Texas Health & Human Services Commission

General Contract Terms & Conditions

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	January 1, 2010	Initial version of the General Terms & Conditions that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2010	Definition for "Material Subcontractor or Major Subcontractor" is revised.
Revision	1.2	September 1, 2010	Definition of CHIP Perinate Newborn is modified. Definition for Primary Care Physician or Primary Care Provider (PCP) is modified to clarify that APNs and PAs must practice under the supervision of a PCP. Section 4.08(b) is modified to clarify the timeframes for notification. Section 5.04 is modified to reflect changes to CHIP Perinatal Program eligibility, effective 9/1/10. Section 7.07 is amended to add subsection (b). Section 9.02(c) is modified to add a reference to the Medicaid Fraud Control Unit. Section 10.06 has been modified to clarify the CHIP Perinate Newborn 0% to 185% rate cell.
Revision	1.3	December 1, 2010	Contract amendment did not revise Attachment A General Contract Terms & Conditions
Revision	1.4	March 1, 2011	Definition of "Major Population Group" is modified. Definition of "Outpatient Hospital Services" is modified to remove language that is included in the UMCM. Definition of "Post-stabilization Care Services" is modified. Definition of STAR+PLUS or STAR+PLUS Program is modified to change "under age 21" to "birth through age 20". Definition of "Texas Health Network" is deleted. Definition of "Uniform Managed Care Manual" is modified. Section 4.08 is modified to prohibit payments to entities located outside the U.S. in conformance with the Affordable Care Act. Section 4.10 is modified to prohibit payments to entities located outside the U.S. in conformance with the Affordable Care Act. Section 5.04 is modified to clarify that infants born to CHIP members are not automatically enrolled in CHIP. Section 8.07 is added to apply generally to all MCO contracts. Section 9.01 is revised to clarify the requirements for record retention in accordance with Federal requirements.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.5	September 1, 2011	Definition of PPACA is added. Section 4.08 is modified to add language for the ACA requirement regarding Healthcare Acquired Conditions (HAC). Section 4.10 is modified to add language for the ACA requirement regarding Healthcare Acquired Conditions (HAC). Section 7.08, "Historically Underutilized Business Participation Requirements" is added. Section 9.01 is modified to clarify compliance with 45 CFR 74.53. Section 10.08(a) is modified to include a new item addressing the State's right to recoup if the CMS has imposed a payment denial as a sanction (42 CFR §438.726(b)), and to modify (a)(1-2). Section 11.08, "Information Security" is added. Section 12.02(d) is modified to refer to the circumstances prompting temporary management in 42 C.F.R. §438.706.
Revision	1.6	March 1, 2012	Section 4.04 is modified to clarify the requirements for Medical Director designees, and to clarify that the provision does not apply to prior authorization determinations made by Texas licensed pharmacists. Section 4.10 is modified to add language required by Gov't Code §533.005(a)(24) (amended by SB 7). New Section 4.11 "Prohibition Against Performance Outside of the United States" is added. Section 5.02(b) is modified to clarify that MCOs may not sell or transfer their Member base. Section 7.02 is modified to include additional legal citations and to clarify applicability to pharmacy. Section 7.08(b) is modified to correct cross-reference. Section 9.02 is modified to comply with the requirements of Gov't §533.012 (as amended by SB 7). Section 10.06(a) is modified to remove the Perinate Newborn 0% - 185% rate cell. Section 12.03(b) is modified to add language regarding terminations for criminal convictions.
Revision	1.7	June 1, 2012	Definition for Allowable Revenue is deleted. Definition for Consolidated FSR Report or Consolidated Basis is added.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition for Experience Rebate is modified. Definition for Financial Statistical Report is added. Definition for FSR is modified to conform to the Uniform Managed Care Contract. Definitions for FSR Reporting Period, FSR Reporting Period 11, FSR Reporting Period 12A, and FSR Reporting Period 12/13 are added. Definition for Material Subcontract is added. Definition for Material Subcontractor is modified to conform to the Uniform Managed Care Contract. Definition for Net Income Before Taxes is modified. Definition for Pre-tax Income is added. Definition for Program is added. Definitions for Rate Period 1, Rate Period 2, and Rate Period 3 are modified. Definition for Revenue is modified. Section 10.10 is modified to consolidate the Experience Rebate across all contracts and all programs. Section 10.10.1 is modified to consolidate the Administrative Expense Cap across all contracts and all programs.
Revision	1.8	September 1, 2012	Definition for “MCO Programs” is modified. Definition for “Medically Necessary” is modified. Definition for “Provider Materials” is added. Section 7.02 is modified to clarify that only applicable provisions of the listed laws apply to the contract.
Revision	1.9	March 1, 2013	Contract amendment did not revise Attachment A, “General Contract Terms & Conditions.”
Revision	1.10	June 1, 2013	Contract amendment did not revise Attachment A, “General Contract Terms & Conditions.”
Revision	1.11	September 1, 2013	Definition for CAHPS is modified to correct the name to which the acronym refers. Definition for Community Health Worker is added. Definition for Court-Ordered Commitment is modified to change “psychiatric facility” to “inpatient mental health facility” for consistency with terminology used in the Health and Safety Code. Definition added for “Default Enrollment.”

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition for DSM is modified to refer to the most current edition of the DSM. Definition for ECI is modified to update the T.A.C. reference. Definition for HEDIS is modified to correct the name to which the acronym refers. Definition for Primary Care Physician is modified to remove the list of provider types as being redundant. Definition for Rate Period is modified to include two sub-periods. Section 5.06 is renamed "Modified Default Enrollment Process" and revised to include a process for all Programs. Section 7.04 is deleted in its entirety and updated within Section 7.02. Section 9.02 is modified for clarification that records must be provided "at no cost." Section 9.04 is modified for clarification that records must be provided "at no cost." Section 10.10.2 Reinsurance Cap is added. Section 13.01 is modified to clarify the required certifications. Section 14.08 Technology Access is added and the subsequent sub-section is renumbered. Section 14.09 Electronic & Information Resources Accessibility Standards is modified to delete outdated language and to conform to language in the Uniform Managed Care Contract.
Revision	1.12	January 1, 2014	Definition for Federal Poverty Level is updated. Section 3.02 is modified to clarify that the contract term may not exceed a total of 8 operational years. Section 5.02 is modified to add requirement for default assignment methodologies. Section 5.03 is modified to clarify that HHSC or the ASC will enroll or disenroll Members. Section 5.04 is modified to clarify that HHSC or the ASC will transmit new Member information, to remove the FPL limits, to remove the default assignment language, and to clarify the enrollment process when CHIP Perinate coverage expires. Section 5.06 is modified to add legal citation. Section 10.06 is modified to clarify the eligibility thresholds. Section 10.09 is modified to clarify the eligibility thresholds.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 11.01(a) is modified to correct an administrative error. Section 12.03 is modified to delete subsection (b)(8) "Termination for Insolvency" and all following subsections are renumbered.
Revision	1.13	February 1, 2014	Definition for Capitation Payment is modified to include associated Administrative Services. Definition for Child (or Children) with Special Health Care Needs (CSHCN) is deleted and reference to CSHCN is added to the definition of Member with Special Health Care Needs. Definition for Fee-for-Service (FFS) is clarified that payment is made after the service is provided. Definition for Material Subcontract is modified to clarify excluded subcontractors. Definition for MCO Administrative Services is modified to include all required deliverables outside of the Covered Services. Definition for "Medical Home" is modified to have the meaning assigned in Gov't Code 533.0029. Definition for Member with Special Health Care Needs (MSHCN) is clarified. Definition for Population Risk Group or Risk Group is modified to add defined criteria. Definition for SED is modified to remove the reference to LMHAs. Definition for SPMI is modified to remove the reference to LMHAs. Section 4.08 is renamed "Subcontractors and Agreements with Third Parties" and is modified to include language from Section 4.10 "Agreements with Third Parties." Section 4.10 "MCO Agreements with Third Parties" is deleted in its entirety. Section 10.01 is modified to clarify the calculation of the monthly Capitation Payment. Section 10.02 is modified to include Liquidated Damages due and unpaid including any associated interest. Section 10.08 is modified to clarify the requirements for adjustments. Section 10.10 is modified to include interest expense associated with Liquidated Damages assessment.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 10.10.1 is modified to clarify the data sources and to update the calculation example. Section 13.02 is modified to include an obligation to comply with 41 U.S.C. § 423.
Revision	1.14	September 1, 2014	Definition for "Community Health Worker" is modified to conform to formatting of other definitions. Definition for "FSR Reporting Period 14" is added. Definition for "FSR Reporting Period 15" is added. Definition for "ICF-MR" is deleted. Definition for "Legally Authorized Representative (LAR)" is added. Definition for Major Systems Change is added. Definition for "Rate Period 4" is added. Definition for "Rate Period 5" is added. Definition for "Texas Women's Health Program" is added. Section 5.04(c) is deleted in its entirety to maintain consistency with updated policy and rule. Section 7.07 is modified to clarify the requirement for MCOs to notify HHSC of all breaches or potential breaches of unsecured PHI. Section 7.09 "Compliance with Fraud, Waste, and Abuse requirements" is added.
Revision	1.15	October 1, 2014	Section 10.17 "Non-Risk Payments for Second Generation Direct Acting Antivirals for Hepatitis C" is added.
Revision	1.16	March 1, 2015	After the first appearance of the term, "Uniform Managed Care Manual" is changed to "UMCM.' Definition for Competent Interpreter is added. Definition for Service management is modified to remove the reference to CHIP RSA. Section 4.11 is modified to clarify subsections (a)(2)(B) and (c)(1) are clarified. Section 7.02 is modified to delete the references to OMB and replace it with 2 C.F.R. Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Section 10.10(c)(2)(iii) is modified to remove the reference to the Experience Rebate Reward. Section 17.01(c)(1)(i) is added to except DME providers from professional liability coverage.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.17	May 1, 2015	Section 10.18 "Payment/Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee" is added.
Revision	1.18	September 1, 2015	Section 1.04 is modified to remove one extraneous word and to replace another. Article 2 is modified to remove an extraneous word. Definition for "Confidential Information" is modified to change "client" to "Member" in part (1). Definition for "Consolidated FSR Report or Consolidated Basis" is modified to exclude the Dual Demonstration. Definition for "Dental Contractor" is added. Definition for "Dual Demonstration" is added. 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 7.02 is modified to clarify the language. Section 10.10 is modified to carve-out the Dual Demonstration from the "Consolidated Basis" with respect to the Experience Rebate and to remove the reference to the Experience Rebate Reward. Section 10.10.1 is modified to carve-out the Dual Demonstration from the "Consolidated Basis" with respect to the Admin Cap. Section 11.01 is modified to clarify part (h).
Revision	1.19	March 1, 2016	All references to "Fraud and Abuse" are changed to "Fraud, Waste, and Abuse" Definition for Clinical Prior Authorization or Clinical PA is added. Section 4.12 "E-Verify System" is renamed "Employment Verification" and the requirements updated. Section 10.17 "Non-Risk Payments for Second Generation Direct Acting Antivirals for Hepatitis C" is renamed "Non-

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Risk Payments for Certain Drugs" and the language is clarified.
Revision	1.20	September 1, 2016	Definition for Breach is added. Definition for Discovery/Discovered is added. Section 7.02 is modified to add item (a)(12) to require MCOs to report all Member health care information upon HHSC's request and subsequent items are renumbered. Item (a)(13) is deleted as redundant. Section 9.03 is modified to add item (a)(2) and an explanation of "reasonable notice." Section 11.09 MCO's Breach Notice, Reporting and Correction Requirements is added.
Revision	1.21	March 1, 2017	Definition for "National CLAS Standards" is added. Section 4.02 (c) is modified to specify notification must be in writing. Section 7.05 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.
Revision	1.22	September 1, 2017	Definition for "Texas Women's Health Program" is changed to "Healthy Texas Women Program" and the citation is updated. Definition for "Complaint and Internal MCO Appeal System" is added. Definition for "indian Health Care Provider" is added. Defnition for "Indivdual Service Plan (ISP)" is added. Definition for "Inquiry" is added Definition for "Limited English Proficient (LEP)" is added. Definition for "Local Behavioral Health Authority" is added. Definition for "Person-Centered" is added. Definition for "Prevalent Language" is added. Definition for "Readily Accessible" is added. Definition for "Service Plan (SP)" is modified for person-centeredness. Section 7.03 "TDI Approval" 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

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			language requiring MCOs to maintain documents subject to litigation hold beyond regular retention schedules. Section 11.09 is deleted in its entirety an replaced with modified language. Section 14.04 is modified to comply with 42 CFR § 438.116.
Revision	1.23	March 1, 2018	Definition for “Action” is added. Definition for “Auxiliary Aids” is modified to comply with 28 C.F.R. § 36.303. Definition for “Breach” is modified to harmonize obligations for the MCO and to add clarification. Definition for “Complaint” is modified. Definition for “Encounter Data” is modified to clarify MCO expectations. Definition for “MCO Internal Appeal” is added. Definition for “Prevalent Language” is modified to elaborate on significant number of percentage and properly cite the C.F.R. Definition for “Retaliation” is added. Definition for STAR+PLUS or STAR+PLUS Program is removed. Definition for “T.A.C.” is removed. Section 4.02 is modified to harmonize obligations for the MCO and to add clarification. Section 4.08 is modified to comply with 42 C.F.R. § 438.230, and clarifies the different mandatory provisions. Section 5.03 is modified to change the title from "eligibility and enrollment" to "eligibility enrollment and disenrollment" and to add requirements to comply with 42 C.F.R. §438.3(c). Section 10.05 is modified to comply with 42 C.F.R. 438.3(e). Section 10.06 is modified to comply with 42 C.F.R. 438.3(e). Section 10.17 is modified to add two drugs to non-risk based category and add language for encounter transaction fee for service. Sections 11.02, 11.09, 11.09.1, and 11.09.2 are modified to harmonize obligations for the MCO and to add clarification.
Revision	1.24	September 1, 2018	Definition for “Agency Sensitive Information” is added. Definition for “Case-by-case Services” is added.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition for "Confidential Information" is modified to comply with Tex. Admin. Code Rule §202.1. Definition for "Information Resources" is added. Definition for "Qualified Mental Health Professional for Community Services" (QMHP-CS) is added. Section 4.12 is modified to address corrective action requested by CMS audit. 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 Informaiton Resources or data. Section 11.09.1 is modified to comply with Tex. Admin. Code Rule § 202.1.
Revision	1.25	January 1, 2019	Definition for "Court-Ordered Commitment " is deleted Definition for "Emergency Behavioral Health Condition" is modified
Revision	1.26	March 1, 2019	Section 10.18 is modified to comply with citation.
Revision	1.27	September 1, 2019	Global change for the phrase, "substance abuse" to "substance use disorder." Substance abuse is changed to substance use disorder to align with the language in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Texas Administrative Code Titles 40 and 25 transfering to Title 26 Definition for "Action" is renamed "Adverse Benefit Determination." Definition for "Adverse Determination" is deleted. Definition f for "Clean Claim" is modified, moved last paragraph to 8.1.18.5. Definition for "Complaint" is modified to align with MCO appeal standards. Definition "HHSC Office of the Inspector General" is added Definition for "Initial Contract Complaint" is added. Definition "Waste" is modified to comply with Texas Statute and TAC Section 4.02 is modified to add SIU to the List. Section 9.01 is modified requirement to retain certain documents.
Revision	1.28	March 1, 2020	Contract amendment did not revise Attachment A, "General Contract Terms & Conditions."
Revision	1.29	September 1, 2020	Definition for "Overpayment" is added Definition "Subcontractor" is modified to clarify Providers are not considered subcontractors.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definitions for "Transition Phase" is modified to provide clarity and expectations when contracts are terminated merged or acquired. Definitions for "Transition Plan" is added Definitions for "Turnover Phase" is modified to provide clarity and expectations when contracts are terminated merged or acquired. Defintions for "Turnover Plan" is modified to be consistent with all Contracts. Definitions for "Readiness Review" is modified to be consistent with all Contracts. Definition for "URAC/American Accreditation Health Care Commission is modified to be consistent across all contracts. ection 5.01 is modified to extend the timeframe to notify HHSC a Member is no longer Medicaid-eligible. Article 12 is modified to be consistent with newly awarded STAR PLUS contract. Section 12.03 is modified to clarify compliance with requirements of 42 CFR 438.710(b). Section 12:15 is deleted. Section 17.02 is modified to comply with TX Insurance Code. Section 17.03 is modified to comply with TDI Fidelity Bond.
Revision	1.30	March 1, 2021	Section 1.07 is added language required by 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 of 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	1.30.1	June 1, 2021	Contract amendment did not revise Attachment A, "General Contract Terms & Conditions."
Revision	1.31	September 1, 2021	Global change is made to maintain consistency with UMCM references among all contracts; Definitions is modified to edit Public Health Entity; Section 10.10 (b) is modified to add Experience Rebate for SFY 2022 only; and Section 17.02 (b) & (c) is added to specify timeline for retiring Performance Bonds after an audit is completed.

