measured Quarterly | Per Day, per each incident of noncompliance. | HHSC may assess up to $250 per Day and per each incident of noncompliance for each Day beyond the due date specified within the MCO notification correspondence. |
| CA-4 | Contract Attachment B-1, §8.1.33.1 MCO Internal Member Complaint Process  
Contract Attachment B-1, §8.1.31.1 Provider Complaints  
UMCM Chapter 3 | The MCO must ensure that the appropriate staff members who have firsthand knowledge of the Member’s appeal in order to be able to speak and provide relevant information on the case attend all State Fair Hearings as scheduled. | Transition Phase and Operations Phase | Per quarter, per incident of noncompliance. | HHSC may assess up to $1000 per quarter and per incident of noncompliance for each State Fair Hearing that the MCO fails to attend as required by HHSC. |
| SHCA-1 | Contract Attachment B-1, §8.1.33.5 Access to State Fair Hearing and External Medical Review (EMR) for Medicaid Members | | | |

Provider Networks (PN)
<table>
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<tr>
<th>#</th>
<th>Service/Component</th>
<th>Performance Standard</th>
<th>Measurement Period</th>
<th>Measurement Assessment</th>
<th>Liquidated Damages</th>
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</thead>
<tbody>
<tr>
<td>PN-1</td>
<td>Contract Attachment B-1, §8.1.3 Access to Care Contract Attachment B-1, §8.1.3.1 Appointment Accessibility Contract Attachment B-1, §8.1.3.2 Access to Network Providers Contract Attachment B-1, §8.1.3.3 Monitoring Access</td>
<td>The MCO must comply with the contract’s mileage and/or time standards and benchmarks for Member access.</td>
<td>Quarterly</td>
<td>Per quarter, per incident of noncompliance, per county, and per Provider type</td>
<td>HHSC may assess up to $1,000 per quarter, per incident of noncompliance, per county, and per Provider type.</td>
</tr>
</tbody>
</table>
| PN-2 | Contract Attachment B-1, §8.1.7.9.2 MCO Alternative Payment Models with Providers (APMs) UMCM Chapter 8 | The MCO must meet minimum APM ratios as follows:  
- Measurement Year 1:  
  - Minimum Overall APM Ratio: >=25%  
  - Minimum Risk Based APM Ratio: >=10%  
- Measurement Year 2:  
  - Minimum Overall APM Ratio: Year 1 Overall APM Ratio +25%  
  - Minimum Risk Based APM Ratio: Year 1 Overall APM Ratio +25% | Measured on July 1 of each calendar year for the previous calendar period. | Per Member per month (PMPM), per period of measurement. | Failure to meet calendar year target for overall APM, and not eligible for exception, based on HHSC’s exception criteria:  
  up to $0.10 per Member per month (PMPM) for period of measurement.  
Failure to meet target for Risk Based APM, and not eligible for exception:  
  up to $0.10 per Member per month (PMPM) for period of measurement. |
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<th>Service/ Component¹</th>
<th>Performance Standard²</th>
<th>Measurement Period³</th>
<th>Measurement Assessment⁴</th>
<th>Liquidated Damages</th>
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<tr>
<td>1</td>
<td>No more than 20% of total dollars billed to the MCO for &quot;other outpatient services&quot; may be billed by Out-of-Network providers.</td>
<td>Quarterly</td>
<td>Per quarter.</td>
<td>HHSC may assess up to $25,000 per quarter.</td>
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<td>2</td>
<td>No more than 15% of the MCO's total hospital admissions may occur in Out-of-Network facilities.</td>
<td>Quarterly</td>
<td>Per quarter.</td>
<td>HHSC may assess up to $25,000 per quarter.</td>
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<tr>
<td>#</td>
<td>Service/Component¹</td>
<td>Performance Standard²</td>
<td>Measurement Period³</td>
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<tr>
<td>PN-5</td>
<td>Contract Attachment B-1, §8.1.4 Provider Network UMCM Chapter 5</td>
<td>No more than 20% of the MCO’s total emergency room visits may occur in Out-of-Network facilities.</td>
<td>Quarterly</td>
<td>Per quarter.</td>
<td>HHSC may assess up to $25,000 per quarter.</td>
</tr>
<tr>
<td>PN-6</td>
<td>Contract Attachment B-1, §8.1.4 Provider Network UMCM Chapter 5</td>
<td>No more than 20% of total dollars billed to the MCO for residential substance use disorder (SUD) treatment may be billed by Out-of-Network residential SUD treatment providers.</td>
<td>Quarterly</td>
<td>Per quarter.</td>
<td>HHSC may assess up to $25,000 per quarter.</td>
</tr>
</tbody>
</table>

