



TO: Medical Care Advisory Committee
DATE: May 17, 2018
FROM: Michelle Erwin, Director of Policy and Program Development, HHSC Medicaid and CHIP Services Department

Agenda Item No.: 10

SUBJECT: Network Adequacy

Amendments to: Texas Administrative Code Title 1, Part 15, Chapter 353, Subchapter A, §353.2

Repeal and Replace: Texas Administrative Code Title 1, Part 15, Chapter 353, Subchapter E, §353.411

Proposed new: Texas Administrative Code Title 1, Part 15, Chapter 353, Subchapter E, §353.423

BACKGROUND: Federal Requirement Legislative Requirement
Other:

The proposed rule changes are necessary to comply with Senate Bill (S.B.) 760, 84th Legislature, Regular Session, 2015, which requires HHSC to establish additional minimum provider access standards for managed care organization (MCO) provider networks, and establish and implement an expedited credentialing process to allow certain providers to provide services to recipients on a provisional basis.

In Texas, Medicaid managed care contracts include provider network requirements for MCOs, designed to ensure all members have access to, and a choice of, a network of providers. To ensure MCOs have adequate provider networks necessary to provide needed services to Medicaid members in a timely manner, HHSC has developed provider network standards for certain provider types outlining the maximum allowable travel times and distances between a provider and a member's residence, as well as a process to monitor MCO compliance.

In certain circumstances where HHSC has identified provider types for which Medicaid clients have an unmet need, HHSC may allow MCOs to utilize an expedited credentialing process to decrease the time before a provider may begin billing for services, and allow MCOs to more quickly address provider network shortages.

ISSUES AND ALTERNATIVES:

HHSC's proposed rule changes regarding managed care network access standards and expedited credentialing are consistent with provisions currently required in the HHSC managed care contracts and are being added to the Texas Administrative Code in order to be consistent with existing contractual requirements.

These standards were developed based on the requirements of S.B. 760 and with the collaboration of stakeholders. HHSC does not anticipate stakeholder objections or concerns.

STAKEHOLDER INVOLVEMENT:

HHSC has provided stakeholders multiple opportunities to provide input on revised network access standards required by S.B. 760, including:

- A public forum held on November 30, 2015, to collect stakeholder feedback related to MCO provider networks
- A public forum held on June 6, 2016, to discuss HHSC provider access proposals and gather additional stakeholder input
- An email sent through the HHSC subscriber service in October 2016 requesting stakeholder feedback on HHSC initiatives related to S.B. 760
- A meeting with MCOs on February 15, 2017, to discuss updates to managed care network access standards
- A webinar on May 9, 2017, to provide an overview of reporting requirements related to the updated standards

Additionally, MCOs and dental MCOs have had opportunities to provide input on the revised standards through the managed care contract amendment process. MCO feedback has focused primarily on obtaining additional flexibility in meeting HHSC's reporting and compliance requirements. HHSC has worked directly with MCOs to address these concerns.

The proposed rule amendments were sent to external stakeholders for review. Comments received from stakeholders were reviewed by staff and taken into consideration. External stakeholders included MCOs and provider associations.

FISCAL IMPACT:

None Yes

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
State	\$63,796	\$55,193	\$55,193	\$55,193	\$55,193
Federal	\$63,796	\$55,194	\$55,194	\$55,194	\$55,194
Total	\$127,592	\$110,387	\$110,387	\$110,387	\$110,387

RULE DEVELOPMENT SCHEDULE:

May 2018 Present to the Medical Care Advisory Committee
May 2018 Present to HHSC Executive Council
June 2018 Publish proposed rules in *Texas Register*
October 2018 Publish adopted rules in *Texas Register*
October 2018 Effective date

REQUESTED ACTION:

The MCAC recommends approval of the proposed rules for publication.

Information Only

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TITLE 1	ADMINISTRATION
PART 15	TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353	MEDICAID MANAGED CARE
SUBCHAPTER A	GENERAL PROVISIONS
SUBCHAPTER E	STANDARDS FOR MEDICAID MANAGED CARE

PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes amendments to §353.2, concerning Medicaid Managed Care Definitions; the repeal of §353.411, concerning Accessibility of Services; new §353.411, concerning Accessibility of Services; and new §353.423, concerning Expedited Credentialing.

BACKGROUND AND PURPOSE

The proposed rule changes are necessary to comply with S.B. 760, 84th Legislature, Regular Session, 2015, which requires HHSC to establish additional minimum provider access standards for managed care organization (MCO) provider networks, and establish and implement an expedited credentialing process to allow certain providers to provide services to recipients on a provisional basis.

In Texas, Medicaid managed care contracts include provider network requirements for MCOs, designed to ensure all members have access to, and a choice of, a network of providers. To ensure MCOs have adequate provider networks necessary to provide needed services to Medicaid members in a timely manner, HHSC has developed provider network standards for certain provider types outlining the maximum allowable travel times and distances between a provider and a member's residence, as well as a process to monitor MCO compliance.

In certain circumstances where HHSC has identified provider types for which Medicaid clients have an unmet need, HHSC may allow MCOs to utilize an expedited credentialing process to decrease the time before a provider may begin billing for services, and allow MCOs to more quickly address provider network shortages.