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Revision	1.32	March 1, 2022	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.33	September 1, 2022	Definition for "Behavioral Health" is added " to align with the TAC §353.2 Definition for Behavioral Health Services is modified to align with the TAC §353.2 Definition ECI is modified due to TAC rules for the ECI program having been moved to new section. Definition for "Service Coordination" is modified due to recommendation for change Definition for "Service Coordinator" is added. Definition for Service Management" is deleted Definition for "Substance Use Disorder" is added to align with the TAC §353.2 Definition "Telehealth" is added Definition "Telemedicine" is added Definition "Telepharmacy" is added Section 7.02(a) is modified to strengthening existing language. Section 10.10(b) is modified to update Fiscal Year date. Section 17.01(c)(1) is modified to strengthening existing language.
Revision	1.34	March 1, 2023	Contract amendment did not revise Attachment A, "General Contract Terms & Conditions."
Revision	1.35	September 1, 2023	Definition for "Telepharmacy" is deleted. Section 4.05 is modified to ensure OIG has access to complete, unredacted information. Section 4.08 is modified to ensure OIG has access to complete, unredacted information. Section 9.01 is modified to ensure OIG has access to complete, unredacted information. Section 9.02 is modified to ensure OIG has access to complete, unredacted information. Section 9.03 is modified to ensure OIG has access to complete, unredacted information. Section 9.05 is modified to ensure OIG has access to complete, unredacted information
Revision	1.36	March 1, 2024	Section 10.17 is modified to align the language in the clinician-administered drugs section with the level of detail

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			provided in the pharmacy section by specifying where the data for non-risk payments comes from as well as which FAC code to use on non-risk encounters

[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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Article 1. Introduction

Section 1.01 ***Purpose.***

The purpose of this Contract is to set forth the terms and conditions for the MCO's participation as a managed care organization in the CHIP Rural Service Area Programs administered by HHSC. Under the terms of this Contract, MCO will provide comprehensive health care 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 an established insurance provider that arranges for the delivery of Health Care Services, and will be fully authorized by TDI to conduct business as an HMO, EPP, or ANHC in the Service Area no later than 120 Days after the Contract's Effective Date;

(2) MCO and any 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 have 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 the needs and requirements of the State during the Contract term;

(4) MCO has had the opportunity to review and understand the State's stated objectives in entering into this Contract and, based on such 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 CHIP Rural Service Area Programs as described in the RFP, including the risk of non-appropriation of funds.

Accordingly, on the basis of the terms and conditions of this Contract, HHSC desires to engage MCO to perform the Services and provide the Deliverables described in this Contract under the terms and conditions set forth 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 and conditions 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 must 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 CHIP Rural Service Area Programs, 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 construed to be illegal or invalid, such interpretation will not affect the legality or validity of any of its other provisions. The illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if never incorporated in this Contract, but all other provisions will remain in full force and effect.

(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 such 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 such 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 where used in this Contract, are deemed to be followed by the words "without limitation."

(2) Any references to "sections," "appendices," "exhibits" or "attachments" are deemed to be references to sections, appendices, exhibits or attachments to this Contract.

(3) Any references to laws, rules, regulations, and manuals in this Contract are deemed 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

CHIP Rural Service Area Programs, and no other agency of the State 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 federal or state 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 CHIP Rural Service Area Program(s), as directed by HHSC.

Section 1.06 ***Legal Authority.***

(a) HHSC is authorized to enter into this Contract under Chapters 531 and 533, Texas Government Code; Section 2155.144, Texas Government Code; and/or Chapter 62, Texas Health & Safety Code. MCO is authorized to enter into this Contract pursuant to the authorization of its governing board or controlling owner or officer.

(b) The person or persons signing and executing this Contract on behalf of the Parties, or representing themselves as signing and executing this Contract on behalf of the Parties, warrant and guarantee that he, she, or they have been duly 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 and conditions have the meanings assigned below:

AAP means the American Academy of Pediatrics.

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

Account Name means the name of the individual who lives with the child(ren) and who applies for CHIP Rural Service Area Program coverage on behalf of the child(ren).

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

Acute Care Hospital means a Hospital that provides Acute Care services

Adjudicate means to deny or pay a Clean Claim.

Administrative Services see MCO Administrative Services.

Administrative Services Contractor see HHSC Administrative Services Contractor.

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 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 set forth 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 Medicaid Members' request 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 more than a five percent (5%) interest in the MCO (either directly, or through one or more intermediaries);

(2) in which the MCO owns or holds more than a five percent (5%) 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 or Contract means this formal, written, and legally enforceable contract between the Parties and all attachments and amendments thereto.

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 Uniform Managed Care Manual's "Cost Principles for Expenses."

Appeal means the formal process by which a Utilization Review agent addresses adverse determinations.

Approved Non-Profit Health Corporation (ANHC) means an organization formed in compliance with Chapter 844 of the Texas Insurance Code and licensed by TDI. See also **HMO**.

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 a 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.

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

Behavioral Health Hotline means the toll-free number operated by the MCO to handle routine behavioral-health related calls.

Behavioral Health 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 health care 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 a defined Rate Cell, 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.

Care Management is an administrative service performed by the MCO to facilitate development of a Care Plan and coordination of services among a Member's PCP, specialty providers and non-medical providers to ensure Members with Special Health Care Needs and/or Members needing high-cost treatment have access to, and appropriately utilize, Medically Necessary Covered Services and other services and supports.

Case Head means the head of the household that is applying for CHIP Rural Service Area Program coverage on behalf of one or more children.

Case-by-case Services means additional services for coverage beyond those specified in Attachments B-2 and B-2.1.

C.F.R. means the Code of Federal Regulations.

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

Children's Health Insurance Program or **CHIP** means the health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and administered by HHSC.

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.

CHIP Program means the State of Texas program in which HHSC contracts with the MCO to provide, arrange for, and coordinate Covered Services for enrolled CHIP Members.

CHIP Perinatal Program means the State of Texas CHIP program in which HHSC contracts with the MCO to provide, arrange for, and coordinate covered services for enrolled CHIP Perinate and CHIP Perinate Newborn Members. Although the CHIP Perinatal Program is part of the CHIP Program, for Contract administration purposes it is identified independently in this Contract.

CHIP Perinate means a CHIP Perinatal Program Member enrolled in the CHIP Perinatal Program prior to birth. At birth, a CHIP Perinate becomes a CHIP Perinate Newborn.

CHIP Perinate Newborn means a CHIP Perinate who has been born alive and whose family income meets the criteria for continued participation in the CHIP Perinatal Program (refer to Section 5.04 for information concerning eligibility).

CHIP Rural Service Area or **Service Area** means the geographic area, defined in Contract Attachment B-6, within which Covered Services are available to Members who reside within such geographic area.

CHIP Rural Service Area Programs or **MCO Programs** means the CHIP Program and CHIP Perinatal Program operated by the MCO pursuant to this agreement.

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

Clean Claim means a claim submitted by a Physician or provider for medical care or 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 defined in the appropriate 837-(claim type) encounter guides as follows:

(1) 837 Professional Combined Implementation Guide;

(2) 837 Institutional Combined Implementation Guide;

(3) 837 Professional Companion Guide; or

(4) 837 Institutional Companion Guide.

Clinical Prior Authorization or Clinical PA means a drug review process authorized by HHSC that is conducted by a healthcare MCO prior to dispensing a drug. All HHSC authorized Clinical PAs are identified on the Medicaid Vendor Drug website. 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, formerly known as the Health Care Financing Administration (HCFA), which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid and CHIP.

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 youth. CRCGs develop individual service plans for children and adolescents 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.

Competent Interpreter means a person who is proficient in both English and the other language being used, 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 allowed by law) proposed by the MCO to make an authorization decision. There is no exception for the reporting of Initial Contact Complaints.

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.

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:

(1) Education records as defined in the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g; 34 C.F.R. Part 99

(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.

Consolidated FSR Report, or **Consolidated Basis** means FSR reporting results for all Programs and all SDAs 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 or **Agreement** means this formal, written, and legally enforceable contract between the Parties and all attachments and amendments thereto.

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

Contractor or **MCO** means the contractor that is a party to this Contract, and is

(1) an Exclusive Provider Benefit Plan (EPP) licensed by the TDI and authorized to do business in the State of Texas as an EPP in accordance with 28 Tex. Admin. Code §§ 3.9201 – 3.9212 and Texas Insurance Code Chapter 1701;

(2) an HMO licensed by TDI as an HMO in accordance with Chapter 843 of the Texas Insurance Code; or

(3) a certified Approved Non-Profit Health Corporation (ANHC) formed in compliance with Chapter 844 of the Texas Insurance Code.

Co-payment (CHIP Program only) means the amount that a CHIP Member is required to pay when utilizing certain benefits within the health care plan. Once the co-payment is made, further payment is not required from the CHIP Member.

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

Covered Services means Health Care Services the MCO must arrange to provide to Members, including all services required by the Contract and state and federal law, and all Value-added Services negotiated by the Parties. Covered Services include Behavioral Health Services.

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

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.

DADS means the Texas Department of Aging and Disability Services or its successor agency (formerly Department of Human Services).

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

Date of Disenrollment means the last day of the last month for which MCO receives payment for a Member.

Day means a calendar day unless specified otherwise.

Default Enrollment means the processes established by HHSC to assign an enrollee who has not selected an MCO to an MCO, per 1 Tex. Admin. Code § 370.303.

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

Delivery Supplemental Payment means a one-time per pregnancy supplemental payment for the CHIP Rural Service Area Programs.

Dental Contractor means the contractors that provide covered services for Medicaid and CHIP clients under the Texas Dental Program.

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

Discharge means a formal release of a Member from an Inpatient Hospital stay when the need for continued care at an inpatient level has concluded. Movement or transfer from one Acute Care Hospital or Long Term Care Hospital /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.

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, and/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.

DSHS means the Texas Department of State Health Services or its successor agency (formerly Texas Department of Health and Texas Department of Mental Health and Mental Retardation).

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

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 the first day of the month for which the MCO has received payment for a Member.

Eligibles means CHIP Rural Service Area Program eligibles residing in the Service Area and eligible to enroll in a CHIP Rural Service Area 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 and/or medical attention without which Members would present an immediate danger to themselves or others, or

(2) 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 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, whom 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) in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Emergency Services means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-stabilization Care Services.

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. This also includes Value-added Services.

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. The data will be submitted by the MCO in accordance with HHSC's required format and required data elements for Medicaid and CHIP MCOs.

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, Diagnosis and Treatment program contained at 42 U.S.C. 1396d(r). The name has been changed to Texas Health Steps (THSteps) in the State of Texas.

Exclusive Provider Benefit Plan (or EPP) an Exclusive Provider Benefit Plan (EPP) licensed by the TDI and authorized to do business in the State of Texas as an EPP in accordance with 28 Tex. Admin. Code §§ 3.9201 – 3.9212 and Texas Insurance Code Chapter 1701.

Exclusive Provider Services means medical, surgical and supplementary Health Care Services that are covered under a group contract only when rendered by an exclusive provider.

Executive Commissioner means the Executive Commissioner of HHSC.

Experience Rebate means the portion of the MCO's Net Income Before Taxes that is returned to the State in accordance with Article 10 ("Terms and Conditions of Payment").

Expiration Date means the expiration date of this Contract.

External Quality Review Organization (EQRO) means the entity that contracted with HHSC to provide external review of access to and quality of healthcare provided to Members of the CHIP Rural Service Area Programs.

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 (FFS) means the traditional Health Care Services payment system under which providers receive a payment for each unit of service, after the service is provided, according to rules adopted pursuant to Chapters 62 and 63, Texas Health & Safety Code.

Financial Statistical Report (see FSR below).

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.

FQHC means a Federally Qualified Health Center, certified by CMS to meet the requirements of

§1861(aa)(3) of the Social Security Act 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.

FSR Reporting Period 11 means the 12-month period of time beginning on September 1, 2010, and ending on August 31, 2011. This is the first FSR Reporting Period under this contract.

FSR Reporting Period 12A means the 6-month period of time beginning on September 1, 2011, and ending on February 29, 2012.

FSR Reporting Period 12/13 means the 18-month period of time beginning on March 1, 2012, and ending on August 31, 2013.

FSR Reporting Period 14 means the 12-month period of time beginning on September 1, 2013, and ending on August 31, 2014.

FSR Reporting Period 15 means the 12-month period of time beginning on September 1, 2014, and ending on August 31, 2015.

General Hospital means an establishment that:

(1) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy; and

(2) regularly maintains, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent.

General Hospitals include Acute Care Hospitals and Children's Hospitals. See Title 25, Texas Administrative Code, Chapter 133.

Habilitative and Rehabilitative Services means Health Care Services described in **Attachments B-2 and B-2.1,** ("Covered Services") that may be required by children who fail to reach (habilitative) or have lost (rehabilitative) age appropriate developmental milestones.

Health and Human Services Commission or **HHSC** means the administrative agency within the executive department of Texas state government established under Chapter 531, Texas Government Code, or its designee, including, but not limited to, the HHS Agencies.

Health Care Services means 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.

Health Maintenance Organization (HMO) means an insurer licensed by TDI as a Health Maintenance Organization in accordance with Chapter 843 of the Texas Insurance Code.

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.

Healthy Texas Women Program means the program that provides primary healthcare services, including family planning services and health screenings, to eligible women under 1 Tex. Admin. Code Chapter 382, Subchapter A.

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

HHS Agency means the Texas health and human service agencies subject to HHSC's oversight under Chapter 531, Texas Government Code, and their successor agencies.

HHSC Administrative Services Contractor (ASC) means an entity under contract with HHSC performing MCO administrative services functions, including Member enrollment functions, for the CHIP Rural Service Area Programs.

HHSC Office of the Inspector General. in accordance with Texas Government Code § 531.102 HHSC's Office of Inspector General is responsible for the prevention, detection, audit, inspection, review, and investigation of Fraud, Waste, and Abuse in the provision and delivery of all health and human services in the State, including services through any state-administered health or human services program that is wholly or partly federally funded or services provided by the Department of Family and Protective Services, and the enforcement of State law relating to the provision of those services.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (August 21, 1996), as amended or modified.

Home and Community Support Services Agency or HCSS means an entity licensed to provide home health, hospice, or personal assistance services provided to individuals in their own home or independent living environment as prescribed by a physician or individualized service plan. Each HCSS must provide clients with a plan of care that includes specific services the agency agrees to perform. The agencies are licensed and monitored by DADS or its successor.