**Marketing and Member Materials (MM)**

<p>| MM-1 | Contract Attachment B-1, §8.1.6 Marketing and Prohibited Practices UMCM Chapter 4 | The MCO must meet all Marketing and Member Materials policy requirements and may not engage in prohibited marketing practices. | Transition Phase, Measured quarterly during the Operations Phase | Per quarter, per incident of noncompliance. | HHSC may assess up to $1,000 per quarter per incident of noncompliance. |
| MM-2 | Contract Attachment B-1, §8.1.6 Marketing and Prohibited Practices UMCM Chapter 4 | The MCO must meet all Social Media policy requirements and may not engage in any prohibited Social Media practices. | Ongoing | Per Business Day, per incident of noncompliance. | HHSC may assess up to $500 per Business Day for each incident of noncompliance. |</p>
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<tr>
<th>#</th>
<th>Service/ Component¹</th>
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<tbody>
<tr>
<td>MM-3</td>
<td>Contract Attachment B-1, §8.1.5.1 Member Materials</td>
<td>No later than the fifth Business Day following the receipt of the enrollment file from the HHSC Administrative Services Contractor, the MCO must mail a Member's ID card and Member Handbook to the Member or Member's Caregiver. When a Caregiver represents two or more new Members, the MCO is required to send only one Member Handbook to the Caregiver.</td>
<td>Transition Phase, Operations Phase, and Turnover Phase</td>
<td>Per each incident of noncompliance.</td>
<td>HHSC may assess up to $500 per each incident of the MCO's failure to mail Member Materials to the Member or Member's Caregiver.</td>
</tr>
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</table>

**Management Information Systems (MI)**

| MI-1 | Contract Attachment B-1, §8.1.24 Management Information System (MIS) Requirements | The MCO’s MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan. | Quarterly during the Operations Phase | Per Day of noncompliance. | HHSC may assess up to $5,000 per Day of noncompliance. |

| MI-2 | Contract Attachment B-1, §8.1.24.3 System-wide Functions | The MCO’s MIS system must meet all requirements in Section 8.1.24.3 of Attachment B-1. | Quarterly during Operations Phase | Per Day of noncompliance. | HHSC may assess up to $5,000 per Day of noncompliance. |