HHSC's proposed rule changes regarding managed care network access standards and expedited credentialing are consistent with provisions currently required in HHSC managed care contracts and are being added to the Texas Administrative Code in order to be consistent with existing contractual requirements.

SECTION-BY-SECTION SUMMARY

The proposed amendment of §353.2 adds definitions for “applicant provider,” “credentialing,” “expedited credentialing,” and “health care provider group” to clarify the meaning of these terms in the proposed new §353.423, concerning Expedited Credentialing.

The proposed repeal of §353.411 deletes the former provider accessibility requirements for MCOs and dental managed care organizations (dental MCOs) and allows for their replacement with a proposed new §353.411.

Proposed new §353.411:

Subsection (a) requires an MCO to have a provider network that ensures member accessibility to a choice of two or more providers. The providers must meet the rule’s specified travel time or distance standards based on provider type and county designation.

Subsection (b) requires an MCO to have sufficient pediatric and family practitioner primary care providers (PCPs), and a dental MCO to have sufficient dental providers, to provide regular and preventive care and Texas Health Steps services to all eligible children enrolled in the service area.

Subsection (c) requires an MCO and dental MCO to have sufficient PCPs and dental providers to ensure no member must wait an unreasonable amount of time for an appointment, and that no member must wait an unreasonable amount of time to be seen at their appointed time.

Subsection (d) requires an MCO to submit an exemption request to HHSC if a service or provider is not available to members within the travel time or distance standards specified in subsection (a).

Subsection (e) allows an MCO to include in its provider network providers from outside its service area of a higher skill or specialty level.

Subsection (f) requires MCOs and dental MCOs to provide education and training to its providers on the specific health problems and needs of its members and the contract and rule requirements for provider accessibility and availability.

Subsection (g) requires an MCO to ensure member accessibility to culturally and linguistically competent providers. MCOs must develop a written cultural competency plan describing how the MCO will effectively provide services to

members from varying cultures, races, ethnic backgrounds, and religions to ensure those characteristics do not deter members' timely access to services.

Subsection (h) requires an MCO to ensure that communication and physical access barriers do not deter members' timely access to services.

Subsection (i) prohibits an MCO from excluding Significant Traditional Providers from its network for a period of time and under certain conditions determined by HHSC.

Proposed new §353.423 requires MCOs to establish an expedited credentialing process that permits certain providers to provide services on a provisional basis. This section requires an MCO, upon submission by the applicant of the information required by the MCO, to treat a qualified applicant provider as though the applicant is part of the MCO's provider network for purposes of Medicaid reimbursement.

FISCAL NOTE

Greta Rymal, HHSC Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years that the sections will be in effect, there is an anticipated cost to state government of \$63,796 General Revenue (GR), (\$127,592 All Funds (AF)), for State Fiscal Year (SFY) SFY 2018 and \$55,193 GR, (\$110,387 AF), each year for SFY 2019 through SFY 2022. There is no anticipated effect on costs or revenues of local governments as a result of enforcing and administering the sections as proposed.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Ms. Rymal has also determined that there will be no adverse impact on small businesses, micro-businesses, or rural communities required to comply with the sections as proposed, as no Texas Medicaid MCO qualifies as a small business, micro-business, or rural community.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the sections as proposed.

There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

Stephanie Muth, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules. The anticipated public benefit will be the increased clarity and transparency of MCO requirements related to Medicaid managed care network adequacy standards.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Jimmy Perez, Medicaid Policy Advisor, 4900 North Lamar Boulevard; by fax to (512) 730-7477; or by e-mail to jimmy.perez@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register*.

To be considered, comments must be submitted no later than 30 days after the date of this issue of the *Texas Register*. The last day to submit comments falls on a Sunday; therefore, comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 1R052" in the subject line.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority, and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas.

The amendment affects Texas Human Resources Code, Chapter 32, and Texas Government Code, Chapters 531, 533, and 2001. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Legend:

Single Underline = Proposed new language

~~[Strikethrough and brackets]~~ = Current language proposed for deletion

Regular print = Current language

(No change.) = No changes are being considered for the designated subdivision

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER A GENERAL PROVISIONS

§353.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Action--

(A) An action is defined as:

(i) the denial or limited authorization of a requested Medicaid service, including the type or level of service;

(ii) the reduction, suspension, or termination of a previously authorized service;

(iii) the failure to provide services in a timely manner;

(iv) the denial in whole or in part of payment for a service; or

(v) the failure of a managed care organization (MCO) to act within the timeframes set forth by the Health and Human Services Commission (HHSC) and state and federal law.

(B) "Action" does not include expiration of a time-limited service.

(2) Acute care--Preventive care, primary care, and other medical or behavioral health care provided by the provider or under the direction of a provider for a condition having a relatively short duration.

(3) Acute care hospital--A hospital that provides acute care services.

(4) Agreement or Contract--The formal, written, and legally enforceable contract and amendments thereto between HHSC and an MCO.

(5) Allowable revenue--All managed care revenue received by the MCO pursuant to the contract during the contract period, including retroactive adjustments made by HHSC. This would include any revenue earned on Medicaid managed care funds such as investment income, earned interest, or third party administrator earnings from services to delegated networks.