Hospital means a licensed public or private institution as defined by Chapter 241, Texas Health and Safety Code, or in Subtitle C, Title 7, Texas Health and Safety Code.

Indian Health Care Provider (IHCP) has the meaning assigned to it in 42 C.F.R. § 438.14. Accordingly, the phrase 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).

Individual Family Service Plan (IFSP) means the plan for services required by the Early Childhood Intervention (ECI) Program and developed by an interdisciplinary team.

Individual Service Plan (ISP) means an individualized and person-centered plan in which a Member enrolled in the STAR+Plus Home and Community Based Services program operated by the MCO, with assistance as needed, identifies and documents his or her preferences, strengths, and health and wellness 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. The ISP is supported by the results of the Member's program-specific assessment and must meet the requirements of 42 C.F.R. § 441.301

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 Contact Complaint means a Complaint that is resolved within one business day.

Initial Contract Period means the Effective Date of the Contract through August 31, 2011.

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.

JCAHO means Joint Commission on Accreditation of Health Care Organizations.

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 ("Contract Administration and Management").

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.

Limited English Proficient (LEP) has the meaning assigned to it in 42 C.F.R. §438.10. Accordingly, the phrase means potential Members and Members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.

Linguistic Access means translation and interpreter services, for written and spoken language to ensure effective communication. Linguistic access includes sign language interpretation, and the provision of other auxiliary aids and services to persons with disabilities.

Local Behavioral Health Authority (LBHA) has the meaning assigned in Texas Health and Safety Code § 533.0356.

Local Health Department means a local health department established pursuant to Health and Safety Code, Title 2, Local Public Health Reorganization Act §121.031.

Local Mental Health Authority (LMHA) means an entity within a specified region responsible for planning, policy development, coordination, and resource development and allocation and for supervising and ensuring the provision of mental health care services to persons with mental illness in one or more local service areas.

Major Population Group means any population, which represents at least 10% of the Member population in the Service Area.

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.

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 but not limited to third party administrator, Network administration, and claims processing);
   b) delegated Networks (including but not limited to Behavioral Health, dental, pharmacy, and vision);
   c) management services (including management agreements with parent)
   d) reinsurance;
   e) Disease Management;
   f) pharmacy benefit management (PBM) or pharmacy administrative services; or
   g) call lines (including nurse and medical consultation); 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 SDA, 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 or **Major Subcontractor** means any entity with a Material Subcontract with the MCO. For purposes of this Agreement, Material Subcontractors do not include Providers in the MCO's Provider Network. Material Subcontractors may include, without limitation, Affiliates, subsidiaries, and affiliated and unaffiliated third parties.

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

(1) enroll with the MCO, or any of the MCO's or its affiliate's other managed care plans; or

(2) not enroll in, or to disenroll from, another MCO.

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

MCO or Contractor means the contractor that is a party to this Contract, and authorized by TDI to do business in the State of Texas as an EPP benefit plan issued by an insurance company in accordance with 28 TAC §§ 3.9201 – 3.9212 and Texas Insurance Code Chapter 1701; an HMO licensed by TDI as an HMO in accordance with Chapter 843 of the Texas Insurance Code; or a certified Approved Non-Profit Health Corporation (ANHC) formed in compliance with Chapter 844 of the Texas Insurance Code.

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; or MIS 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 the MCO or a Utilization Review agent addresses the MCO's Adverse Benefit Determination.

MCO Internal Appeal and Complaint System means the process the MCO implements to handle MCO Internal Aappeals of a Complaint or Adverse Benefit Determination, as well as the process to collect and track information about the MCO Internal Appeal of a Complaint or Adverse Benefit Determination.

MCO Programs or **CHIP Rural Service Area Programs** means the State of Texas programs in which HHSC contracts with a contractor to provide, arrange for, and coordinate Covered Services to CHIP Program Members.

Medicaid means the medical assistance entitlement program authorized and funded pursuant to Title XIX, Social Security Act (42 U.S.C. §1396 *et seq*.) and administered by HHSC.

Medical Home has the meaning assigned to a patient-centered Medical Home in Texas Government Code § 533.0029(a).

Medically Necessary has the meaning defined in 1 Tex. Admin. Code § 370.4.

Member means any child who has met CHIP Rural Service Area Program eligibility criteria, and is enrolled in the MCO under a CHIP Rural Service Area Program.

Member Materials means all written materials produced or authorized by the MCO and distributed to Members or potential members containing information concerning the CHIP Rural Service Area Programs. Member Materials include, but are not limited to, Member ID cards, Member handbooks, Provider directories, and Marketing Materials.

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(s) with Special Health Care 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 health care personnel.

MIS means Management Information System.

National Committee for Quality Assurance (NCQA) means the independent organization that accredits managed care organizations, managed Behavioral Health organizations, and accredits and certifies disease management programs. HEDIS and the Quality Compass are registered trademarks of NCQA.

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.

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

Network or Provider Network means all Providers that have a contract with the MCO, or any Subcontractor, for the delivery of Covered Services to the MCO's Members under the Contract.

Network Provider or Provider means an appropriately 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.

Non-capitated Services means the services that are not Covered Services provided by the MCO, but may be available to Members through alternative sources.

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

OB/GYN means obstetrician-gynecologist.

Open Panel means Primary Care Providers who are accepting new patients for the Service Area.

Open Practice means a specialty Provider who is accepting new patients, usually through the referral process.

Operational Start Date means the first day on which the 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 for the Service Area. The Operations Phase begins on the Operational Start Date.

Outpatient Hospital Services means diagnostic, therapeutic, and rehabilitative services that are provided to Members in an organized medical facility, for less than a 24-hour period, by or under the direction of a physician.

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 to 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 to under Title XIX or Title XXI of the Act.

Parties means HHSC and MCO, collectively.

Party means either HHSC or MCO, individually.

Pediatric Specialists means physicians who are board eligible/board certified in pediatrics by the American Board of Pediatrics.

Pediatric Sub-specialists and Pediatric Surgical Specialists means physicians who are board eligible/board certified and/or have pediatric qualifications under their respective American Boards of Pediatrics, Surgery, or Psychiatry/Neurology.

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

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.

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 means Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized 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), together known as the Affordable Care Act (ACA).

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

Prevalent Language has the meaning assigned to it in 42 C.F.R. § 438.10. Accordingly, the phrase 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 Physician or Primary Care Provider (PCP) means a physician or provider who has agreed with the MCO to provide a Medical Home to Members and who is responsible for providing initial and primary care to Members, maintaining the continuity of Member care, and initiating referral for care.

Program means a managed care program operated by HHSC. Depending on the context, the term may include one or more of the following: STAR, STAR+PLUS, STAR Health, CHIP, Children's Medicaid Dental Services or CHIP Dental Services.

Proposal means the proposal submitted by the MCO in response to the RFP.

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

Provider Contract means a contract entered into by a direct provider of Health Care Services and the MCO or an intermediary entity.

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

Provider Network or Network means all Providers that have contracted with the MCO for the provision of Health Care Services to CHIP and/or CHIP Perinatal Program Members.

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 UseDisorder 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 Member safety provided in a restricted environment. See Title 26, Texas Administrative 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 (or Quality Assurance) means a system to continuously examine, monitor and revise processes and systems that support and improve administrative and clinical functions.

Rate Cell means a Population Risk Group for which a Capitation Rate has been determined.

Rate Period 1 means the 12-month period beginning on September 1, 2010 and ending on August 31, 2011.

Rate Period 2 means the 12-month period beginning on September 1, 2011 and ending on August 31, 2012.

Rate Period 3 means the 12-month period beginning on September 1, 2012 and ending on August 31, 2013. For purposes of rate setting only, Rate Period 3 will be divided into two sub-periods: September 1, 2012 to May 31, 2013, and June 1, 2013 to August 31, 2013.

Rate Period 4 means the 12-month period beginning on September 1, 2013 and ending on August 31, 2014.

Rate Period 5 means the 12-month period beginning on September 1, 2014 and ending on August 31, 2015.

Readily Accessible has the meaning assigned to it in 42 C.F.R. § 438.10. Accordingly, the phrase 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.

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.

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.

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

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

Revenue means all revenue received by the MCO pursuant to 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 shall 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 the **Uniform Managed Care Manual's** "Cost Principles for Expenses."

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

Routine Care means health care for covered preventive and medically necessary Health Care 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 1861(aa)(1) of the Social Security Act and approved for participation in the Texas Medicaid Program.

Scope of Work means the description of Services and Deliverables specified in this Contract, and all attachments and agreed modifications thereto.

SDX means State Data Exchange.

Severe and Persistent Mental Illness (SPMI) means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another vehavioral 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 the 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.

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

Service Coordinator means the person with primary responsibility for providing Service Coordination and care management to Members

Service Plan (SP) means an individualized and person-centered plan in which an individual, with assistance as needed, identifies and documents his or her preferences, strengths, and needs in order to

develop short-term objectives and action steps to ensure personal outcomes are achieved within the most integrated setting by using identified supports and services. The Service Plan which is described in 8.1.12.4 supported by the results of the Member's program-specific assessment.

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

Significant Traditional Provider or STP (for CHIP) means all DSHs in the Service Area, and PCPs participating in the CHIP Rural Service Area Programs prior to the Effective Date of this Contract.

Skilled Nursing Facility Services means services provided in a facility that provides nursing or rehabilitation services and Medical supplies and use of appliances and equipment furnished by the facility.

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

Specialty Hospital means any inpatient Hospital that is not a General Hospital.

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

SSA means the Social Security Administration.

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 or STAR Program stands for the State of Texas Access Reform, and means the State of Texas Medicaid managed care program in which HHSC contracts with MCOs to provide, arrange for, and coordinate preventive, primary, and Acute Care Covered Services to non-disabled children and families, and pregnant women.

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 other 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 such person or entity directly or indirectly through one or more intermediaries.

Substance Use Disorder 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 described in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance Use Disorders.

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.

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

TDI means the Texas Department of Insurance.

Telehealth has the meaning defined at Section 531.001(7) of the Government Code.

Telemedicine has the meaning defined at Section 531.001(8) of the Government Code.

Temporary Assistance to Needy Families (TANF) means the federally funded program that provides assistance to single parent families with children who meet the categorical requirements for aid. This program was formerly known as the Aid to Families with Dependent Children (AFDC) 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 TAC §§ 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.

TP 13 means Type Program 13, which is a Medicaid program eligibility type assigned to persons determined eligible for federal SSI assistance by the Social Security Administration (SSA). If a subsequent eligibility system uses a different identifier for this eligibility type, references to TP 13 include the subsequent identifier.

Transfer means the movement of the Member from one Acute Care Hospital or Long Term Care Hospital/facility and readmission to another Acute Care Hospital or Long Term Care Hospital/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.

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. The Turnover Plan describes MCO's policies and procedures that will assure:

(1) the least disruption in the delivery of Health Care Services to those Members who are enrolled with the MCO during the transition to a subsequent health plan;

(2) cooperation with HHSC and the subsequent health plan in notifying Members of the transition and of their option to select a new plan, as requested and in the form required or approved by HHSC; and

(3) cooperation with HHSC and the subsequent health plan in transferring information to the subsequent health plan, as requested and in the form required or approved by HHSC.

Uniform Managed Care Manual or **UMCM** means the manual published by or on behalf of HHSC that contains policies and procedures required of all managed care organizations participating in HHSC's managed care programs, including the MCO. 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 twenty-four (24) hours but which 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 twenty-four (24) hours by a Provider 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 Health Care 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 Attachments B-2, "CHIP Covered Services", and B-2.1, "CHIP Perinatal Program Covered Services". Value-added Services may be actual Health Care 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.

Article 3. General Terms & Conditions

Section 3.01 ***Contract elements.***

(a) Contract documentation.

The Contract between the Parties will consist of the 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 Contract, and all amendments thereto;

(2) **Attachment A** to the Contract – "General Contract Terms and Conditions," and all amendments thereto;

(3) **Attachment B** to the Contract – "Scope of Work/Performance Measures," and all attachments and amendments thereto;

(4) the **Uniform Managed Care Manual (UMCM)**, and all attachments and amendments thereto;

(5) **Attachment C** to the Contract **–** "MCO's Proposal," and all attachments and amendments thereto.

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 extension(s).

Section 3.03 ***Funding.***

This Contract is expressly 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, withdrawal, or failure of funding to 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 such 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 right, power, or duty so imposed or conferred is possessed and exercised by the Executive Commissioner unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of HHSC. The Executive Commissioner will reduce any such delegation of authority to writing and provide a copy to MCO on request.

Section 3.05 ***No waiver of sovereign immunity.***

The Parties expressly 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 such failure or delay is due to a Force Majeure Event. The existence of such 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 (1) electronic copy of any information described in Subsection 3.07(a) prior to public release. MCO will provide additional copies, including hard copies, at the request of HHSC.

(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 such information, or

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

(3) Member Materials (the MCO must comply with the UMCM's provisions 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 pursuant to the Contract.

(b) Assignment by HHSC.

MCO understands and agrees HHSC may in one or more transactions assign, pledge, transfer, or hypothecate 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, without limitation, 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 thereof. MCO will reasonably cooperate with such 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 pursuant to 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").

(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 and/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 right to terminate all or part of the Contract, as set forth in Article 12 ("Remedies and Disputes").

Section 3.11 ***RFP errors and omissions.***

MCO will not take advantage of any errors and/or omissions in the RFP or the resulting Contract. MCO must promptly notify HHSC of any such errors and/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 such 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 ***Time of the essence.***

In consideration of the need to ensure uninterrupted and continuous CHIP Rural Service Area Program performance, time is of the essence in the performance of the Scope of Work under the Contract.

Section 3.15 ***Notice***

(a) Any notice or other legal communication required or permitted to be made or given by either Party pursuant to 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 the Contract. In addition, legal notices must be sent to the Legal Contact identified in the Contract.

(d) Routine communications that are administrative in nature will be provided in a manner agreed to by the Parties.

Article 4. Contract Administration & 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 are to 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 for each MCO Program included within the scope of the Contract:

(1) Member Services;

(2) Management Information Systems;

(3) Claims Processing,

(4) Provider Network Development and Management;

(5) Benefit Administration and Utilization and Care Management;

(6) Quality Improvement;

(7) Behavioral Health Services;

(8) Financial Functions;

(9) Reporting;

(10) 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);

(11) Executive Director(s) for applicable HHSC MCO Program(s) as defined in Section 4.03 ("Executive Director");

(12) Medical Director(s) for applicable HHSC MCO Program(s) as defined in Section 4.04 ("Medical Director"); and

(13) Special Investigative Unit (SIU).

(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.

Section 4.03 ***Executive Director.***

(a) The MCO must employ a qualified individual to serve as the Executive Director for the MCO Programs. Such Executive Director must be employed full-time by the MCO, be primarily dedicated to the CHIP Rural Service Area Programs, 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, but are not limited to, the following:

(1) ensuring the MCO's compliance with the terms of the Contract, including securing and coordinating resources necessary for such 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 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 representative(s) 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 theMedical Director for the MCO Programs. The Medical Director must be currently licensed in Texas under the Texas Medical Board as an M.D. or D.O. with no restrictions or other licensure 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, 7 Days a week, for Utilization Review decisions. The Medical Director, and his/her designee, must either possess expertise with Behavioral Health Services, or ready access to such 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 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:

(1) a physician that meets the qualifications for a Medical Director, as described in subparts (a) through (c), above; or

(2) for prior authorization determinations for outpatient pharmacy benefits, a Texas-licensed pharmacist working under the direction of the Medical Director, provided such delegation is included in the MCO's TDI-approved utilization review plan.

(e) The Medical Director, or his or her physician designee, must make determinations regarding Utilization Review appeals, including appeals of prior authorization denials for outpatient pharmacy benefits.