**Financial Reporting (FR)**
<table>
<thead>
<tr>
<th>#</th>
<th>Service/ Component¹</th>
<th>Performance Standard²</th>
<th>Measurement Period³</th>
<th>Measurement Assessment⁴</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>FR-1</td>
<td>Contract Attachment B-1, §8.1.23.1 Financial Reporting Requirements UMCM Chapter 5</td>
<td>Financial Statistical Reports (FSR): The MCO must file quarterly and annual FSRs. Quarterly reports are due no later than 30 Days after the conclusion of each State Fiscal Quarter (SFQ). The first annual SFY FSR report is due no later than 120 Days after the end of the Contract Year, and subsequent annual reports are due no later than 365 Days after the end of each Contract Year.</td>
<td>Quarterly during the Operations Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $1,000 per Day of noncompliance a FSR is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
<tr>
<td>FR-2</td>
<td>Contract Attachment B-1, §8.1.23.1 Financial Reporting Requirements UMCM Chapter 5</td>
<td>Claims Lag Report must be submitted by the last Day of the month following the reporting period.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
<tr>
<td>FR-3</td>
<td>Contract Attachment B-1, § 8.1.23.1 Financial Reporting Requirements UMCM Chapter 5</td>
<td>Affiliate Report must be submitted on an as-occurs basis and annually by September 1 of each year in accordance with the UMCM. The “as-occurs” update is due within 30 Days of the event triggering the change.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
</tbody>
</table>
| FR-4 | Contract Attachment B-1, §8.1.23.1 | Report of Legal and Other Proceedings and Related Events: The MCO must comply with Transition Phase and Operations Phase | Transition Phase and Operations Phase | Per Day of noncompliance. | HHSC may assess up to $1,000 per Day of noncompliance the report is }
<table>
<thead>
<tr>
<th>#</th>
<th>Service/Component</th>
<th>Performance Standard</th>
<th>Measurement Period</th>
<th>Measurement Assessment</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>FR-5</td>
<td>Financial Reporting Requirements</td>
<td>UMCM requirements regarding the disclosure of certain matters involving the MCO, its Affiliates, or its Material Subcontractors, as specified. This requirement is both on an as-occurs basis and an annual report due by September 1. The as-occurs report is due no later than 30 Days after the event that triggered the notification requirement.</td>
<td>Operations Phase</td>
<td>Per Day of noncompliance, per TPL/TPR report.</td>
<td>HHSC may assess up to $500 per Day of noncompliance and per TPL/TPR report that is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
<tr>
<td>FR-6</td>
<td>Financial Reporting Requirements</td>
<td>Third Party Liability and Recovery (TPL/TPR) Reports: The MCO must submit TPL/TRP reports quarterly, by MCO Program and plan code, as described in UMCM Chapter 5.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
<tr>
<td>FR-7</td>
<td>Financial Reporting Requirements</td>
<td>MCO Disclosure Statement: The MCO must submit an annual submission no later than September 1st each year and a change notification after a certain specified change, no later than 30 Days after the change.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.</td>
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<td>#</td>
<td>Service/ Component</td>
<td>Performance Standard</td>
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<td>Liquidated Damages</td>
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<td>no later than ten Days after receipt of the final version from TDI.</td>
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<tr>
<td>FR-8</td>
<td>Contract Attachment B-1, §8.1.23.1 Financial Reporting Requirements</td>
<td>TDI Financial Filings: The MCO must submit copies to HHSC of reports submitted to TDI no later than ten Days after the MCO’s submission to TDI.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
<tr>
<td>FR-9</td>
<td>Contract Attachment B-1, §8.1.23.1 Financial Reporting Requirements</td>
<td>Filings with Other Entities and Other Existing Financial Reports: The MCO must submit an electronic copy of the reports or filings pertaining to the MCO, or its parent, or its parent’s parent no later than 30 Days after such report is filed or otherwise initially distributed.</td>
<td>Operations Phase and Turnover Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
<tr>
<td>FR-10</td>
<td>Contract Attachment B-1, §8.1.23.1 Financial Reporting Requirements UMCM Chapter 5</td>
<td>Audit Reports: The MCO must comply with UMCM requirements regarding notification or submission of audit reports.</td>
<td>Operations Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
<tr>
<td>FR-11</td>
<td>Contract Attachment B-1, §8.1.23.1 Financial Reporting Requirements</td>
<td>Employee Bonus and/or Incentive Payment Plan must be submitted no later than 30 Days after the Effective Date of the Contract.</td>
<td>Operations Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.</td>
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<td>#</td>
<td>Service/ Component¹</td>
<td>Performance Standard²</td>
<td>Measurement Period³</td>
<td>Measurement Assessment⁴</td>
<td>Liquidated Damages</td>
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<tr>
<td>FR-12</td>
<td>Contract Attachment B-1, §8.1.23.1 Financial Reporting Requirements</td>
<td>Registration Statement (aka “Form B”) must be submitted by ten Days after the MCO’s submission of the item to TDI.</td>
<td>Operations Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.</td>
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Office of the Inspector General (IG)