(6) Appeal--The formal process by which a member or his or her representative requests a review of the MCO's action.

(7) Applicant Provider--A physician or other health care provider applying for expedited credentialing as defined in Texas Government Code §533.0064.

(8) [~~(7)~~] Behavioral health service--A covered service for the treatment of mental, emotional, or substance use disorders.

(9) [~~(8)~~] Capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is responsible for payment.

(10) [~~(9)~~] Capitation rate--A fixed predetermined fee paid by HHSC to the MCO each month, in accordance with the contract, for each enrolled member in exchange for which the MCO arranges for or provides a defined set of covered services to the member, regardless of the amount of covered services used by the enrolled member.

(11) [~~(10)~~] CFR--Code of Federal Regulations.

(12) [~~(11)~~] Children's Medicaid Dental Services--The dental services provided through a dental MCO to a client birth through age 20.

(13) [~~(12)~~] Clean claim--A claim submitted by a physician or provider for health care 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 further defined under the terms of the contract executed between the MCO and HHSC.

(14) [~~(13)~~] Client--Any Medicaid-eligible recipient.

(15) [~~(14)~~] CMS--The Centers for Medicare & Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

(16) [~~(15)~~] Complainant--A member, or a treating provider or other individual designated to act on behalf of the member, who files a complaint.

(17) [~~(16)~~] Complaint--Any dissatisfaction expressed by a complainant, orally or in writing, to the MCO about any matter related to the MCO other than an action. Subjects for complaints may include:

(A) the quality of care of services provided;

(B) aspects of interpersonal relationships such as rudeness of a provider or employee; and

(C) failure to respect the member's rights.

(18) [~~(17)~~] Consumer Directed Services (CDS) option--A service delivery option (also known as self-directed model with service budget) in which an individual or legally authorized representative employs and retains service providers and directs the delivery of certain program services.

(19) [~~(18)~~] Covered services--Unless a service or item is specifically excluded under the terms of the state plan, a federal waiver, a managed care services contract, or an amendment to any of these, the phrase "covered services" means all health care, long term services and supports, or dental services or items that the MCO must arrange to provide and pay for on a member's behalf under the terms of the contract executed between the MCO and HHSC, including:

(A) all services or items comprising "medical assistance" as defined in §32.003 of the Human Resources Code; and

(B) all value-added services under such contract.

(20) Credentialing--The process through which an MCO collects, assesses, and validates qualifications and other relevant information pertaining to a Medicaid enrolled health care provider to determine whether the provider may be contracted to deliver covered services as part of the network of the managed care organization.

(21) [~~(19)~~] Cultural competency--The ability of individuals and systems to provide services effectively to people of various disabilities, cultures, races,

ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and their dignity.

(22) [~~(20)~~] Day--A calendar day, unless specified otherwise.

(23) [~~(21)~~] Default enrollment--The process established by HHSC to assign a Medicaid managed care enrollee to an MCO when the enrollee has not selected an MCO.

(24) [~~(22)~~] Dental managed care organization (dental MCO)--A dental indemnity insurance provider or dental health maintenance organization licensed or approved by the Texas Department of Insurance.

(25) [~~(23)~~] Dental contractor--A dental MCO that is under contract with HHSC for the delivery of dental services.

(26) [~~(24)~~] Dental home--A provider who has contracted with a dental MCO to serve as a dental home to a member and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as dental homes are federally qualified health centers and individuals who are general dentists or pediatric dentists.

(27) [~~(25)~~] Dental service--The routine preventive, diagnostic, urgent, therapeutic, initial, and primary care provided to a member and included within the scope of HHSC's agreement with a dental contractor. For purposes of this chapter, "dental service" does not include dental devices for craniofacial anomalies; treatment rendered in a hospital, urgent care center, or ambulatory surgical center setting for craniofacial anomalies; or emergency services provided in a hospital, urgent care center, or ambulatory surgical center setting involving dental trauma. These types of services are treated as health care services in this chapter.

(28) [~~(26)~~] Disability--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, socializing, or working.

(29) [~~(27)~~] Disproportionate Share Hospital (DSH)--A hospital that serves a higher than average number of Medicaid and other low-income patients and receives additional reimbursement from the State.

(30) [~~(28)~~] Dual eligible--A Medicaid recipient who is also eligible for Medicare.

(31) [~~(29)~~] Elective enrollment--Selection of a primary care provider (PCP) and MCO by a client during the enrollment period established by HHSC.

(32) [~~(30)~~] Emergency behavioral health condition--Any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

(A) requires immediate intervention and/or medical attention without which the client would present an immediate danger to themselves or others; or

(B) renders the client incapable of controlling, knowing, or understanding the consequences of his or her actions.

(33) [~~(31)~~] Emergency medical condition--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 to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

(E) serious jeopardy to the health of a pregnant woman or her unborn child.

(34) [~~(32)~~] Emergency service--A covered inpatient and outpatient service, furnished by a network provider or out-of-network provider that is qualified to furnish such service, that is needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition. For health care MCOs, the term "emergency service" includes post-stabilization care services.

(35) [~~(33)~~] Encounter--A covered service or group of covered services delivered by a provider to a member during a visit between the member and provider. This also includes value-added services.