Section 4.05 ***Responsibility for MCO Personnel and Subcontractors.***

(a) MCO employees and Subcontractor employees will not in any sense be considered employees of HHSC or the State of Texas, but will be considered for all purposes as the MCO's employees or its Subcontractor's employees, as applicable.

(b) Except as expressly provided in this Contract, neither MCO nor any of MCO's employees or Subcontractors may act in any sense 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, but not limited to, 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 and hold harmless the State from any and all claims asserted against the State arising out of such 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, but not limited to, tenure rights, medical and hospital care, sick and annual/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 pursuant to 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 such judgments rendered against MCO or its Subcontractors.

Section 4.06 ***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 CHIP Rural Service Area 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, but not limited to 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 and/or Deliverables under this Contract or other delivery of information to HHSC or other agencies' investigators or legal staff.

Section 4.07 ***Conduct of MCO personnel.***

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

(1) comply with applicable State rules and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; 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 such conduct. Upon receipt of such 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 such 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 the members of the HHSC's staff. In such 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 the event of any such replacement so as not to disrupt the overall project schedule.

(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 and/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 4.08 ***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 such obligations, services, and functions were performed by MCO's employees, and for purposes of this Contract such work will be 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 found by HHSC to be unacceptable and unable to meet the requirements of the Contract, and to object to the selection of a 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 HMO 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, the MCO has shown good cause for a shorter notice period.

(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 CHIP Rural Service Area Program;

(4) an existing Material Subcontractor changes location 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 Article 4 ("Submission Requirements"). Refer to **Attachment B-1 Sections 8.1.1.2 and 8.1.18** for additional information regarding Readiness Reviews during the Contract Period.

(d) MCO must not disclose Confidential Information of HHSC or the State of Texas to a Subcontractor unless and until such Subcontractor has agreed in writing to protect the confidentiality of such 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 of any and all charges resulting from the Contract.

(f) Except as provided herein, all Subcontracts must be in writing and must provide HHSC the right to examine the Subcontract and complete and unredacted originals or copies of all Subcontractor records and information 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 without limitation 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 complete and unredacted originals or copies of all records and information 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 & 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. The MCO must allow HHSC and the Office of the Attorney General to examine the Subcontract or agreement and complete and unredacted originals or copies of all related records and information.

(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 five Business Days after execution or amendment.

(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 attachment, 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 4.08 to HHSC, or to the Office of the Attorney General, if requested, at no cost.

Section 4.09 ***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 4.10 ***This Section Intentionally Left Blank***

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 such 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 software and hardware so developed or acquired.

(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 but not limited to 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 determinesthat 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 pursuant to 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 republic of the United States of America, including of any of the 48 coterminous states in North America, 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 republic of the United States of America, including of any of the 48 coterminous states in North America, 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 have remote access to HHSC information, systems, or Deliverables from a location outside the United States.

(d) Performance of Work under Agreement.

(1) Subject to the exceptions specified in paragraph (e) of this Section 4.11, MCO and all subcontractors, vendors, agents, and service providers of or for MCO must perform all services under the Agreement, including all tasks, functions, and responsibilities assigned and delegated to MCO under this Agreement, within the United States.

(A) This obligation includes, but is not limited to, all Services, including but not limited to information technology services, processing, transmission, storage, archiving, data center services, disaster recovery sites and services, customer support, medical, dental, laboratory and clinical services.

(B) All custom software prepared for performance of this Agreement, and all modifications of custom, third party, or vendor proprietary software, must be performed within the United States.

(2) Subject to the exceptions specified in paragraph (e) of this Section 4.11, 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 and/or liquidated damages in accordance with this Agreement.

(2) HHSC may terminate the Agreement with notice to MCO at least one Day before the effective date of such 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 (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 CFR §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

Section 5.01 ***Eligibility Determination***

The State or its designee will make eligibility determinations for the CHIP Rural Service Area Programs.

Section 5.02 ***Member Enrollment & Disenrollment.***

(a) HHSC or the HHSC Administrative Services Contractor will enroll and disenroll eligible individuals in the CHIP Rural Service Area Programs. The HHSC Administrative Services Contractor will use HHSC's default assignment methodologies, as described in 1 Tex. Admin. Code § 370.303, to enroll individuals who do not select an MCO or PCP. To enroll in an CHIP Rural Service Area Program, the Member's permanent residence must be located within the CHIP Rural Service Area Programs Service Area. The MCO is not allowed to induce or accept disenrollment from a Member. The MCO must refer the Member to the HHSC Administrative Services Contractor.

(b) 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 such enrolling Members remain enrolled with the MCO beyond the minimum mandatory enrollment periods established for each CHIP Rural Service Area Program. The MCO has no ownership interest in its Member base, and therefore cannot sell or transfer this base to another entity.

(c) The HHSC Administrative Services Contractor will electronically transmit to the MCO new Member information and change information applicable to active Members.

(d) As described in the following Sections, depending on the CHIP Rural Service Area Program, special conditions may also apply to enrollment and span of coverage for the MCO.

(i) Members taken into conservatorship by the Department of Family and Protective Services (DFPS) will be disenrolled from the MCO, effective the date of conservatorship, and enrolled in the STAR Health Program (formerly known as the Comprehensive Healthcare Program for Foster Care).

Section 5.03 ***CHIP Program eligibility, enrollment, and disenrollment.***

(a) Term of coverage.

HHSC or the Administrative Services Contractor, on HHSC's behalf, determines CHIP Program eligibility. HHSC or the Administrative Services Contractor will enroll and disenroll eligible individuals into and out of the CHIP. A child who is CHIP Program -eligible will have twelve (12) months of coverage. Should a Member become ineligible for CHIP, HHSC will disenroll the Member from the managed care plan. If

an MCO becomes aware that a Member is no longer CHIP-eligible (for example the Member has moved outside of the state or is deceased) or that Member has moved outside of the MCO's service area, the MCO must inform HHSC within 10 Business Days.

(b) Pregnant Members and Infants.

(1) If notified of a CHIP Member's pregnancy prior to birth, HHSC or the HHSC Administrative Contractor will refer pregnant the CHIP Member to Medicaid for an eligibility determination (with the exception of a Legal Permanent Resident or other legally qualified alien barred from Medicaid due to federal eligibility restrictions). Those CHIP Members who are determined to be Medicaid Eligible will be disenrolled from the MCO. Medicaid coverage will be coordinated to begin after CHIP eligibility ends to avoid gaps in health care coverage.

(2) A pregnant CHIP Member's facility and professional costs associated with the delivery will be covered by CHIP in accordance with Attachment B-2, "CHIP Covered Services." This includes the post-delivery costs for the newborn's care while in the facility, as described in Attachment B-2, "CHIP Covered Services." HHSC or the HHSC Administrative Services Contractor will set the pregnant CHIP Member's eligibility expiration date at the later of (1) the end of the second month following the month of the pregnancy termination or the baby's birth or (2) the Member's original eligibility expiration date.

HHSC or the Administrative Services Contractor will screen the newborn's eligibility for Medicaid, and then CHIP, if the newborn is not eligible for Medicaid. If the newborn is eligible for CHIP, HHSC or the Administrative Services Contractor will enroll the newborn in the mother's CHIP plan prospectively, following standard cut-off rules. The newborn's CHIP eligibility ends when the mother's CHIP eligibility expires, as described above.

Section 5.04 ***CHIP Perinatal Program eligibility, enrollment, and disenrollment***

(a) HHSC or the HHSC Administrative Contractor will electronically transmit to the MCO new CHIP Perinate Member information based on the appropriate CHIP Perinate or CHIP Perinate Newborn Rate Cell. There is no waiting period for CHIP Perinatal Program Members.

(b) A CHIP Perinate born on or after September 1, 2010, and who lives in a family with an income at or below below the Medicaid eligibility threshold will be deemed eligible for 12 months of continuous Medicaid coverage (beginning on the date of birth). A CHIP Perinate will continue to receive coverage through the CHIP Perinatal Program as a "CHIP Perinate Newborn" if: (1) born before September 1, 2010, and (2) if born on or after September 1, 2010, to a family with an income above the Medicaid eligibility threshold. A CHIP Perinate Newborn is eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

(c) Once a CHIP Perinate Newborn Member's coverage expires, the child will be added to his or her siblings' active CHIP program case. If there is no active CHIP program case, then in the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program Members' information.

Section 5.05 ***Span of Coverage.***

If a CHIP Member's or CHIP Perinate Member's Effective Date of Coverage occurs while the Member is confined in a Hospital, MCO is responsible for the CHIP Member's costs of Covered Services beginning on the Effective Date of Coverage. If a CHIP Member or CHIP Perinate Member is disenrolled while the Member is confined in a Hospital, the MCO's responsibility for the Member's costs of Covered Services terminates on the Date of Disenrollment. If a CHIP Perinate Newborn is disenrolled while confined in a Hospital, the MCO's responsibility for the CHIP Perinate Newborn's costs of Covered Services terminates on: (1) the effective date of Medicaid eligibility, if the CHIP Perinate Newborn is disenrolled from the CHIP Perinatal Program based on a determination of Medicaid eligibility, or (2) on the Date of Disenrollment, if the CHIP Perinate Newborn is disenrolled from the CHIP Perinatal Program for any other reason.

(a) Effective Date of SSI Status.

In accordance with Section 10.10, SSI status is effective on the date the State's eligibility system identifies a CHIP or CHIP Perinatal Program Member as Type Program 13 (TP 13). 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 CHIP or CHIP Perinatal Program Member as TP13, following standard eligibility cut-off rules, HHSC will allow the Member to prospectively move to Medicaid FFS.

HHSC will not retroactively disenroll a Member from the CHIP or CHIP Perinatal Programs.

Section 5.06 ***Modified Default Enrollment Process***

Under the circumstances described in HHSC's administrative rules at 1 Tex. Admin. Code § 370.303, HHSC may implement a modified default enrollment process to equitably assign enrollees who have not selected an MCO. To the extent possible, HHSC will make assignments based on an enrollee's prior history with and geographic proximity to a PCP. HHSC will determine the length of the modified default enrollment period by considering factors such as MCO market share, viability, and Member choice. HHSC reserves

the right to extend the modified default period, or implement additional modified default periods, as it determines necessary and with prior written notice to impacted MCOs.

Article 6. Service Levels & 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 Attachment B-5 ("Deliverables/Liquidated Damages Matrix");

(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.

Article 7. Governing Law & 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 Texas law. 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 provisions set forth in this Contract, all provisions of state and federal laws, rules, regulations, federal waivers, policies and guidelines, and any court-ordered consent decrees, settlement agreements, or other court orders that govern the performance of the Scope of Work including, but not limited to, all applicable provisions of the following:

(1) Title XXI of the Social Security Act;

(2) Chapters 62, 63, and 109 of the Texas Health and Safety Code;

(3) Chapter 531, of the Texas Government Code;

(4) 42 C.F.R. Parts 447 and 457, as applicable;

(5) 45 C.F.R. Parts 74

(6) 45 C.F.R. Parts 92;

(7) 48 C.F.R. Part 31 and 2 C.F.R. Part 200;

(8) 1 Tex. Admin. Code Part 15, Chapters 361, 370, 391, and 392;

(9) 28 Tex. Admin. Code §§ 3.92201 *et seq*.;

(10) The Patient Protection and Affordable Care Act ("PPACA"; Public Law 111-148);

(11) The Health Care and Education Reconciliation Act of 2010 ("HCERA"; Public Law 111-152);

(12) 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"); and

(13) The Immigration and Nationality Act (8 U.S.C. §§ 1101 *et seq*.) and all subsequent immigration laws and amendments; and

(14) An MCO is prohibited from requiring a Network Provider who is a governmental entity to agree to indemnify the MCO if such indemnification by the governmental entity is prohibited by law .

(b) The Parties acknowledge that the federal and/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 CHIP Rural Service Area 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 such changes. The Parties further acknowledge that MCO was selected, in part, because of its expertise, experience, and knowledge concerning applicable Federal and/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 such changes and must work with HHSC to identify the impact of such 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) 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.

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

(f) 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 such law, regulation, code, ordinance, or policy.

Section 7.03 ***This Section Intentionally Left Blank***
Section 7.04 ***This Section Intentionally Left Blank***
Section 7.05 ***Compliance with state and federal anti-discrimination laws.***

(a) MCO agrees to comply with State and federal anti-discrimination Laws, including:

(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.

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 its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16, as applicable. 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 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 ten Days after receipt of a complaint. Notice provided pursuant to this section 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 7.06 ***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.*).

(e) Safe Drinking Water Act of 1974.

MCO must comply with applicable provisions relating to the protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (21 U.S.C. § 349; 42 U.S.C. §§ 300f to 300j-9).

Section 7.07 ***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 pursuant to 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 the HITECH Act, then HHSC may require the MCO to provide this 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 7.08 ***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 8.1.17.2, the MCO must submit an HSP for HHSC's approval during the Transition Phase, and maintain the HSP thereafter.

(2) MCO must report to HHSC's contract manager and HUB Office monthly, in the format required by Chapter 5.4.4.5 of the UMCM, 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 7.09 ***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 & 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, the effect of which is to alter 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. Such modifications or alterations must be in writing and signed by individuals with authority to bind the Parties, equitably adjust the terms and conditions 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 and conditions.

(b) MCO must respond to HHSC's proposed modification within the timeframe 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 HHSC UMCM (a change that materially and substantively alters the MCO's ability to fulfill its obligations under the Contract). The UMCM, and all modifications thereto made during the Contract Term, is incorporated by reference into this Contract. HHSC will provide MCO with a reasonable amount of time to comment on such changes, generally at least ten 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.

(b) The Parties agree to work in good faith to resolve disagreements concerning material and substantive changes to the HHSC 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 such changes will be incorporated into the HHSC UMCM. If the MCO has raised an objection to a material and substantive change to the HHSC UMCM and submitted a notice of termination in accordance with Section 12.04(d) ("Notice of Intent to Terminate"), 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 ***Required compliance with amendment and modification procedures.***

No different or additional Services, Deliverables, 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, Deliverables, work or products that are not authorized by a properly executed Contract amendment or modification.

Section 8.07 ***CMS approval of amendments***

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

Article 9. Audit & 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 investigate, audit, inspect, and review complete and unredacted originals or copies of all records and information related to this Contract of the MCO or to contracts between the MCO and MCO's Subcontractors 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 ensure that services are provided and payments are made in accordance the requirements of this Contract, including UMCM Chapter 18 and applicable Federal and State requirements. Such 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 later.

The MCO and the MCO's Subcontractors 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 retain, and to 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.

This Article survives the termination or expiration of the Contract.

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 complete and unredacted originals or copies of any information records, books, and documents that are related to the performance of the Scope of Work.

(b) MCO and its Subcontractors must provide the access described in this Section upon HHSC's request. This request may be for, but is not limited to, 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 and/or entities:

(1) the United States Department of Health and Human Services or its designee;

(2) the Comptroller General of the United States or its designee;

(3) CHIP Rural Service Area Program personnel from HHSC or its designee;

(4) the 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 wherever MCO maintains such information, books, records, and supporting documentation. MCO further agrees to provide such 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 complete and unredacted originals or copies of the records and information described in this Section free of charge to HHSC and the entities described in subsection (c).

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

Section 9.03 ***Audits of Services, Deliverables and inspections.***

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

(1) MCO service locations, facilities, or installations;

(2) complete and unredacted originals or copies of MCO and Subcontractor records and information related to this Contract; and

(3) MCO 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, inspecting, auditing, reviewing, 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) detection of Fraud, Waste and/or Abuse; or

(5) other purposes HHSC deems necessary to perform its regulatory function and/or enforce the provisions of this Contract.

(c) MCO must provide, as part of the Scope of Work, any assistance that such investigators, auditors, reviewers, and inspectors reasonably may require to complete such investigations, audits, reviews, or inspections.