<p>| IG-1 | Contract Attachment B-1, §7.2.7 Operations Readiness Contract Attachment B-1, §8.1.25 Fraud, Waste, and Abuse | The MCO must submit or comply with the requirements of the HHSC-approved Fraud, Waste, and Abuse Compliance Plan. | Transition Phase, Operations Phase, and Turnover Phase | Per Day, per each incident of noncompliance. | HHSC may assess up to $1,000 per Day for each incident of noncompliance. |
| IG-2 | Contract Attachment B-1, §8.1.25 Fraud, Waste, and Abuse | The MCO must perform pre-payment review for identified providers as directed by the HHSC OIG within ten Business Days after notification. | Transition Phase, Operations Phase, and Turnover Phase | Per Day, per each incident of noncompliance. | HHSC may assess up to $1,000 per Day and per each incident of noncompliance. |
| IG-3 | Contract Attachment B-1, §8.1.25.2 General requests for and access to data, records, and other information | The MCO must respond to HHSC OIG requests for information in the manner and format requested. | Transition Phase, Operations Phase, and Turnover Phase | Per Day of noncompliance. | HHSC may assess up to $1,000 per Day of noncompliance that the information is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per Day of noncompliance for the |</p>
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<tr>
<th>#</th>
<th>Service/Component¹</th>
<th>Performance Standard²</th>
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<th>Measurement Assessment⁴</th>
<th>Liquidated Damages</th>
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<td>The MCO must submit a Fraudulent Practices Referral to the HHSC OIG within 30 Business Days of receiving a report of possible Fraud, Waste, or Abuse from the MCO’s Special Investigative Unit (SIU).</td>
<td>Transition Phase, Operations Phase, and Turnover Phase</td>
<td>Per Day of noncompliance.</td>
<td>fourth and each subsequent occurrence within a 12-month period.</td>
</tr>
<tr>
<td>IG-4</td>
<td>Contract Attachment B-1, §8.1.26.2 Reports  UMCM Chapter 5</td>
<td>The MCO must submit monthly MCO Open Case List Reports.</td>
<td>Transition Phase, Operations Phase, and Turnover Phase</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $1,000 per Day of noncompliance that the referral is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per Day of noncompliance for the fourth and each subsequent occurrence within a 12-month period.</td>
</tr>
<tr>
<td>IG-5</td>
<td>Contract Attachment B-1, §8.1.25.4 Payment Holds and Settlements  UMCM Chapter 5</td>
<td>The MCO must respond to HHSC OIG requests for payment hold amounts accurately and in the manner and format requested.</td>
<td>Transition Phase, Operations Phase, and Turnover Phase</td>
<td>Per incident of noncompliance.</td>
<td>HHSC may assess, per incident of noncompliance, up to the difference between the amount required to be reported by the MCO under UMCM Chapter 5.5 and the amount received by the HHSC OIG.</td>
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<td>#</td>
<td>Service/Component</td>
<td>Performance Standard</td>
<td>Measurement Period</td>
<td>Measurement Assessment</td>
<td>Liquidated Damages</td>
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<tr>
<td>IG-7</td>
<td>Contract Attachment B-1, §8.1.25.2 General requests for and access to data, records, and other information</td>
<td>The MCO fails to submit claims data as prescribed by HHSC OIG.</td>
<td>Transition Phase, Operations Phase, and Turnover Phase</td>
<td>Per Day, per each incident of noncompliance.</td>
<td>HHSC may assess up to $1,000 per Day and per each incident of noncompliance that the data is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per Day and per each incident of noncompliance for the fourth and each subsequent occurrence within a 12-month period.</td>
</tr>
<tr>
<td>IG-8</td>
<td>Contract Attachment B-1, §8.1.25.4 Payment Holds and Settlements</td>
<td>The MCO must impose payment suspensions or lift payment holds as directed by HHSC OIG.</td>
<td>Transition Phase, Operations Phase, and Turnover Phase</td>
<td>Per incident of noncompliance.</td>
<td>HHSC may assess up to the amount not held or released improperly per incident of noncompliance.</td>
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</tbody>
</table>