(36) [~~(34)~~] Enrollment--The process by which an individual determined to be eligible for Medicaid is enrolled in a Medicaid MCO serving the service area in which the individual resides.

(37) [~~(35)~~] EPSDT--The federally mandated Early and Periodic Screening, Diagnosis, and Treatment program defined in 25 TAC Chapter 33 (relating to Early and Periodic Screening, Diagnosis, and Treatment). The State of Texas has adopted the name Texas Health Steps (THSteps) for its EPSDT program.

(38) [~~(36)~~] EPSDT-CCP--The Early and Periodic Screening, Diagnosis and Treatment-Comprehensive Care Program described in Chapter 363 of this title (relating to Texas Health Steps Comprehensive Care Program).

(39) [~~(37)~~] Exclusive provider benefit plan (EPBP)--An MCO that complies with 28 TAC §§3.9201 - 3.9212, relating to the Texas Department of Insurance's requirements for EPBPs, and contracts with HHSC to provide Medicaid coverage.

(40) Expedited Credentialing--The process under Texas Government Code §533.0064 in which an MCO allows an applicant provider to provide Medicaid services to members on a provisional basis pending completion of the credentialing process.

(41) [~~(38)~~] Experience rebate--The portion of the MCO's net income before taxes that is returned to the State in accordance with the MCO's contract with HHSC.

(42) [~~(39)~~] Fair hearing--The process adopted and implemented by HHSC in Chapter 357, Subchapter A of this title (relating to Uniform Fair Hearing Rules) in compliance with federal regulations and state rules relating to Medicaid fair hearings.

(43) [~~(40)~~] Federally Qualified Health Center (FQHC)--An entity that is certified by CMS to meet the requirements of 42 U.S.C. §1395x(aa)(3) as a Federally Qualified Health Center and is enrolled as a provider in the Texas Medicaid program.

(44) [~~(41)~~] Federal Poverty Level (FPL)--The household income guidelines issued annually and published in the *Federal Register* by the

United States Department of Health and Human Services under the authority of 42 U.S.C. §9902(2) and as in effect for the applicable budget period determined in accordance with 42 C.F.R. §435.603(h). HHSC uses the FPL to determine an individual's eligibility for Medicaid.

(45) [~~(42)~~] Federal waiver--Any waiver permitted under federal law and approved by CMS that allows states to implement Medicaid managed care.

(46) [~~(43)~~] Former Foster Care Children (FFCC) program--The Medicaid program for young adults who aged out of the conservatorship of Texas Department of Family and Protective Services (DFPS), administered in accordance with Chapter 366, Subchapter J of this title (relating to Former Foster Care Children's Program).

(47) [~~(44)~~] Functional necessity--A member's need for services and supports with activities of daily living or instrumental activities of daily living to be healthy and safe in the most integrated setting possible. This determination is based on the results of a functional assessment.

(48) [~~(45)~~] Habilitation--Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks based on the individual's person-centered service plan.

(49) [~~(46)~~] Health care managed care organization (health care MCO)--An entity that is licensed or approved by the Texas Department of Insurance to operate as a health maintenance organization or to issue an EPBP.

(50) Health care provider group--A legal entity, such as a partnership, corporation, limited liability company, or professional association, enrolled in Medicaid with at least one individual provider also enrolled in Medicaid, under which certified or licensed individual health care providers provide health care items or services.

(51) [~~(47)~~] Health care services--The acute care, behavioral health care, 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.

(52) [~~(48)~~] Health and Human Services Commission (HHSC)--The single state agency charged with administration and oversight of the Texas Medicaid program or its designee.

(53) [~~(49)~~] Health maintenance organization (HMO)--An organization that holds a certificate of authority from the Texas Department of Insurance to

operate as an HMO under Chapter 843 of the Texas Insurance Code, or a certified Approved Non-Profit Health Corporation formed in compliance Chapter 844 of the Texas Insurance Code.

(54) [~~(50)~~] Hospital--A licensed public or private institution as defined in the Texas Health and Safety Code at Chapter 241, relating to hospitals, or Chapter 261, relating to municipal hospitals.

(55) [~~(51)~~] Intermediate care facility for individuals with an intellectual disability or related condition (ICF-IID)--A facility providing care and services to individuals with intellectual disabilities or related conditions as defined in §1905(d) of the Social Security Act (42 U.S.C. 1396(d)).

(56) [~~(52)~~] Legally authorized representative (LAR)--A person authorized by law to act on behalf of an individual with regard to a matter described in this chapter, and may, depending on the circumstances, include a parent, guardian, or managing conservator of a minor, or the guardian of an adult, or a representative designated pursuant to 42 C.F.R. 435.923.

(57) [~~(53)~~] Long term service and support (LTSS)--A service provided to a qualified member in his or her home or other community-based setting necessary to allow the member to remain in the most integrated setting possible. LTSS includes services provided under the Texas State Plan as well as services available to persons who qualify for STAR+PLUS Home and Community-Based Program services or Medicaid 1915(c) waiver services. LTSS available through an MCO in STAR+PLUS, STAR Health, and STAR Kids varies by program model.

(58) [~~(54)~~] Main dental home provider--See definition of "dental home" in this section.