(d) If, as a result of an investigation, audit, inspection, or review of payments made to the MCO, HHSC discovers a payment error or overcharge, HHSC will notify the MCO of such error or overcharge. HHSC will be entitled to recover such funds as an offset to future payments to the MCO, or to collect such 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 the Department of Treasury's Median Rate (resulting from the Treasury's auction of 13-week bills) for the week in which liability is assessed. 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 such errors, including the cost of the investigation, audit, inspection, or review.

Section 9.04 ***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 4.10 (a-b) ("MCO Agreements With Third Parties").

Section 9.05 ***Response/compliance with findings.***

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

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

(1) Required by Texas 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 9.06 ***Notification of Legal and Other Proceedings, and Related Events.***

The MCO must notify HHSC of all proceedings, actions, and events as specified in UMCM Chapter 5.

Article 10. Terms & Conditions of Payment

Section 10.01 ***Calculation of monthly Capitation Payment.***

(a) This is a Risk-based contract. For each applicable CHIP Rural Service Area Program, HHSC will pay the MCO fixed monthly Capitation Payments based on the number of eligible enrolled Members. HHSC will calculate the monthly Capitation Payments by multiplying the number of Members in each Rate Cell category by the Capitation Rate for each Rate Cell. 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, but not limited to, 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 31st of each year

(d) The fixed monthly Capitation Rate consists of the following components:

(1) an amount for Health Care Services performed during the month;

(2) an amount for administering the program, and

(3) an amount for the MCO's Risk margin.

(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, including any associated interest, for at-risk Capitation Payment adjustments, or 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 for all participating Contractors, and reduce scope of service requirements as appropriate in accordance with Article 8 ("Amendments and Modifications"),

2) terminate the Contract in accordance with Article 12 ("Remedies and Disputes").

Section 10.03 ***Certification of Capitation Rates.***

HHSC will employ or retain a qualified actuary to certify the actuarial soundness of the Capitation Rates contained in this Contract. HHSC will also employ or retain a qualified actuary to certify all revisions or modifications to the Capitation Rates.

Section 10.04 ***Modification of Capitation Rates.***

The Parties expressly understand and agree that the agreed Capitation Rates are subject to modification in accordance with Article 8 ("Amendments and Modifications,") if changes in state or federal laws, rules, regulations or policies affect the rates or the actuarial soundness of the rates. HHSC will provide the MCO notice of a modification to the Capitation Rates 60 Days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the MCO does not accept the rate change, either Party may terminate the Contract in accordance with Article 12 ("Remedies and Disputes").

Section 10.05 ***CHIP Program Capitation Rates Structure.***

(a) CHIP Rate Cells.

CHIP Capitation Rates are defined on a per Member per month basis by the Rate Cells applicable to the Service Area. CHIP Rate Cells are based on the Member's age group as follows:

(1) under age 1;

(2) ages 1 through 5;

(3) ages 6through 14; and

(4) ages 15 through 18.

(b) CHIP Capitation Rate development.

HHSC will establish base Capitation Rates by analyzing Encounter Data and financial data for the Service Area. 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.

(c) Value-added Services.

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

(d) Case-by-case Services.

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

Section 10.06 ***CHIP Perinatal Program Capitation Rates Structure.***

(a) CHIP Perinatal Program Rate Cells.

CHIP Perinatal Capitation Rates are defined on a per Member per month basis by the Rate Cells applicable to the Service Area. CHIP Perinatal Rate Cells are based on the Member's birth status and household income as follows:

(1) CHIP Perinate at or Below Medicaid Eligibility Threshold (an unborn child who will qualify for Medicaid once born);

(2) CHIP Perinate above Medicaid Eligibility Threshold (an unborn child who will not qualify for Medicaid once born); and

(3) CHIP Perinate Newborn above Medicaid Eligibility Threshold (newborn that does not qualify for Medicaid).

(b) CHIP Perinatal Program Capitation Rate development.

(1) HHSC will establish base Capitation Rates by analyzing Encounter Data and financial data for the Service Area. 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.

(2) The Capitation Rate for CHIP Perinates at or below below Medicaid Eligibility Threshold (an unborn child who will qualify for Medicaid once born) includes an amount that the MCO must pass through for corresponding physician delivery services. All physicians involved in a labor with delivery for CHIP Perinate Members at or below Medicaid Eligibility Threshold (an unborn child who will qualify for Medicaid once born will share in the increase. The MCO's Chief Executive Officer will attest that the MCO has appropriately increased physician fees as required above. HHSC will perform sample audits to verify payments to physicians are in accordance with this Contract requirement.

(c) Value-added Services.

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

(d) Case-by-case Services.

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

Section 10.07 ***MCO input during rate setting process.***

(1) MCO must provide certified Encounter Data and financial data as prescribed in the UMCM. Such information may include, without limitation: claims lag information by Rate Cell, capitation expenses, and stop loss reinsurance expenses. HHSC may request clarification or for 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.

(2) HHSC will allow the MCO to review and comment on data used by HHSC to determine Capitation Rates.

(3) 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 method deemed appropriate 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 such comments, HHSC will conduct a second meeting to discuss the final Capitation Rates and changes resulting from MCO comments, if any.

Section 10.08 ***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 the CMS in accordance with the requirements in 42 C.F.R. § 438.730.

(b) Appeal of adjustment.

The MCO may appeal the adjustment of capitations in the above circumstances using the HHSC dispute resolution process set forth in Section 12.13, ("Dispute Resolution").

Section 10.09 ***Delivery Supplemental Payment.***

(a) The Delivery Supplemental Payment (DSP) is a function of the average delivery cost. Delivery costs include facility and professional charges.

(b) The MCO will receive a Delivery Supplemental Payment (DSP) from HHSC for each live or stillbirth by a CHIP Member. The MCO will also receive a DSP from HHSC for each live or stillbirth of a CHIP Perinate above the Medicaid eligibility threshold (i.e., a Perinate who does not qualify for Medicaid once born, measured at the time of enrollment in the CHIP Perinatal Program). The MCO will not receive a DSP from HHSC for a live or stillbirth of a CHIP Perinate at or below the Medicaid eligibility threshold (i.e., a Perinate who qualifies for Medicaid once born). For the CHIP Rural Service Area Programs, this one-time DSP payment is made in the amount identified in the Contract regardless of whether there is a single birth or there are multiple births at time of delivery. A delivery is the birth of a live born infant, regardless of the duration of the pregnancy, or a stillborn (fetal death) infant of 20 weeks or more of gestation. A delivery does not include a spontaneous or induced abortion, regardless of the duration of the pregnancy.

(c) MCO must submit a monthly DSP Report as described in Section 8 ("Operations Phase Requirements") to the Contract, in the format prescribed in the UMCM.

(d) HHSC will pay the Delivery Supplemental Payment within 20Business Days after receipt of a complete and accurate report from the MCO.

(e) The MCO will not be entitled to Delivery Supplemental Payments for deliveries that are not reported to HHSC within 300 Days after the date of delivery, or within 30 Days from the date of discharge from the hospital for the stay related to the delivery, whichever is later.

(f) MCO must maintain complete claims and adjudication disposition documentation, including paid and denied amounts for each delivery. The MCO must submit the documentation to HHSC within five Business Days after receiving a request for such information from HHSC.

Section 10.10 ***Experience Rebate***

(a) MCO's duty to pay.

(1) General.

At the end of each FSR Reporting Period beginning with FSR Reporting Period 11, 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 set forth below. The Net Income Before Taxes and the total Revenues are as measured by the FSR, as reviewed and confirmed by HHSC. The final amount used in the calculation of the percentage may be impacted by various factors herein, including the Loss Carry Forward and/or the Admin Cap,

(2) Basis of consolidation.

Effective for FSR Reporting Period 12/13 and thereafter, and with the exception of the Dual Demonstration, 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.

(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:

Pre-tax Income as a % of Revenues	MCO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	0%	100%
> 7% and ≤ 9%	0%	100%
> 9% and ≤ 12%	0%	100%
> 12%	0%	100%

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:

Pre-tax Income as a % of Revenues	MCO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

HHSC and the MCO will share the Net Income Before Taxes as follows:

(1) The MCO will retain all 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% but less than or equal to 5% of the total 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 7% 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% but less than or equal to 9% 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% but less than or equal to 12% 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 the UMCM's Chapter 6 and Chapter 5 and applicable federal regulations. The Net Income Before Taxes will be confirmed by HHSC or its agent for the Rate Year relating to all revenues and expenses incurred pursuant to the Contract. HHSC reserves the right to modify UMCM Chapters 6 and Chapter 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, including without limitation any incentives described in Section 6.3.2.

(iv) financial disincentives, including without limitation: the Performance-based Capitation Rate described in Section 6.3.2.2 ("Performance-Based Capitation Rate"); and

(v) the liquidated damages, and any interest expense associated, as described in Attachment B-5 "Deliverables /Liquidated Damages Matrix".

(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 award of such 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 by the MCO for one FSR Reporting Period may be carried forward to the next FSR Reporting Period, and applied as an offset against pre-tax net income. Prior losses may be carried forward for two contiguous FSR Reporting Periods for this purpose.

In the case when a loss in a given FSR Reporting Period is carried forward and applied against profits in either or both of the next two FSR Reporting Periods, the loss must first be applied against the first subsequent FSR Reporting Period such that the profit in the first subsequent FSR Reporting Period is reduced to a zero pre-tax income; any additional loss then remaining unapplied may be carried forward to any profit in the next subsequent FSR Reporting Period. In such 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.

Carry forward of losses may be impacted by the Admin Cap; see Section 10.10.1 (e) below.

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.

Losses will be consolidated for potential carry forward on the same basis as is applied to the Experience Rebate consolidation for the FSR Reporting Period in which the loss is generated. Any such consolidated losses may then be eligible to be applied to the consolidated income of a qualified future FSR Reporting Period, whereby the income generated during that future period is consolidated according to the consolidation rules in effect for Experience Rebates in that period.

(i) For any losses generated during FSR Reporting Period 12A or prior, the loss eligible for potential carry forward is based on the Net Income Before Taxes for the MCO's CHIP RSA Service Area.

(ii) For any losses generated during FSR Reporting Period 12/13 or thereafter, the loss eligible for potential carry forward is based on Net Income Before Taxes on a Consolidated Basis.

(e) Settlements for payment.

(1) There may be one or more MCO payment(s) of the State share of the Experience Rebate on income generated for a given FSR Reporting Period under the CHIP Rural Service Area Programs. The first scheduled payment (the "Primary Settlement") will equal 100% of the State 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 herein, refers strictly to what should be paid with the 90-Day FSR, and does not refer to the first instance in which the MCO may tender a payment. For example, 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 such 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 10.10(f) describes the interest expenses associated with any payment after the Primary Settlement.

MCO may make non-scheduled payments at any time to reduce the accumulation of interest under Section 10.10(f). For any nonscheduled payments prior to the 334-day FSR, the MCO is not required to submit a revised FSR, but is required to submit an Experience Rebate calculation form and an adjusted summary page of the FSR. The FSR summary page is labeled "Summary Income Statements (Dollars), All Coverage Groups Combined (FSR, Part I)."

(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 10.10(f).

(4) In the event that any Experience Rebates and/or corresponding interest payments owed to the State are not paid by the required due dates, then HHSC may offset such amounts from any future Capitation Payments, or collect such 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, and allowable in accordance with the HHSC UMCM's "Cost Principles for Expenses," the HHSC "FSR Instructions for Completion," 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 10.10(e)(1). Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at 35 Days after the due date for the 90-Day FSR Report. For example, any Experience Rebate payment (s) made in conjunction with the 334-Day FSR, or as a result of audit findings, will accrue interest back to 35 Days after the due-date for submission of the 90-Day FSR.

The MCO has the option of preparing an additional FSR based on 120 Days of claims run-out (a "120- Day FSR"). If a 120-Day FSR, and an Experience Rebate payment based on it, are received by HHSC before the interest commencement date above, then such a payment would be counted as part of the Primary Settlement.

(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 pursuant to Section 10.10 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 pursuant to Section 10.10 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 45 Days after the start of interest, then the $75,000 will be subject to 45 Days of interest, and the $25,000 balance will continue to accrue interest until paid. The accrual of interest as defined under Section 10.10 (f) 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 pursuant to Section 10.10, HHSC will assess such interest at 12% per annum, compounded daily. If any interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then in such specific case the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

(6) Any such interest expense incurred pursuant to Section 10.10 is not an Allowable Expense for reporting purposes on the FSR.

Section 10.10.1 Administrative Expense Cap.

(a) General requirement.

Beginning with FSR Reporting Period 12A, the calculation methodology of Experience Rebates described in Section 10.10 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.

Such limitations will be calculated as follows:

(b) Calculation methodology.

HHSC will determine the administrative expense component of the applicable Capitation Rate structure for the CHIP Rural Service Area Program 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 (earned 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 earned by the MCO (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 MCO during the annual rate setting process via email, labeled as "the final rate exhibits for your health plan." The email has one or more spreadsheet files attached, which are particular to the 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 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 such document, there is a section entitled "Administrative Fees," where it refers to "the amount allocated for administrative expenses."

   In cases where the administrative expense portion of the Capitation Rate refers to "the greater of (a) [one set of factors], and (b) [another set of factors]," then the Admin Cap will be calculated each way, and the larger of the two results will be the Admin Cap utilized for the determination of any Experience Rebates due.

(d) Example of Calculation

By way of example only, HHSC will calculate the Admin Cap for an FSR Reporting Period 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 for the FSR:
   - ($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 specific Program for the FSR Reporting Period.

(e) Consolidation and offsets.

The Admin Cap will be consolidated on the same basis as is applied to the Experience Rebate consolidation for the FSR Reporting Period. Additional details are provided in the applicable FSR Template and FSR Instructions in the UMCM. There will be one aggregate amount of dollars determined as the total Admin Cap, which will be applied to the aggregate administrative expenses of the MCO on the same consolidation basis excluding the Dual Demonstration. (The Dual Demonstration will have its own separate Admin Cap calculated). The net impact of the Admin Cap will be applied to the Experience Rebate calculation.

(f) Impact on Loss carry-forward.

For Experience Rebate calculation purposes, the calculation of any loss carry-forward, as described in Section 10.10(d), will be based on the allowable pre-tax loss as determined under the Admin Cap.

(g) MCOs entering a Service Delivery Area or Program.

If an MCO enters a new Service Area or offers a Program that it did not offer under a previous contract, it may be exempt from the Admin Cap for those Service Areas and Programs for a period of time to be determined by HHSC, up through the first FSR Reporting Period, or portion thereof.

(h) 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 it deems necessary.

10.10.2 Reinsurance Cap

Beginning with FSR Reporting Period 12/13, the MCO is subject to the 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 the UMCM Cost Principles.

Section 10.11 ***Payment by Members.***

(a) CHIP Program.

(1) Families that meet the enrollment period cost share limit requirement must report it to the HHSC Administrative Services Contractor. The HHSC Administrative Service Contractor notifies the MCO that a family's cost share limit has been reached. Upon notification from the HHSC Administrative Services Contractor that a family has reached its cost-sharing limit for the term of coverage, the MCO will generate and mail to the CHIP Member a new Member ID card within five Days, showing that the CHIP Member's cost-sharing obligation for that term of coverage has been met. No cost-sharing may be collected from these CHIP Members for the balance of their term of coverage.

(2) Providers are responsible for collecting all CHIP Member co-payments at the time of service. Co-payments that families must pay vary according to their income level.

(3) Co-payments do not apply, at any income level, to Covered Services that qualify as well-baby and well-child care services, as defined by 42 C.F.R. § 457.520.