**Frew (FW)**

<table>
<thead>
<tr>
<th></th>
<th>Service/Component</th>
<th>Performance Standard</th>
<th>Measurement Period</th>
<th>Measurement Assessment</th>
<th>Liquidated Damages</th>
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</thead>
<tbody>
<tr>
<td>SHFW-1</td>
<td>Contract Attachment B-1, §8.1.26.2 Reports UMCM Chapter 12</td>
<td><em>Frew Quarterly Monitoring Report</em> – The MCO must submit the report as described in UMCM Chapter 12.</td>
<td>Quarterly</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
<tr>
<td>SHFW-2</td>
<td>Contract Attachment B-1, §8.1.26.2 Reports UMCM Chapter 12</td>
<td><em>Medicaid Managed Care Texas Health Steps Medical Checkups Reports</em> – The MCO must submit an annual report of the number of New Members and Existing</td>
<td>Annually</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $1,000 per Day of noncompliance the reports are not submitted or are late, inaccurate, or incomplete.</td>
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<tr>
<td>#</td>
<td>Service/Component¹</td>
<td>Performance Standard²</td>
<td>Measurement Period³</td>
<td>Measurement Assessment⁴</td>
<td>Liquidated Damages</td>
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<td>Members as described in UMCM Chapter 12.</td>
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<td>Turnover (TO)</td>
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<tr>
<td>TO-1</td>
<td>Contract Attachment B-1, §9.5 Post-Turnover Services</td>
<td>The MCO must provide HHSC with a Turnover Results Report documenting the completion and results of each step of the Turnover Plan 30 Days after the turnover of operations.</td>
<td>Measured 30 Days after the turnover of operations</td>
<td>Per Day of noncompliance.</td>
<td>HHSC may assess up to $250 per Day of noncompliance that the report is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
<tr>
<td>TO-2</td>
<td>Contract Attachment B-1, §9.4 Turnover Services</td>
<td>Twelve months prior to the end of the Contract Period or any extension thereof, unless otherwise specified by HHSC, the MCO must propose a Turnover Plan covering the possible turnover of the records and information maintained to either the HHSC or a successor MCO. If HHSC terminates the Contract prior to the expiration of the initial Contract Period or Contract Period, then HHSC may require the MCO to propose or update the Turnover Plan sooner.</td>
<td>Measured at twelve months prior to the end of the Contract Period, or any extension thereof, and ongoing until satisfactorily completed</td>
<td>Each Day of noncompliance.</td>
<td>HHSC may assess up to $1,000 per Day of noncompliance that the Turnover Plan is not submitted or is late, inaccurate, or incomplete.</td>
</tr>
<tr>
<td>TO-3</td>
<td>Contract Attachment B-1, §9.3 Transfer of Data and Information</td>
<td>The MCO must transfer all data regarding the provision of Covered Services to Members to HHSC or a new MCO at the sole discretion</td>
<td>Measured at time of transfer of data and ongoing after the transfer of</td>
<td>Per Day, per incident of noncompliance (failure to provide</td>
<td>HHSC may assess up to $10,000 per Day and per incident of noncompliance that the data is not submitted, is not provided in the</td>
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<td>#</td>
<td>Service/Component¹</td>
<td>Performance Standard²</td>
<td>Measurement Period³</td>
<td>Measurement Assessment⁴</td>
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<td>of HHSC and as directed by HHSC. All transferred data must comply with the Contract requirements, including HIPAA.</td>
<td>data until satisfactorily completed</td>
<td>data and/or failure to provide data in required format.</td>
<td>required format, or is late, inaccurate, or incomplete.</td>
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**Pharmacy (PH)**

**PH-1**

Contract Attachment B-1, §8.1.20.1 Formulary and Preferred Drug List (PDL)

Contract Attachment B-1, §8.1.20.2 Prior Authorization (PA) for Prescription Drugs and 72-Hour Emergency Supplies

The MCO must allow Network Providers free access to a point-of-care web-based application accessible to smart phones, tablets, or similar technology. The application must be operational, identify preferred/non-preferred drugs, Clinical PAs, and any preferred drugs that can be substituted for non-preferred drugs, updated at least weekly.

If the MCO has Clinical PAs that are identical to HHSC VDP’s Clinical PAs, then the MCO can reference VDP’s Texas Medicaid formulary on Epocrates.

Ongoing, Per incident of noncompliance. HHSC may assess up to $10,000 for an incident of noncompliance if the web-based application is not operational, does not identify preferred/non-preferred drugs, or Clinical PAs, and any preferred drugs that can be substituted for non-preferred drugs, is not updated at least weekly.