(59) [~~(55)~~] Main dentist--See definition of "dental home" in this section.

(60) [~~(56)~~] Managed care--A health care delivery system or dental services delivery system in which the overall care of a patient is coordinated by or through a single provider or organization.

(61) [~~(57)~~] Managed care organization (MCO)--A dental MCO or a health care MCO.

(62) [~~(58)~~] Marketing--Any communication from an MCO to a client who is not enrolled with the MCO that can reasonably be interpreted as

intended to influence the client's decision to enroll, not to enroll, or to disenroll from a particular MCO.

(63) [~~(59)~~] Marketing materials--Materials that are produced in any medium by or on behalf of the MCO that can reasonably be interpreted as intending to market to potential members. Materials relating to the prevention, diagnosis, or treatment of a medical or dental condition are not marketing materials.

(64) [~~(60)~~] MDCP--Medically Dependent Children Program. A §1915(c) waiver program that provides community-based services to assist Medicaid beneficiaries under age 21 to live in the community and avoid institutionalization.

(65) [~~(61)~~] Medicaid--The medical assistance program authorized and funded pursuant to Title XIX of the Social Security Act (42 U.S.C. §1396 et seq) and administered by HHSC.

(66) [~~(62)~~] Medical Assistance Only (MAO)--A person who qualifies financially and functionally for Medicaid assistance but does not receive Supplemental Security Income (SSI) benefits, as defined in Chapters 358, 360, and 361, of this title (relating to Medicaid Eligibility for the Elderly and People with Disabilities, Medicaid Buy-In Program and Medicaid Buy-In for Children Program).

(67) [~~(63)~~] Medicaid for transitioning foster care youth (MTFCY) program--The Medicaid program for young adults who aged out of the conservatorship of Texas Department of Family and Protective Services (DFPS), administered in accordance with Chapter 366, Subchapter F of this title (relating to Medicaid for Transitioning Foster Care Youth).

(68) [~~(64)~~] Medical home--A PCP or specialty care provider who has accepted the responsibility for providing accessible, continuous, comprehensive, and coordinated care to members participating in an MCO contracted with HHSC.

(69) [~~(65)~~] Medically necessary--

(A) For Medicaid members birth through age 20, the following Texas Health Steps services:

(i) screening, vision, dental, and hearing services; and

(ii) other health care services or dental services that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:

(I) must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole; and

(II) may include consideration of other relevant factors, such as the criteria described in subparagraphs (B)(ii) - (vii) and (C)(ii) - (vii) of this paragraph.

(B) For Medicaid members over age 20, non-behavioral health services that are:

(i) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;

(ii) provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;

(iii) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(iv) consistent with the member's medical need;

(v) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

(vi) not experimental or investigative; and

(vii) not primarily for the convenience of the member or provider.

(C) For Medicaid members over age 20, behavioral health services that:

(i) are reasonable and necessary for the diagnosis or treatment of a mental health or substance use disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

(ii) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(iii) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(iv) are the most appropriate level or supply of service that can safely be provided;

(v) could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;

(vi) are not experimental or investigative; and

(vii) are not primarily for the convenience of the member or provider.

(70) [~~(66)~~] Member--A person who is eligible for benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included in the Medicaid managed care program, and is enrolled in a Medicaid MCO.

(71) [~~(67)~~] Member education program--A planned program of education:

(A) concerning access to health care services or dental services through the MCO and about specific health or dental topics;

(B) that is approved by HHSC; and

(C) that is provided to members through a variety of mechanisms that must include, at a minimum, written materials and face-to-face or audiovisual communications.

(72) [~~(68)~~] Member materials--All written materials produced or authorized by the MCO and distributed to members or potential members containing information concerning the managed care program. Member materials include member ID cards, member handbooks, provider directories, and marketing materials.

(73) [~~(69)~~] Non-capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is not responsible for payment.

(74) [~~(70)~~] Outside regular business hours--As applied to FOHCs and rural health clinics (RHCs), means before 8 a.m. and after 5 p.m. Monday through Friday, weekends, and federal holidays.

(75) [~~(71)~~] Participating MCO--An MCO that has a contract with HHSC to provide services to members.

(76) [~~(72)~~] Post-stabilization care service--A covered service, related to an emergency medical condition, that is provided after a Medicaid member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. §438.114(b) and (e) and 42 C.F.R. §422.113(c)(iii) to improve or resolve the Medicaid member's condition.

(77) [~~(73)~~] Primary care provider (PCP)--A physician or other provider who has agreed with the health care MCO to provide a medical home to members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

(78) [~~(74)~~] Provider--A credentialed and licensed individual, facility, agency, institution, organization, or other entity, and its employees and subcontractors, that has a contract with the MCO for the delivery of covered services to the MCO's members.

(79) [~~(75)~~] Provider education program--Program of education about the Medicaid managed care program and about specific health or dental care issues presented by the MCO to its providers through written materials and training events.

(80) [~~(76)~~] Provider network or Network--All providers that have contracted with the MCO for the applicable managed care program.

(81) [~~(77)~~] Quality improvement--A system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(82) [~~(78)~~] Rural Health Clinic (RHC)--An entity that meets all of the requirements for designation as a rural health clinic under §1861(aa)(1)

of the Social Security Act (42 U.S.C. §1395x(aa)(1)) and is approved for participation in the Texas Medicaid program.