(4) Except for costs associated with unauthorized non-emergency services provided to a Member by Out-of-Network providers and for non-covered services, the co-payments outlined in the CHIP Cost Sharing table in the UMCM are the only amounts that a provider may collect from a CHIP-eligible family. As required by 42 C.F.R. § 457.515, this includes, without limitation, Emergency Services that are provided at an Out-of-Network facility. Cost sharing for such Emergency Services is limited to the co-payment amounts set forth in the CHIP Cost Sharing Table.

(5) Federal law prohibits charging premiums, deductibles, coinsurance, co-payments, or any other cost-sharing to CHIP Members of Native Americans or Alaskan Natives. The HHSC Administrative Services Contractor will notify the MCO of CHIP Members who are not subject to cost-sharing requirements. The MCO is responsible for educating Providers regarding the cost-sharing waiver for this population.

(6) An MCO's monthly Capitation Payment will not be reduced for a family's failure to make its CHIP premium payment. There is no relationship between the per Member/per month amount owed to the MCO for coverage provided during a month and the family's payment of its CHIP premium obligation for that month.

(7) With the exception of copayments authorized by the CHIP State Plan, the MCO, Network Providers, and Out-of-Network Providers are prohibited from billing or collecting any amount from a CHIP Member for Covered Services. MCO must inform CHIP Members of costs for non-covered services, and must require its Network Providers to:

(a) inform CHIP Members of costs for non-covered services prior to rendering such services; and

(b) obtain a signed Private Pay form from such CHIP Members.

(b) CHIP Perinatal Program.

(1) Cost-sharing does not apply to CHIP Perinatal Program Members. The exemption from cost-sharing

applies through the end of the original 12-month enrollment period.

(2) The MCO, Network Providers, and Out-of-Network Providers are prohibited from billing or collecting any amount from a CHIP Perinatal Program Member for Covered Services. MCO must inform CHIP Perinatal Program Members of costs for non-covered services, and must require its Network Providers to:

(a) inform CHIP Perinatal Program Members of costs for non-covered services prior to rendering such services; and

(b) obtain a signed Private Pay form from such CHIP Perinatal Program Members.

Section 10.12 ***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 pursuant to this Contract. This restriction does not apply to fees paid to Subcontractors.

Section 10.13 ***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 and all such 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 10.14 ***Liability for employment-related charges and benefits.***

MCO will perform work under this Contract as an independent contractor and not as agent or representative of HHSC. MCO is solely and exclusively liable for payment of all employment-related charges incurred in connection with the performance of this Contract, including but not limited to salaries, benefits, employment taxes, workers compensation benefits, unemployment insurance and benefits, and other insurance or fringe benefits for Staff.

Section 10.15 ***No additional consideration.***

(a) MCO will not be entitled to nor 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 such incidental or ancillary services entitle the MCO to withhold Services and Deliverables due under the Agreement.

(c) MCO will not be entitled by virtue of the Contract to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever.

Section 10.16 ***Federal disallowance.***

If the federal government recoups money from the state for expenses and/or costs that are deemed unallowable by the federal government, the state has the right to, in turn, recoup payments made to the MCOs for these same expenses and/or costs, even if they had not been previously disallowed by the state and were incurred by the MCO, and any such expenses and/or costs would then be deemed unallowable by the state. If the state retroactively recoups money from the MCOs due to a federal disallowance, the state will recoup the entire amount paid to the MCO for the federally disallowed expenses and/or costs, not just the federal portion.

Section 10.17 ***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 CHIP 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, generally no later than 95 calendar days after HHSC's Administrative Services Contractor has processed the encounter data. Non-risk payments will be limited to the actual amounts 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 effective date of the drugs specified on the CAD_Formulary_NRP file, as defined in Chapter 2 of the UMCM, 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, generally 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 theingredient cost of these drugs up to the Fee-for-Service reimbursement amount. To be eligible for reimbursement, medical encounters must contain a Financial Arrangement Code "20" in segment NTE02 on the encounter transaction.

Section 10.18 ***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.

Article 11. Disclosure & 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 the CHIP Rural Service Area 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 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 thereof made by the MCO must be returned to HHSC or, at HHSC's option, erased or destroyed. MCO must provide HHSC certificates evidencing such destruction.

(g) The obligations in this Section must not restrict any disclosure by the MCO pursuant to any applicable law, or by order of any court or government agency, provided that the MCO must give prompt notice to HHSC of such order.

(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 such 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 Subcontractors', consultants', 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 or its Subcontractors', 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 7.07 ("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 such 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, Chapter 552 of the Texas Government Code, that consists of the MCO'S confidential information, including without limitation, 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 such communications.

(c) 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, and that all matters related thereto 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 such documents, data, database, or communications are privileged work product, only MCO personnel, for whom such 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 such 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 such resistance;

(2) to retain counsel to represent MCO; or

(3) to reimburse MCO for reasonable attorneys' fees and expenses incurred in resisting such access.

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

Section 11.06 ***Unauthorized acts.***

Each Party agrees to:

(1) Notify the other Party promptly of any unauthorized possession, use, or knowledge, or attempt thereof, by any person or entity that may become known to it, 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 attempt thereof, and use reasonable efforts to assist the other Party in investigating or preventing the reoccurrence of any unauthorized possession, use, or knowledge, or attempt thereof, of Confidential Information;

(3) Cooperate with the other Party in any litigation and investigation against third Parties deemed necessary by such Party to protect its proprietary rights; and

(4) Promptly prevent a reoccurrence of any such unauthorized possession, use, or knowledge of such information.

Section 11.07 ***Legal action.***

Neither party may commence any legal action or proceeding in respect to any unauthorized possession, use, or knowledge, or attempt thereof by any person or entity of HHSC's Confidential Information or information identified by the MCO as confidential or proprietary, which action or proceeding identifies the other Party information without such Party's consent.

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 HHSC' 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 HHSC 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 (IS-Policy, IS-AUP, AUA, IS-Web and Mobile Minimum Security Standard, IS-RAMP, ISSG/IS-Controls);

(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 HHS data types accessed, transmitted, stored, or maintained by the system and identify applicable state, federal and regulatory requirements;

(9) 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;

(10) 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;

(11) prohibit the use of free cloud services with Texas HHS Agency Sensitive Information or Confidential Information;

(12) 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;

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

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

(15) keep current on security update/patch releases and maintain up-to-date anti-virus/malware protection;

(16) 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;

(18) establish standards and methods to securely return, destroy or dispose of Texas HHS Agency Sensitive Information or Confidential Information;

(19) provide documentation of information security and privacy policies/standards to HHSC Information Security if requested;

(20) 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.

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 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 year, MCOs 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.

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.

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) IfMCO 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 propose 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 the("Deliverables/Liquidated Damages Matrix") to the Contract;

(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 "Deliverables/Liquidated Damages Matrix" to the Contract. 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 or, 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; or nonfeasance, by any party concerning the Contract;, and the MCO failed to take appropriate action; or

(iv) 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 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 theContract 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 of such termination.(3) Breach of confidentiality.

HHSC may terminate theContract 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 tthe 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 30Days 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.

(i) 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.

(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) MCO 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 to terminate or allow the Contract to expire 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 tthe Contract, termination will be effective as of the date specified in the notice of termination. The Turnover Phase 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 tothe 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 Tite 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 shallbe 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 theContract. 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 theContract.

Article 13. Assurances & 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 the 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 a 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, at any time hereafter, 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 or in connection with the procurement process 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 pursuant to Subsection 12.03(b)(9) ("Termination for MCO's Material Breach of the Contract"). 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 the contracting officer, such nondisclosure will be considered a material breach of the Contract. Furthermore, such 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 the State'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 (2) years following the completion of this Contract.

Section 13.05 ***Anti-kickback provision.***

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

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

In accordance with Section 403.055 of the Texas Government Code, MCO agrees that any payments due to MCO under the Contract will be first applied toward any debt and/or back taxes MCO owes State of Texas. MCO further agrees that payments will be so applied until such debts and back taxes are paid in full.

Section 13.07 ***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 State of Texas against MCO for collection of the balance. For purposes of this Section, an indebtedness is any amount sum 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 & 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 to be obtained 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) $2,000,000.00; (b) an amount equal to the sum of twenty-five dollars ($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 Chapter 843 of the Texas Insurance Code.

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 C.F.R. § 438.116, for basic-service health maintenance organizations, including but not limited to, all reserve requirements, net worth standards, debt-to-equity ratios, or other debt limitations. Provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI. In the event the MCO fails to maintain such compliance, HHSC, without limiting any other rights it may have by law or under the Contract, may terminate the Contract.

(b) If the MCO becomes aware of any impending changes to its financial or business structure that could adversely impact its compliance with the requirements of the Contract or its ability to pay its debts as they come due, the MCO must notify HHSC immediately in writing.

(c) The MCO must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

(1) continuation of Covered Services, until the time of discharge, to Members who are confined on the date of insolvency in a hospital or other inpatient facility;

(2) payments to unaffiliated health care providers and affiliated healthcare providers whose Contracts do not contain Member "hold harmless" clauses acceptable to the TDI;

(3) continuation of Covered Services for the duration of the Contract Period for which a capitation has been paid for a Member;

(4) provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI and the Contract.

Should TDI determine that there is an immediate risk of insolvency or the MCO is unable to provide Covered Services to its Members, HHSC, without limiting any other rights it may have by law, or under the Contract, may terminate the Contract.

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 pursuant to 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 as described in the Contract during the period following its acceptance by HHSC, through the term of the Contract, including any subsequently negotiated by MCO and HHSC. MCO will promptly repair or replace any such 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 and conditions 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 Texas Government Code § 531.0162. This includes providing technological solutions that meet federal accessibility standards for persons with disabilities, as applicable.

Section 14.09 ***Electronic & Information Resources Accessibility Standards***

(a) Applicability.

The following Electronic and Information Resources (EIR) requirements apply to the Contract because the MCO perform 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 or will be used by the 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, but is not limited to, 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 Texas Government 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 such Products are available in the commercial marketplace or when such 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 such 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 such Accessibility Standards after the expiration or termination of the Contract Term, unless HHSC and/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 but not limited to 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) Pursuant to Texas Government Code Sec. 2054.465, neither MCO nor any other person has cause of action against HHSC for a claim of a failure to comply with Texas Government 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, and/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 and all 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 without limitation reasonable attorneys' fees and expenses, from any claim or action against HHSC that is based on a claim of breach of the warranty set forth in the preceding paragraph. 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 thereof, is in such action held to constitute an infringement or misappropriation, or the use thereof 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

(2) modify or replace the Deliverables to comply with the Specifications and to not violate any intellectual property rights.

If neither of the alternatives set forth in (1) or (2) above are available to the MCO on commercially reasonable terms, MCO may require that HHSC return the allegedly infringing Deliverable(s) in which case MCO will refund all amounts paid for all such Deliverables.

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 15.03, the following terms have the meanings set forth below:

(1) "**Custom Software**" means any software 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 software: (i) developed by the MCO prior to the Effective Date of the Contract, or (ii) software developed by the MCO after the Effective Date of the Contract that is not developed: for HHSC; in connection with the Contract; and 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.

(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 and the Deliverables provided by the MCO, including without limitation the Custom Software and associated documentation. For purposes of this Section 15.03, the Deliverables will not include MCO Proprietary Software or Third Party Software. MCO will take all actions necessary and transfer ownership of the Deliverables to HHSC, including, without limitation, the Custom Software and associated documentation prior to Contract termination.

(2) MCO will furnish such 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 such 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 without limitation all copyrights, inventions, patents, trade secrets, and other proprietary rights therein, including renewals thereof,to HHSC.

(3) MCO will, at the expense of HHSC, assist HHSC or its nominees to obtain copyrights, trademarks, or patents for all such Deliverables in the United States and any other countries. MCO agrees to execute all papers and to give all facts known to it necessary to secure United States or foreign country copyrights and patents, and to transfer or cause to transfer to HHSC all the right, title, and interest in and to such Deliverables. MCO also agrees not to assert any moral rights under applicable copyright law with regard to such 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. Such data will include all results, technical information, and materials developed for and/or obtained by HHSC from MCO in the performance of the Services hereunder, including but not limited to all reports, surveys, plans, charts, recordings (video and/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 such 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 thereof, and associated documentation designed, developed, or installed with federal financial participation under the Contract, including but not limited to those materials covered by copyright, 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 thereof 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 thereto, unless such loss or damage is caused by the negligence or intentional misconduct of HHSC. After HHSC accepts a Deliverable, the risk of loss or damage to the Deliverable will be borne by HHSC, 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 such 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.

Article 17. Insurance & 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 herein, all exceptions to the Contract's insurance requirements must be approved in writing by HHSC. An MCO is 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.

(i) An MCO may waive the Professional Liability Insurance requirement described in 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) MCO or the Network Provider is responsible for any and all 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, with the exception of Professional Liability Insurance and Business Automobile Liability Insurance, all insurance coverage 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 such 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 to be given to HHSC at least 30 Days before coverage is reduced below minimum HHSC contractual requirements, canceled, or non-renewed. MCO must submit a new coverage binder to HHSC to ensure no break in coverage.

(8) The Parties expressly understand and agree that any insurance coverages and limits furnished by MCO will in no way expand or limit MCO's liabilities and responsibilities specified within the Contract documents or by applicable law.

(9) MCO expressly understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by MCO under the Contract.

(10) If MCO, or its Network Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, MCO or its Network Providers will be responsible for the acquisition and cost of such additional protection. Such 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 such evidence from MCO will not be deemed to be a waiver by HHSC and 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 such 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 (1) 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 (1) year following the expiration of the final renewal period or the date the contract terminates. MCO must obtain and maintain the performance bond in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, securing MCO's faithful performance of the terms and conditions of this Contract. The performance bonds must comply with Chapter 843 of the Texas Insurance Code. At least one performance bond must be issued. The

amount of the performance bond(s) should total $100,000.00. 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) Since the CHIP Perinatal Program is a subprogram of the CHIP Program, neither a separate performance bond for the CHIP Perinatal Program nor a combined performance bond for the CHIP and CHIP Perinatal Programs is required. The same bond that the MCO obtains for its CHIP Program within a particular Service Area also will cover the MCO's CHIP Perinatal Program in that same Service Area.

(c) 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 Chapter 843 of the Texas Insurance Code. The MCO must promptly provide HHSC with copies of the bond and any amendments or renewals thereto.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	Version 1.0	January 1, 2010	Initial version of Attachment B-1, Section 6 that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2010	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.2	September 1, 2010	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.3	December 1, 2010	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.4	March 1, 2011	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.5	September 1, 2011	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.6	March 1, 2012	Section 6.3.2.2 is modified to change the 1% at risk to 5%.
Revision	1.7	June 1, 2012	Section 6.3.2.1 is modified to change “Rate Period 1” to “FSR Reporting Period 11 or FSR Reporting Period12A.” Section 6.3.2.2 is modified to add “(5%-at-risk)’ to the section name and to change “Rate Period” to “FSR Reporting Period.”
Revision	1.8	September 1, 2012	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.9	March 1, 2013	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.10	June 1, 2013	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.11	September 1, 2013	Section 6.3.2.2 is modified to add the word “Program” to the section title. Section 6.3.2.3 “Performance-Incentive Program” is added. Subsection 6.3.2.3.1 “Quality Challenge Award Program” and Subsection 6.3.2.3.2 “State-MCO Shared Savings Program” are added.
Revision	1.12	January 1, 2014	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.13	February 1, 2014	Section 6.3.2.3.2 is renamed “Other Incentive Programs’ and updated.
Revision	1.14	September 1, 2014	Section 6.3.2.1 “Experience Rebate Reward” is deleted in its entirety.
Revision	1.15	October 1, 2014	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.16	March 1, 2015	After the first appearance of the term, “Uniform Managed Care Manual” is changed to “UMCM.’ Section 6.3.2.2 is modified to change the name from “Performance-Based Capitation Rate Program (5%-at-risk)” to “Pay for Quality (P4Q) Program” and to clarify the P4Q program requirements.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 6.3.2.3 “Performance Based Incentive Program” is deleted in its entirety. Section 6.3.2.3.1 “Quality Challenge Award Program” is deleted in its entirety. Section 6.3.2.3.2 “Other Incentive Programs” is deleted in its entirety. Section 6.3.2.5 is modified to include additional methodologies.
Revision	1.17	May 1, 2015	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.18	September 1, 2015	Section 6.3.2.2 is modified to change the name of the section from “Pay for Quality (P4Q) Program Performance-Based Capitation Rate Program (5%-at-risk)” to “Pay for Quality (P4Q) Program,” to correct a typo and to clarify the requirements. Section 6.3.2.5 is modified to correct a typo.
Revision	1.19	March 1, 2016	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.20	September 1, 2016	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.21	March 1, 2017	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.22	September 1, 2017	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.23	March 1, 2018	Section 6.3.2.2 is modified to comply with redesigned medical P4Q program.
Revision	1.24	September 1, 2018	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.25	January 1, 2019	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.26	March 1, 2019	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.27	September 1, 2019	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.28	March 1, 2020	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.29	September 1, 2020	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.30	March 1, 2021	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.30.1	June 1, 2021	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.31	September 1, 2021	Global change is made to maintain consistency with UMCM references among all contracts.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.32	March 1, 2022	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.33	September 1, 2022	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.34	March 1, 2023	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.35	September 1, 2023	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.
Revision	1.36	March 1, 2024	Contract amendment did not revise Attachment B-1, Section 6 “Premium Payment, Incentives, & Disincentives”.