**PH-2**

Contract Attachment B-1, §8.1.20.1 Formulary and Preferred Drug List (PDL)

Contract Attachment B-1, §8.1.20.10 Specialty Drugs

The MCO must adhere to HHSC’s formularies and the Specialty Drug List (SDL) for drugs provided through selective specialty pharmacy contracts.

Ongoing, Quarterly during Operations Phase, Per incident of noncompliance. For the initial quarter of noncompliance, HHSC may assess up to $5,000 per incident of noncompliance.

For each subsequent quarter of noncompliance, HHSC may assess
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<th>Service/ Component</th>
<th>Performance Standard</th>
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<tbody>
<tr>
<td>PH-3</td>
<td>Contract Attachment B-1, §8.1.20.2 Prior Authorization (PA) for Prescription Drugs and 72-Hour Emergency Supplies</td>
<td>The MCO must allow and reimburse a pharmacy for dispensing a 72-hour supply of a prescription if the MCO cannot make a prior authorization determination within 24 hours and the dispensing pharmacist determines it is an emergency situation as outlined in this section.</td>
<td>Ongoing</td>
<td>Per incident of noncompliance.</td>
<td>HHSC may assess up to $5,000 per incident of noncompliance.</td>
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<tr>
<td>PH-4</td>
<td>RESERVED</td>
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<tr>
<td>PH-5</td>
<td>Contract Attachment B-1, §8.1.20.5 Pharmacy Rebate Program UMCM Chapter 2</td>
<td>The MCO must include rebatable National Drug Codes (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 HCPCS code and billing units per the applicable date of service according to HHSC NDC-to-HCPCS Crosswalk.</td>
<td>Ongoing</td>
<td>Per month, per incident of noncompliance.</td>
<td>HHSC may assess up to $500 per month for each incident of noncompliance.</td>
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<tr>
<td>#</td>
<td>Service/ Component¹</td>
<td>Performance Standard²</td>
<td>Measurement Period³</td>
<td>Measurement Assessment⁴</td>
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<tr>
<td>PH-6</td>
<td>Contract Attachment B-1, §8.1.20.1 Formulary and Preferred Drug List (PDL)</td>
<td>The MCO must maintain a minimum 95% utilization of preferred drugs in each therapeutic class on the PDL.</td>
<td>Ongoing, Quarterly during Operations Phase</td>
<td>Per incident of noncompliance, per therapeutic class.</td>
<td>HHSC may assess up to $1,000 for each incident of noncompliance and per therapeutic class in which the MCO does not meet the standard.</td>
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<td>PH-8</td>
<td>Contract Attachment B-1, §8.1.20.2 Prior Authorization (PA) for Prescription Drugs and 72-Hour Emergency Supplies</td>
<td>The Medicaid MCO must ensure at least 98% of PA requests received from prescriber calls to the MCO’s PA call center for Medicaid are approved or denied immediately at the time of the call when all necessary information is received to complete the review.</td>
<td>Ongoing, Quarterly during Operations Phase</td>
<td>Per each percentage point below the standard.</td>
<td>HHSC may assess up to $100 per each percentage point below the standard each quarter.</td>
</tr>
<tr>
<td>PH-9</td>
<td>Contract Attachment B-1, §8.1.20.2 Prior Authorization (PA) for Prescription Drugs and 72-Hour Emergency Supplies</td>
<td>The Medicaid MCO must ensure at least 98% of all other PA requests received by a prescriber’s office are approved or denied no later than 24 hours after the MCO receives the request.</td>
<td>Ongoing, Quarterly during Operations Phase</td>
<td>Per each percentage point below the standard.</td>
<td>HHSC may assess up to $100 per each percentage point below the standard each quarter.</td>
</tr>
<tr>
<td>PH-10</td>
<td>Contract Attachment B-1, §8.1.20.11 Maximum Allowable</td>
<td>The MCO must ensure at least 98% of MAC challenge requests are resolved by the 15th Day after the MCO receives the request.</td>
<td>Ongoing, Quarterly during Operations Phase</td>
<td>Per incident of noncompliance below the percentage rate.</td>
<td>HHSC may assess up to $1000 per incident of noncompliance below the percentage rate each quarter.</td>
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**Medically Dependent Children Program (MD)**