(83) [~~(79)~~] Service area--The counties included in any HHSC-defined service area as applicable to each MCO.

(84) [~~(80)~~] Significant traditional provider (STP)--A provider identified by HHSC as having provided a significant level of care to the target population, including a DSH.

(85) [~~(81)~~] STAR--The State of Texas Access Reform (STAR) managed care program that operates under a federal waiver and primarily provides, arranges for, and coordinates preventive, primary, acute care, and pharmacy services for low-income families, children, and pregnant women.

(86) [~~(82)~~] STAR Health--The managed care program that operates under the Medicaid state plan and primarily serves:

(A) children and youth in Texas Department of Family and Protective Services (DFPS) conservatorship;

(B) young adults who voluntarily agree to continue in a foster care placement (if the state as conservator elects to place the child in managed care); and

(C) young adults who are eligible for Medicaid as a result of their former foster care status through the month of their 21st birthday.

(87) [~~(83)~~] STAR Kids--The program that operates under a federal waiver and primarily provides, arranges, and coordinates preventative, primary, acute care, and long-term services and supports to persons with disabilities under the age of 21 who qualify for Medicaid.

(88) [~~(84)~~] STAR+PLUS--The managed care program that operates under a federal waiver and primarily provides, arranges, and coordinates preventive, primary, acute care, and long-term services and supports to persons with disabilities and elderly persons age 65 and over who qualify for Medicaid by virtue of their SSI or MAO status.

(89) [~~(85)~~] STAR+PLUS Home and Community-Based Services Program--The program that provides person-centered care services that are delivered in the home or in a community setting, as authorized through a federal waiver under §1115 of the Social Security Act, to qualified Medicaid-eligible

clients who are age 21 or older, as cost-effective alternatives to institutional care in nursing facilities.

(90) [~~(86)~~] State plan--The agreement between the CMS and HHSC regarding the operation of the Texas Medicaid program, in accordance with the requirements of Title XIX of the Social Security Act.

(91) [~~(87)~~] Supplemental Security Income (SSI)--The federal cash assistance program of direct financial payments to people who are 65 years of age or older, are blind, or have a disability administered by the Social Security Administration (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, which then notifies the states through the State Data Exchange (SDX).

(92) [~~(88)~~] Texas Health Steps (THSteps)--The name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [~~program~~], described at 42 U.S.C. §1396d(r) and 42 CFR §440.40 and §§441.40 - 441.62.

(93) [~~(89)~~] Value-added service--A service provided by an MCO that is not "medical assistance," as defined by §32.003 of the Texas Human Resources Code.

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REPEAL AND PROPOSE AS NEW

~~§353.411. Accessibility of Services.~~

~~(a) Requirements for health care managed care organizations (health care MCOs).~~

~~(1) A health care MCO must provide a broad-based and accessible primary care provider (PCP) network within the service area to ensure member accessibility to providers in time, distance, cultural competency, and language.~~

~~(2) A health care MCO must have pediatric and family practitioner PCPs in their network of providers in sufficient numbers to provide regular and preventive pediatric care and Texas Health Steps (THSteps) services to all eligible children enrolled in the service area.~~

~~(3) A health care MCO must have PCPs and acute care hospitals available throughout the service area to ensure that no member must travel more than 30 miles from his or her residence to access the PCP, unless the Health and Human Services Commission (HHSC) has made an exception.~~

~~(4) A health care MCO must have PCPs in sufficient numbers to ensure that no member must wait an unreasonable amount of time for an appointment, and that no member must wait an unreasonable amount of time to be seen at their appointed time.~~

~~(5) A health care MCO must ensure the reasonable availability and accessibility of specialists for all covered services requiring specialty care. Specialists must also be reasonably accessible to members in time, distance, cultural competency, and language.~~

~~(6) A member of a health care MCO must not be required to travel in excess of 75 miles from his or her residence to secure initial contact with referral specialists; special hospitals; psychiatric hospitals; diagnostic and therapeutic services; and single service health care physicians, dentists, or providers, except as provided in subsections (c) and (d) of this section.~~

~~(b) Requirements for dental managed care organizations (MCOs).~~

~~(1) A dental MCO must provide a broad-based and accessible main dentist network within the service area to ensure member accessibility to providers in time, distance, cultural competency, and language.~~

~~(2) A dental MCO must have main dentist providers in their network in sufficient numbers to provide regular and preventive dental care and THSteps services to all eligible children enrolled in the service area.~~

~~(3) A dental MCO must have general dental providers throughout the service area to ensure that no member must travel more than 30 miles to~~

access such providers in urban counties and 75 miles in rural counties, unless HHSC has made an exception.