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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6. Premium Payment, Incentives, & Disincentives

This section documents how the Capitation Rates are developed and describes performance incentives and disincentives related to HHSC's value-based purchasing approach. For further information, refer to **Attachment A** ("General Contract Terms and Conditions").

Under the Contract, health care coverage for Members will be provided on a fully insured basis. The MCO must provide the Services and Deliverables, including Covered Services to enrolled Members in order for monthly Capitation Payments to be paid by HHSC. Section 8 ("Operations Phase Requirements") includes the MCO's financial responsibilities regarding out-of-network Emergency Services and Medically Necessary Covered Services not available through Network Providers.

6.1 Capitation Rate Development

Refer to the **Attachment A** ("General Contract Terms & Conditions") for information concerning Capitation Rate development.

6.2 Financial Payment Structure and Provisions

HHSC will pay the MCO monthly Capitation Payments based on the number of eligible and enrolled Members. HHSC will calculate the monthly Capitation Payments by multiplying the number of Member Months times the applicable monthly Capitation Rate by Member Rate Cell. The MCO must provide the Services and Deliverables, including Covered Services to Members, described in the MCO Contract for monthly Capitation Payments to be paid by HHSC.

The MCO must understand and expressly assume the risks associated with the performance of the duties and responsibilities under the Contract, including the failure, termination, or suspension of funding to HHSC, delays or denials of required approvals, cost of claims incorrectly paid by the MCO, and cost overruns not reasonably attributable to HHSC. The MCO must further agree that 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 such incidental or ancillary services entitle the MCO to withhold Services or Deliverables due under the Contract.

6.2.1 Capitation Payments

The MCO must refer to the **Attachment A (**"General Contract Terms & Conditions") for information and Contract requirements on the:

1. Time and manner of payment,

2. Adjustments to Capitation Payments,
3. Delivery Supplemental Payment, and
4. Experience Rebate.

6.3 Performance Incentives and Disincentives

HHSC introduces several financial and non-financial performance incentives and disincentives through this Contract. These incentives and disincentives are subject to change by HHSC over the course of the Contract Period. The methodologies required to implement these strategies will be refined by HHSC after collaboration with the MCO through the incentives workgroup to be established by HHSC. The MCO is prohibited from passing down financial disincentives and/or sanctions imposed on the MCO to health care providers, except on an individual basis and related to the individual provider's inadequate performance.

6.3.1 Non-financial Incentives

6.3.1.1 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 to HHSC standards and/or external Benchmarks. HHSC will recognize when the MCO obtains superior performance and/or improvement by publicizing the MCO's achievements. For example, HHSC may post information concerning exceptional performance on its website, where it will be available to both stakeholders and members of the public. Likewise, HHSC may post its final determination regarding poor performance or peer group performance comparisons on its website, where it will be available to both stakeholders and members of the public.

6.3.2 Financial Incentives and Disincentives

6.3.2.1 This Section Intentionally Left Blank

6.3.2.2 Medical Pay-for-Quality (P4Q) Program

Under the medical pay-for-quality (P4Q) program, HHSC will place at risk a percentage of each MCO's Capitation Payment(s) for performance in a calendar year. HHSC may modify the percentage of the Capitation Payment placed at risk.

HHSC will pay the MCO the full monthly Capitation Payments as described in **Section 6.2**. Then, at the end of the medical P4Q data collection period, HHSC will evaluate the MCO's performance and assign points and dollar amounts using the methodology set out in Uniform Managed Care Manual, Chapter 6.

Failure to timely provide HHSC with necessary data related to the calculation of the P4Q performance indicators will result in HHSC's assignment of a zero percent performance rate for each related performance indicator.

MCOs will report actual Capitation Payments received on the Financial Statistical Report (FSR) during the FSR Reporting Periods that are at risk (for example, if four percent was at risk, the MCO will not report Revenues at a level equivalent to 96% of the payments received, leaving four percent as contingent). Any subsequent loss of the at-risk amount that may be realized will be reported below the income line as an informational item, and not as an offset to Revenues or as an Allowable Cost (as described in the Uniform Managed Care Manual, Chapter 5).

HHSC may modify the methodology and measures of the medical P4Q program as it deems necessary and appropriate, in order to motivate, recognize, and reward MCOs for superior performance.

6.3.2.3 This Section Intentionally Left Blank

6.3.2.3.1 This Section Intentionally Left Blank

6.3.2.3.2 This Section Intentionally Left Blank

6.3.2.4 Remedies and Liquidated Damages

All areas of responsibility and all requirements in the MCO Contract will be subject to performance evaluation by HHSC. Any and all responsibilities or requirements not fulfilled may have remedies and HHSC will assess either actual or liquidated damages. Refer to the **Attachment A** ("General Contract Terms and Conditions") and **Attachment B-5** ("Deliverables/Liquidated Damages Matrix") for performance standards that carry liquidated damage values.

6.3.2.5 Additional Incentives and Disincentives

HHSC will evaluate all performance-based incentive and disincentive methodologies annually and 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.

Information about the data collection period to be used, performance indicators selected or developed, and MCO ranking methodologies for any specific period will be found in the UMCM.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	Version 1.0	January 1, 2010	Initial version of Attachment B-1, Section 7 that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2010	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.2	September 1, 2010	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.3	December 1, 2010	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.4	March 1, 2011	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.5	September 1, 2011	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.6	March 1, 2012	Section 7.1 is modified to add termination of the contract to the list of remedies for failure to timely satisfy Transition Phase requirements. Section 7.3.1.6 is modified to reference the MCO’s PBM and other Material Subcontractors. Section 7.3.1.7 is modified to reference the MCO’s PBM and other Material Subcontractors, to require the MCOs to submit a written plan for providing pharmacy services, and to require an attestation from the PBM to comply with the requirements of SB 7.
Revision	1.7	June 1, 2012	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.8	September 1, 2012	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.9	March 1, 2013	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.10	June 1, 2013	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.11	September 1, 2013	Section 7.3.1.7 is modified for clarification and for consistency with requirements of SB 7, 83R.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.12	January 1, 2014	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.13	February 1, 2014	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.14	September 1, 2014	Section 7.2.7 is modified to update SAS70 to SSAE16.
Revision	1.15	October 1, 2014	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.16	March 1, 2015	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.17	May 1, 2015	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.18	September 1, 2015	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.19	March 1, 2016	All references to “Fraud and Abuse” are changed to “Fraud, Waste, and Abuse”
Revision	1.20	September 1, 2016	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.21	March 1, 2017	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.22	September 1, 2017	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.23	March 1, 2018	Section 7.3.1.7 is modified to align the timeframe requirement for uploading files.
Revision	1.24	September 1, 2018	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.25	January 1, 2019	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.26	March 1, 2019	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.27	September 1, 2019	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.28	March 1, 2020	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.29	September 1, 2020	Section 7.1 Introduction is modified to clarify language to include expectations required of contracted MCO’ should they terminate, merge, or acquire new business. Section 7.2 is deleted “Intentionally Left Blank” Section 7.3 is deleted “Intentionally Left Blank” Section 7.3.1 Transition Phase Schedule and tasks is modified to clarify language to include expectations required of contracted MCO’ should they terminate, merge, or acquire new business. Section 7.3.1.1 Contract Start Up and Planning is modified to clarify language to include expectations required of contracted MCO’ should they terminate, merge, or acquire new business. Section 7.3.1.2 Administration and Key MCO Personnel is modified to clarify language to include expectations required of contracted MCO’ should they terminate, merge, or acquire new business.
Revision	1.30	March 1, 2021	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.30.1	June 1, 2021	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.31	September 1, 2021	Global change is made to maintain consistency with UMCM references among all contracts.
Revision	1.32	March 1, 2022	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.33	September 1, 2022	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.34	March 1, 2023	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.35	September 1, 2023	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.
Revision	1.36	March 1, 2024	Contract amendment did not revise Attachment B-1, Section 7 “Transition Phase Requirements”.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]

[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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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 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.

7.2 Intentionally Left Blank

7.3 Intentionally Left Blank

7.3.1 Transition Phase Tasks 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.

7.3.1.1 Transition Phase Planning

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

- define reporting standards;
- establish communication protocols between HHSC and the MCO;
- establish contacts with other HHSC contractors;
- establish a schedule for key activities and milestones; and
- clarify expectations for the content and format of Contract Deliverables.

The MCO must update the Transition Plan provided with its Proposal no later than30 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.

7.3.1.2 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** ("General Contract Terms and Conditions," Article 4, "Contract Administration and Management."). 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, including Management Information System (MIS) job descriptions and an MIS staff organizational chart, if applicable. If the MCO is using Material Subcontractors, the MCO must also provide the organizational chart for these Material Subcontractors.
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.

7.3.1.3 Organizational and Financial Readiness Review

In order to complete an organizational and financial Readiness Review and assess the most current corporate environment, HHSC will require that the MCO update the organizational and financial information submitted in its proposal. See Section 4.2 ("Business Specifications") of the RFP for a list of Financial Statements, Corporate Background and Status, Corporate Experience, and Material Subcontractor Information the MCO must update for the Readiness Review.

7.3.1.4 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 8.1.18 ("Management Information System Requirements"). For example, the MCO's MIS system must comply with the HIPAA as indicated in Section 8.1.18.4 ("HIPAA Compliance").

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 an 837-encounter file no later than 120 Days prior to the Operational Start Date. The MCO is not required to produce separate encounter files for the CHIP and CHIP Perinatal Programs.

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. This includes testing of the required telephone lines for Providers and Members and any necessary connections to the HHSC Administrative Services Contractor. The HHSC Administrative Services Contractor will provide enrollment test files to the MCO if it does not have previous HHSC enrollment files. The MCO will demonstrate its system capabilities and adherence to Contract specifications during readiness review.

7.3.1.5 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 the business and systems continuity for the processing of all health care claims and data as required under the Contract.

The MCO must submit to HHSC, descriptions of interface and data and process flow for each key business processes described in Section 8.1.18.3 (“System-wide Functions”).

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 State review and approval, the following information no later than 120 Days prior to the Operational Start Date.

- Joint Interface Plan
- Disaster Recovery Plan
- Business Continuity Plan
- Risk Management Plan, and
- Systems Quality Assurance Plan

Separate plans are not required for the CHIP Perinatal Program.

7.3.1.6 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. 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 that have been conducted in the past three years. The MCO must promptly make additional information on the detail of such system audits available to HHSC upon request.

In addition, HHSC will provide to the MCO a test plan that will outline the activities that need to be performed by the MCO 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 MCO Programs. This Readiness Review of the 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 MCO Program 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 is required to provide a Corrective Action Plan in response to any Readiness Review deficiency no later than ten Days after notification of any such deficiency by HHSC. If the MCO documents to HHSC's satisfaction that the deficiency has been corrected within ten Days of such deficiency notification by HHSC, no Corrective Action Plan is required.

7.3.1.7 Operations Readiness

The MCO must clearly define and document the policies and procedures that will be followed to support day-to-day business activities related to the provision of MCO Program 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 Readiness Review prior to the Operational Start Date. Readiness Review will include all CHIP RSA Programs. At a minimum, the MCO shall:

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 comprehensive plan for Network adequacy that includes a list of all contracted and credentialed Providers, in an HHSC-approved format. At a minimum, the list must include the acute care Provider types identified in Texas Government Code § 533.005(20)(A). The plan must include 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.
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 to HHSC the draft Member Handbook, draft Provider Manual, draft Provider Directory, and draft Member Identification Card for HHSC's review and approval. The materials must at a minimum meet the requirements specified in Section 8.1.5 ("Member Services") and include the Critical Elements to be defined in the Uniform Managed Care Manual.
6. Develop and submit to HHSC the MCO's proposed Member complaint and appeals processes for MCO Program participation.
7. Provide sufficient copies of the final Provider Directory to the HHSC Administrative Services Contractor in sufficient time to meet the enrollment schedule.
8. Demonstrate toll-free telephone systems and reporting capabilities for the Member services hotline, the Behavioral Health hotline, and the Provider Services hotline.
9. 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 8.1.19 ("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 shall:

- 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 persons 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, Abuse, and Waste 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.
- Designate an officer or director within the organization responsible for carrying out the provisions of the Fraud, Waste, and Abuse Compliance Plan.
- The MCO is held to the same requirements and must ensure that, if this function is subcontracted to another entity, the Subcontractor also meets all the requirements in this section and the Fraud, Waste, and Abuse section as stated in Section 8 ("Operations Phase Requirements").

10. Submit a written plan for providing pharmacy services, including proposed policies and procedures for:

- routinely updating formulary data following receipt of HHSC's daily files (within two Business Days, and off-cycle upon HHSC's request);
- prior authorization of drugs, including how HHSC's preferred drug lists (PDLs) will be incorporated into prior authorization systems and processes. The MCO must adopt HHSC's prior authorization processes, criteria, and edits unless HHSC grants a written exception, and HHSC's approval is required for all Clinical Edit policies;
- implementing drug utilization review;
- overriding standard drug utilization review criteria and clinical edits when Medically Necessary based on the individual Member's circumstances (e.g, overriding quantity limitations, drug-drug interactions, refill too soon, etc.);
- call center operations, including how the MCO will ensure that staff for all appropriate hotlines are trained to respond to prior authorization inquiries and other inquiries regarding pharmacy services, and
- monitoring the 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 (3) 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 PMB Subcontractor cannot affirmatively attest to any of

these items, then it must provide a comprehensive description of the matter and all related corrective actions.

HHSC may require the MCO to resubmit one or more of the above items if the MCO begins providing a new service or benefit, expands into a new Program or Service Area, or implements a major system change after the Contract's Effective Date.

During the Readiness Review, HHSC may request from the MCO certain operating procedures and updates to documentation to support the provision of MCO Program Services. HHSC will assess the MCO's understanding of its responsibilities and its 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 promptly provide a Corrective Action Plan or Risk Mitigation Plan 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 ten Days after HHSC's notification of deficiencies. If the Contractor documents to HHSC's satisfaction that the deficiency has been corrected within ten Days of such deficiency notification by HHSC, no Corrective Action Plan is required.