| SHMD-1 | Contract Attachment B-1, §8.2 Additional Requirements Regarding the Medically Dependent Children Program (MDCP) | The MCO must complete and electronically submit the Screening and Assessment Instrument (SAI) to HHSC's Administrative Services Contractor in the specified format within 45 Days: 1) from the date of referral for MDCP services or 2) prior to the annual ISP expiration date for all Members receiving MDCP services as specified in Section 8.2. | Operations Phase and Turnover Phase | Per Day of noncompliance, per Member. | HHSC may assess up to $500 per Day of noncompliance and per Member for each Day required documentation is not submitted or is late, inaccurate, or incomplete. |
Texas Medicaid and CHIP County Designations

<table>
<thead>
<tr>
<th>HHSC County Type</th>
<th>MA County Type</th>
<th>Population</th>
<th>Density</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro</td>
<td>Large Metro</td>
<td>≥ 1,000,000</td>
<td>≥ 1,000/mi²</td>
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<td>500,000 – 999,999</td>
<td>≥ 1,500/mi²</td>
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<td>Any</td>
<td>≥ 5,000/mi²</td>
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<td>Metro</td>
<td>≥ 1,000,000</td>
<td>10 – 999.9/mi²</td>
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<td>---</td>
<td>200,000 – 499,999</td>
<td>10 – 4,999.9/mi²</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>50,000 – 199,999</td>
<td>100 – 4,999.9/mi²</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>10,000 – 49,999</td>
<td>1,000 – 4,999.9/mi²</td>
</tr>
<tr>
<td>Micro</td>
<td>Micro</td>
<td>50,000 – 199,999</td>
<td>10 – 99.9/mi²</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>10,000 – 49,999</td>
<td>50 – 999.9/mi²</td>
</tr>
<tr>
<td>Rural</td>
<td>Rural</td>
<td>10,000 – 49,999</td>
<td>10 – 49.9/mi²</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>&lt;10,000</td>
<td>10 – 4,999.9/mi²</td>
</tr>
<tr>
<td>---</td>
<td>CEAC</td>
<td>Any</td>
<td>&lt;10/mi²</td>
</tr>
</tbody>
</table>

A county must meet both the population and density thresholds for inclusion in a given designation.

Data Source: CMS Medicare Advantage
The County Designations in Attachment B-4 are for purposes of assessing access to network providers (excluding pharmacies). The designations build upon CMS Medicare Advantage (MA) designations. The table above lists the population and density parameters applied to county type designations. A county must meet both thresholds for inclusion in a given designation. In order to facilitate monitoring, HHSC has combined the Large Metro and Metro MA categories into one category for Metro. The categories for Counties with Extreme Access Considerations (CEAC) and Rural counties have been combined to create the Rural category.

<table>
<thead>
<tr>
<th>Designation</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro</td>
<td>Angelina, Bell, Bexar, Bowie, Brazoria, Brazos, Cameron, Collin, Comal, Dallas, Denton, Ector, El Paso, Ellis, Fort Bend, Galveston, Grayson, Gregg, Guadalupe, Harris, Hays, Hidalgo, Hood, Hunt, Jefferson, Johnson, Kaufman, Lubbock, McLennan, Midland, Montgomery, Nueces, Orange, Parker, Potter, Randall, Rockwall, Smith, Tarrant, Taylor, Travis, Victoria, Webb, Wichita, Williamson</td>
</tr>
</tbody>
</table>

**Notes**

The County Designations in Attachment B-4 are for purposes of assessing access to network providers (excluding pharmacies). The designations build upon CMS Medicare Advantage (MA) designations. The table above lists the population and density parameters applied to county type designations. A county must meet both thresholds for inclusion in a given designation. In order to facilitate monitoring, HHSC has combined the Large Metro and Metro MA categories into one category for Metro. The categories for Counties with Extreme Access Considerations (CEAC) and Rural counties have been combined to create the Rural category.