~~(4) A dental MCO must have general dental providers in sufficient numbers to ensure that no member must wait an unreasonable amount of time for an appointment, and that no member must wait an unreasonable amount of time to be seen at their appointed time.~~

~~(5) A dental MCO must ensure the reasonable availability and accessibility of dental specialists for all covered services. Dental specialists must also be reasonably accessible to members in time, distance, cultural competency, and language.~~

~~(6) A member of a dental MCO must not be required to travel in excess of 75 miles from his or her residence to secure initial contact with referral dental specialists, unless HHSC has made an exception.~~

~~(c) Service or provider not available. If any service or provider is not available to a member within the mileage radius specified in subsections (a)(3), (a)(6), (b)(3), or (b)(6) of this section, the MCO must submit to HHSC for approval data that indicates covered health care services or dental services are not available to the member within the required distance.~~

~~(d) Service or provider outside the service area. The provisions in subsections (a)(3), (a)(6), (b)(3), and (b)(6) of this section do not preclude an MCO from making arrangements with another source outside the service area for members to receive a higher level of skill or specialty than the level that is available within the MCO service area. For health care MCOs, this can include treatment of cancer, burns, and cardiac diseases.~~

~~(e) Provider education and training.~~

~~(1) A health care MCO must provide education and training to providers on the specific health and behavioral health problems and needs of members.~~

~~(2) A dental MCO must provide education and training to providers on the specific dental health problems and needs of members.~~

~~(3) All MCOs must provide education and training regarding the contract and rule requirements for accessibility and availability. MCOs and HHSC will cooperate and coordinate education and training activities for providers.~~

~~(f) Cultural competency plan. An MCO must develop a written cultural competency plan describing how the MCO will effectively provide health care services or dental services to members from varying cultures, races, ethnic backgrounds, and religions to ensure those characteristics do not pose barriers to gaining access to needed services. As part of the requirement to develop the cultural competency plan, the MCO must at a minimum:~~

~~(1) employ multi-cultural and multi-lingual staff;~~

~~(2) make available interpreter services for members as necessary to ensure availability of effective communication regarding treatment, medical history, or health education;~~

~~(3) display to HHSC through the written plan a method for incorporating the plan into the MCO's policy-making process, administration, and daily practices; and~~

~~(4) submit the written plan to HHSC for review and approval at intervals specified by HHSC.~~

~~(g) Verbal and physical barriers. An MCO must ensure that communication and physical access barriers do not deter members' timely access to health care services or dental services. The MCO must provide information in appropriate communication formats, including formats accessible to people with disabilities.~~

~~(h) Significant traditional providers. An MCO must not exclude Significant Traditional Providers from its network for a period of time and under conditions determined by HHSC and specified in the contract.~~

~~(i) Provider manual. An MCO must develop a written provider manual clearly stating the policies and procedures adopted by the MCO to meet the provider's duties and obligations required by these and other agency rules and the contract.~~

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§353.411. Accessibility of Services.

(a) Provider accessibility.

(1) A managed care organization (MCO) must provide a broad-based and accessible provider network within the service area to ensure member accessibility to a choice of two or more of each of the managed care program's provider types within the time or distance standards set forth below and as otherwise required by HHSC.

Provider Type	Distance in Miles			Travel Time in Minutes		
	Metropolitan County	Micro County	Rural County	Metropolitan County	Micro County	Rural County
Behavioral Health-Outpatient	30	30	75	45	45	90
Hospital- Acute Care	30	30	30	45	45	45
Prenatal	10	20	30	15	30	40
Primary Care Provider¹	10	20	30	15	30	40
Cardiovascular Disease	20	35	60	30	50	75
ENT (otolaryngology)	30	60	75	45	80	90
General Surgeon	20	35	60	30	50	75
OB/GYN	30	60	75	45	80	90
Ophthalmologist	20	35	60	30	50	75
Orthopedist	20	35	60	30	50	75
Pediatric Sub-Specialists	20	35	60	30	50	75
Psychiatrist	30	45	60	45	60	75
Urologist	30	45	60	45	60	75
Specialty Care Provider¹						
Occupational, Physical, or Speech Therapy	30	60	60	45	80	75

Nursing Facility		75	75	75	N/A	N/A	N/A
Main Dentist (general or pediatric)		30	30	75	45	45	90
Dental Specialists	Pediatric Dental	30	30	75	45	45	90
	Endodontist, Periodontist, or Prosthodontist	75	75	75	90	90	90
	Orthodontist	75	75	75	90	90	90
	Oral Surgeons	75	75	75	90	90	90

¹ Services include acute, chronic, preventive, routine, or urgent care for adults and children.

(2) For STAR+PLUS, STAR Health, and STAR Kids, a healthcare MCO must ensure the reasonable availability and accessibility of a choice of two or more of each of the LTSS and community-based services providers. These providers must be reasonably accessible to members in accordance with provider network access standards, as required by HHSC.

(3) For providers not specifically listed in paragraphs (1) or (2) of this subsection, an MCO must provide reasonable availability and accessibility of providers within the service area to ensure member accessibility to providers in time or distance, or as otherwise required by HHSC.

(4) An MCO must allow a member to choose his network provider to the extent required by 42 C.F.R. 438.3(l).

(b) Texas Health Steps. In addition to the requirements in subsection (a) of this section:

(1) a healthcare MCO must have a network of providers in sufficient numbers to provide medical checkups, diagnostic services, and treatment services to all enrolled members age 20 and younger in the service area, in accordance with state and federal regulations, including 42 U.S.C. 1396d(r) and 25 TAC Chapter 33 (relating to Early and Periodic Screening, Diagnosis, and Treatment); and

(2) a dental MCO must have main dentist providers in their network in sufficient numbers to provide dental checkups, diagnostic services, and treatment services to all enrolled members age 20 and younger in the service area, in accordance with state and federal regulations, including 42 U.S.C. 1396d(r) and 25 TAC Chapter 33.

(c) Wait times.

(1) A health care MCO must have PCPs in sufficient numbers to ensure that no member must wait an unreasonable amount of time for an appointment, and that no member must wait an unreasonable amount of time to be seen at their appointed time.

(2) A dental MCO must have main dentist providers in sufficient numbers to ensure that no member must wait an unreasonable amount of time for an appointment, and that no member must wait an unreasonable amount of time to be seen at their appointed time.

(d) Service or provider not available. If any service or provider is not available to a member within the time or distance requirement specified in subsection (a) of this section, the MCO must submit an exemption request to HHSC. Exemptions are considered on a case-by-case basis.

(e) Service or provider outside the service area. The provisions in subsection (a) of this section do not preclude an MCO from making arrangements with a provider outside the service area for members to receive services from a provider with a higher level of skill or specialty than the level that is available within the MCO service area. For health care MCOs, this can include treatment of cancer, burns, and cardiac diseases.

(f) Provider education and training.

(1) A health care MCO must provide education and training to providers on the specific health and behavioral health problems and needs of members.

(2) A dental MCO must provide education and training to providers on the specific dental health problems and needs of members.

(3) All MCOs must provide education and training regarding the contract and rule requirements for accessibility and availability. Each MCO must coordinate education and training activities for providers with HHSC.

(g) Cultural competency.

(1) An MCO must provide a broad-based and accessible provider network within the service area to ensure member accessibility to providers that meet cultural competency and language requirements. An MCO must ensure that cultural barriers do not deter members' timely access to health care services or dental services.

(2) An MCO must develop a written cultural competency plan describing how the MCO will effectively provide health care services or dental services to members from varying cultures, races, ethnic backgrounds, and religions as well as those with disabilities, to ensure those characteristics do not pose barriers to gaining access to needed services.

(A) The cultural competency plan must adhere to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards); and

(B) The MCO must:

(i) employ multi-cultural and multi-lingual staff;

(ii) arrange and pay for interpreter services, including written, spoken, and sign language interpretation, for members to ensure availability of effective communication regarding treatment, medical history, or health condition;

(iii) display to HHSC through the written plan a method for incorporating the plan into the MCO's policy-making process, administration, and daily practices;

(iv) maintain policies and procedures, and make information available to members and providers, outlining the manner in which members and the members' providers can access competent interpreter services, including written, spoken, and sign language interpretation, when the member is in a provider's office or accessing emergency services; and

(v) submit the written plan and plan updates and edits to HHSC for review and approval at intervals specified by HHSC.

(h) Verbal and physical barriers. An MCO must ensure that communication and physical access barriers do not deter members' timely access to health care services or dental services. The MCO must provide information in appropriate communication formats, including formats accessible to people with disabilities.

(i) Significant traditional providers. An MCO must not exclude Significant Traditional Providers from its network for a period of time and under conditions determined by HHSC and specified in the contract.

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§353.423. Expedited Credentialing.

(a) HHSC identifies applicant provider types for which an expedited credentialing process must be established and implemented.

(b) Each MCO must establish and implement an expedited credentialing process that allows applicant providers to provide services to members for the following provider types:

(1) dentists;

(2) dental specialists (endodontist, oral/maxillofacial surgeon, orthodontist, pediatric dentist, periodontist, prosthodontist, and physicians providing dental specialty care);

(3) licensed clinical social workers;

(4) licensed professional counselors;

(5) licensed marriage and family therapists; and

(6) psychologists.

(c) To qualify for expedited credentialing under this section and payment under subsection (d) of this section, an applicant provider must:

(1) be a member of an established health care provider group that has a current contract with an MCO;

(2) be a Medicaid-enrolled provider;

(3) agree to comply with the terms of the contract described in paragraph (1) of this subsection; and

(4) submit all documentation and information required by the MCO as necessary for the MCO to begin the credentialing process.

(d) An MCO must establish and implement an expedited credentialing process for a nursing facility that successfully undergoes a change of ownership (CHOW). The requirements for applicant providers to qualify for expedited credentialing listed in subsection (c) of this section apply to CHOWs, with the exception of paragraph (1).

(e) On submission by the applicant provider of the information required by the MCO under subsection (c) of this section, and for Medicaid reimbursement purposes only, the MCO must treat the provider as if the provider were in the MCO's provider network when the provider provides services to recipients, subject to subsections (f) and (g) of this section.

(f) Except as provided by subsection (g) of this section, if, on completion of the credentialing process, an MCO determines that the applicant provider does not meet the MCO's credentialing requirements, the MCO may recover from the provider or provider group the difference between payments for in-network benefits and out-of-network benefits.

(g) If an MCO determines on completion of the credentialing process that the applicant provider does not meet the MCO's credentialing requirements and that the provider or provider group made fraudulent claims in the provider's application for credentialing, the MCO may recover from the provider or provider group the entire amount of any payment paid to the provider or provider group.