7.3.1.8 Assurance of System and Operational Readiness

In addition to successfully providing the Deliverables described in Section 7.3.1 ("Transition Phase Tasks"), the MCO must assure HHSC that all processes, MIS systems, and staffed functions are ready and able to successfully assume responsibilities 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, communications procedures are in place, Provider Manuals have been distributed, and that Provider training sessions have occurred according to the schedule approved by HHSC.

7.3.1.9 TDI Licensure, Certification or Approval

The MCO must receive TDI licensure, certification or approval (as applicable to the type of MCO) for all zip codes in the Service Area no later than 120 Days after the Contract Effective Date. If the MCO fails to receive such licensure, certification, or approval by this deadline, HHSC will terminate the contract. The MCO must indemnify HHSC for all costs incurred by HHSC or its authorized representatives prior to termination. The MCO must also indemnify HHSC for all costs relating to replacing the MCO. Such costs include, without limitation, the cost of securing a replacement vendor, as well as the cost of any claim or litigation that is reasonably attributable to the MCO's failure to receive TDI licensure, certification, or approval.

7.3.1.10 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.

If the 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 impose contractual remedies, including monetary damages, equitable, injunctive, or regulatory relief. HHSC's assessment of remedies will be based on the severity of the non-compliance and the potential impact on Members and Providers.

Refer to **Sections 8.1.1.2** ("Additional MCO Readiness Review") **and 8.1.18** ("Management Information Requirements") for additional information regarding MCO Readiness Reviews during the Operations Phase.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	Version 1.0	January 1, 2010	Initial version of Attachment B-1, Section 8 that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2010	Section 8.1.17.2 Financial Disclosure Report is revised to conform to federal requirements.
Revision	1.2	September 1, 2010	Section 8.1.1.2 is modified to change the title to "Additional Readiness Reviews and Monitoring Efforts", to clarify that HHSC may conduct desk and/or onsite reviews as part of its normal Contract monitoring activities, and to require the MCOs to pay all reasonable costs for HHSC to conduct those onsite reviews. Section 8.1.2.1 is modified to conform to timeframes for the Health Plan Comparison Chart process. Section 8.1.4.2 is modified to remove the reference to Certified Nurse Midwives and replace it with the broader term Advanced Practice Nurses. Section 8.1.4.11 is modified to add liquidated damages. Section 8.1.5.9 is modified to add liquidated damages. Section 8.1.17.2 Financial Disclosure Report is revised to clarify federal requirements. Section 8.1.18 is modified to revise the timeframe for notification and to require the MCOs to pay all reasonable costs for HHSC to conduct onsite reviews. Section 8.1.18.2 is modified to require HMOs to submit their Disaster Recovery Plan, Business Continuity Plan, and Security Plan annually and to require HMOs to include checklists when submitting modified JIPs, Risk Management Plans and Systems Quality Assurance Plans. Section 8.1.18.5 is modified to conform to the timeframes for notification in Attachment A, Section 4.08(b)(3). New Section 8.1.18.6 is added, as required by Section 6507 of the Patient Protection and Affordable Care Act of 2010 (PPACA). Section 8.1.21 is modified to change "date of service" to "date of adjudication".
Revision	1.3	December 1, 2010	Contract amendment did not revise Attachment B-1, Section 8 "Operations Phase Requirements".

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.4	March 1, 2011	Section 8.1.1.1 is modified to change all "Performance Improvement Goals" references to "Performance Improvement Projects" and to establish new Overarching Goals for FY2012. Section 8.1.3.2 is revised to be consistent with the TDI requirement to allow pregnant Members past the 24th week of pregnancy to remain under the care of their current OB/GYN, even if provider is Out-of-Network. Section 8.1.3.2 is amended to allow the MCO to request an exception to the 30-mile Hospital access requirement for their CHIP Members on a case by case basis. Section 8.1.4.8 is modified to prohibit payments to entities located outside the U.S. in conformance with the Affordable Care Act. Section 8.1.4.11 is revised to add the 98% standard for complaint resolution and to remove the 30 day request for extension requirement for complaints received directly by the HMO. Section 8.1.19 is modified to require MCO to designate a primary and secondary contact for all OIG requests and to outline the process and timeframes for responding to the OIG. New Section 8.1.23 "Immunizations" is added to clarify immunization requirements.
Revision	1.5	September 1, 2011	Section 8.1.1.1 is modified to remove redundant language. Section 8.1.4 is modified to require HMOs to contract with any willing ambulance provider that meets the HMO's credentialing requirements and agrees to the HMO's contract terms and rates. Section 8.1.4.8 is modified to add language for the ACA requirement regarding Healthcare Acquired Conditions (HAC) pursuant to the Patient Protection and Affordable Care Act of 2010 (Pubic Law 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA). Section 2702 of ACA prohibits federal payments to States for any amount expended under Medicaid for health care-acquired conditions. Section 8.1.4.9 is modified to clarify compliance with 42 CFR 438.10(f)(5).

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.5.6 is modified to add clarification that the HMOs provide oral interpretive services free of charge, as required by 42 CFR 438.10(c)(4). Section 8.1.7.8 is modified to clarify physician incentive plan requirements for CHIP. Section 8.1.8, Second Paragraph, is amended to refer to federal regulations regarding medical record content. Section 8.1.9 is modified to clarify the age requirements. Section 8.1.12.1 is modified to clarify that appropriate health care professionals must perform assessments, as required by 42 CFR 438.208(c)(2). Section 8.1.18.5 is modified pursuant to the Patient Protection and Affordable Care Act of 2010 (Pubic Law 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA). Section 6401(b)(7) of the ACA requires the State to require all ordering or referring providers or other professionals to be enrolled in the program and that the national provider identifier (NPI) of any ordering or referring physician or other professional to be specified on the claims for payments for Medicaid and CHIP.
Revision	1.6	March 1, 2012	Section 8.1.1.1 is modified to clarify timelines, and to add language incorporating HHSC's PIPs templates (UMCM Chapters 10.2.4, 10.2.5, and 10.2.6) into the contract. Section 8.1.2.1 is modified to add language incorporating HHSC's Value-Added Services template (UMCM Chapter 4.5) into the contract. Section 8.1.3 is modified to add a requirement regarding timely access to Network Providers, as required by 42 CFR §438.206(c)(1)(ii). Section 8.1.3.2 is modified to add pharmacy access requirements. Section 8.1.4 is modified to require Provider contracts to include reasonable administrative and professional terms, to require that all Pharmacy Providers be enrolled with HHSC's Vendor Drug Program, and to clarify State Hospital and Pharmacy Provider contracting requirements.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.5.1 is modified to comply with SB & by adding a requirement to post Member Materials on the MCO's website. Section 8.1.5.5 is modified to require the MCOs to include a link to financial literacy information on the OCCC web page as required by HB 2615. Section 8.1.8 is modified to add prior authorizations by pharmacists. Section 8.1.14 is modified to encourage MCOs to develop provider incentive programs for Designated Providers who meet the requirements for patient-centered medical homes, as required by SB 7. Section 8.1.17 is modified to remove the requirement to submit an accounting policy manual. Section 8.1.17.2 "Financial Disclosure Report" is renamed "MCO Disclosure Statement" and the submission date is updated. In addition "Report of Legal and other Proceedings" is added. Section 8.1.18 is modified to clarify that Subcontractor's MIS to comply with the requirements of this section. Section 8.1.18.1 is modified to require MCOs to submit pharmacy encounter data no later than 25 calendar days after the date of adjudication. Section 8.1.18.4 is modified to clarify claims transaction formats for pharmacy claims. Section 8.1.18.5 is modified to add requirement for MCO to file pharmacy claims in accordance with the timeframes specified in the Pharmacy Claims Manual (to be published on HHSC's website), to require MCOs to maintain a mechanism to receive claims in addition to the HHSC claims portal, and to add enforcement language. In addition, the section is modified pursuant to the Patient Protection and Affordable Care Act of 2010 (Pubic Law 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA). Section 6401(b)(7) of the ACA requires the State to require all ordering or referring providers or other professionals to be enrolled in the program and that the national provider identifier (NPI) of any ordering or referring physician or other professional to be specified on the claims for payments for Medicaid and

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			CHIP. Section 8.1.19 is modified to outline the process and timeframes for responding to the OIG, to change the 60 day timeline for submitting the annual plan to 90 days, to add a reference to the OAG, as required by Gov't Code §533.005(a)(10) (as modified by SB 7) and to add enforcement language. Section 8.1.20.2 "Fraudulent Practices Report" is modified to include additional required documentation and "Drug Utilization Review (DUR) Reports" is added. Section 8.1.23 is modified to clarify that MCOs must notify CHIP Providers of availability of vaccines through Texas Vaccines for Children Program and work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac Registry. Section 8.1.24 "Pharmacy Services" is added. Section 8.1.24.1 "Prior Authorization for Prescription Drugs" is added. Section 8.1.24.2 "Coverage Exclusions" is added. Section 8.1.24.3 "DESI Drugs" is added. Section 8.1.24.4 "Pharmacy Rebate Program" is added. Section 8.1.24.5 "Drug Utilization Review Program" is added. Section 8.1.24.6 "Pharmacy Benefit Manager (PBM)" is added. Section 8.1.24.7 "Financial Disclosures for Pharmacy Services" is added. Section 8.1.24.8 "Limitations Regarding Registered Sex Offenders" is added, as required by SB 7. Section 8.1.24.9 "Specialty Drugs' is added, as required by SB 7. Section 8.1.25 "Payment by Members" is added. Section 8.1.25.1 "Cost Sharing" is added.
Revision	1.7	June 1, 2012	The Document History Log for Version 1.6 is modified to correct a typographical error in the numbering of Section 8.1.24.2 "Coverage Exclusions". Section 8.1.24 is modified to add pharmaceutical

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			delivery requirements. Section 8.1.24.9 is modified to correct a typographical error in the section number.
Revision	1.8	September 1, 2012	Section 8.1.1.1 is modified to conform to the timelines in the UMCM. Section 8.1.3.2 is modified to clarify language regarding additional benchmark performance standards. Section 8.1.4.6 is modified to require HHSC review of all provider materials relating to Medicaid managed care or CHIP. Section 8.1.4.8 is modified to clarify the applicable federal regulations. Section 8.1.5.1 is modified to prohibit the MCOs from including any language in their member materials which limits the members' ability to contest or appeal denial of a benefit. Section 8.1.5.2 is modified to clarify that PCP name is not required for Dual Eligible STAR+PLUS Members or CHIP Perinates. Section 8.1.8 is modified to correct URL for UM guidelines. Section 8.1.9 is modified to clarify the requirements regarding IFSPs. Section 8.1.19 is modified to update the time frames for responding to the OIG and to add language regarding Credible Allegation of Fraud notices. Section 8.1.21 is modified for consistency with the Medicaid pay and chase requirements. Section 8.1.26 Health Home Services is added. Section 8.1.26.1 Health Home Services and Participating Providers is added. Section 8.1.26.2 MCO Health Home Services Evaluation is added.
Revision	1.9	March 1, 2013	Section 8.1.2.1 is modified to add language regarding reducing or deleting Value-added Services. Section 8.1.3.2 is modified to clarify network provider access and compliance rating. Section 8.1.4.12 Provider Advisory Groups is added.

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			Section 8.1.5.10 Member Advisory Groups is added. Section 8.1.18.5 is modified to add new language modeled off of insurance code requirements.
Revision	1.10	June 1, 2013	Contract amendment did not revise Attachment B-1, Section 8 "Operations Phase Requirements".
Revision	1.11	September 1, 2013	Section 8.1.1.1 is modified to remove references to overarching goals and to clarify that HHSC will provide the PIP topics. Section 8.1.2.1 is modified to clarify that MCOs may not charge copayments for Value-added Services, but may offer discounts for non-covered services as Value-added Services. Section 8.1.3.1 is modified to clarify timeframes for PCP referrals. Section 8.1.4 is modified to add new pharmacy requirements as required by SB 1106 and HB 1358. Section 8.1.4.2 is modified for clarification and for consistency with the requirements of SB 406, 83R. Section 8.1.4.4 is modified to add timeframes for completing the credentialing process and to comply with requirements of SB 365, 83R. Section 8.1.4.8 is modified to clarify the MCO's obligations for payment and Network Provider agreements and to comply with requirements of SB 7, 83R. Section 8.1.4.8.1 "Provider Incentives" is added. Section 8.1.4.14 "Out-of-State Providers" is added to comply with requirements of SB 1401, 83R. Section 8.1.4.15 "Provider Protection Plan" is added as required by SB 1150, 83R. Section 8.1.5.5 is modified to allow MCOs to offer provider search functionality on their websites instead of PDF versions of the Provider Directory. In addition, duplicative language is removed. Section 8.1.5.6.1 Nurseline is added. Section 8.1.5.7 is modified to allow MCOs to use certified community health workers/promotoras to conduct outreach and member education activities. Section 8.1.8.1 "Compliance with State and Federal Prior Authorization Requirements" is added as

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			required by SB8, SB 644, and SB1216, 83R. Section 8.1.9 is modified to update the T.A.C. references and to align the age reference with the definition. Section 8.1.14 is modified to add a new Subsection 8.1.14.1 Special Populations. Subsequent subsections are renumbered. Section 8.1.14.3 is modified to add requirements for special populations. Section 8.1.15 is modified to clarify which DSM edition is referenced. Section 8.1.15.7 is modified to delete the duplicative definition. The term “Court-Ordered Commitment” is defined in Attachment A. Section 8.1.18.1 is modified to require MCO Provider Agreements to comply with Texas Gov’t. Code regarding reimbursement of claims based on orders or referrals by supervising providers. Section 8.1.18.5 is modified for clarification, for consistency with Section 1213.005 of the Insurance Code. Section 8.1.20 is modified for clarification that records must be provided “at no cost.” Section 8.1.22 is modified to add more detail regarding FQHC/RHC payments. Section 8.1.24 Pharmacy Services is modified to reorganize the section and to add requirements as required by SB 644, HB 1358, 83R. Section 8.1.24.1 Formulary and Preferred Drug List (PDL) is added. Section 8.1.24.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies is modified to add “and 72-hour Emergency Supplies” to the title and to add requirements as required by SB 644, HB 1358, 83R. Section 8.1.24.3-Coverage Exclusions is modified for clarity. Section 8.1.24.5 Pharmacy Rebate Program is modified to require MCOs to include NDCs on all encounters. Section 8.1.24.6 Drug Utilization Review (DUR) Program is modified to add requirements as required

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			by SB 644, HB 1358, 83R. Section 8.1.24.7 Pharmacy Benefit manager (PBM) is modified to add requirements as required by SB 644, HB 1358, 83R. Section 8.1.24.8-Financial Disclosures for Pharmacy Services is modified for clarity. Section 8.1.24.9 Limitations Regarding Registered Sex Offenders is modified for clarity. Section 8.1.24.10 Specialty Drugs is modified to add requirements as required by SB 644, HB 1358, 83R. Section 8.1.24.11 Maximum Allowable Cost (MAC) Requirements is added. Section 8.1.24.12 Mail-order and Delivery is added. Section 8.1.24.13 Health Resources and Services Administration 340B Discount Drug Program is added. Section 8.1.24.14 Pharmacy Claims and File Processing is added. Section 8.1.24.15 Pharmacy Audits is added. Section 8.1.24.16 E-prescribing is added. Section 8.1.27 Cancellation of Product Orders is added.
Revision	1.12	January 1, 2014	Section 8.1.4.4 is modified to clarify the timeframes for completing the credentialing process. Section 8.1.13 is modified to conform to the Uniform Managed Care Contract. Section 8.1.24.6 is modified to add requirements for assessing prescribing patterns for psychotropic medications. Section 8.1.24.14 is modified to clarify timeframes.
Revision	1.13	February 1, 2014	Section 8.1.1.1 is modified to clarify that absent HHSC's direction the MCO may choose to collaborate with other MCOs in the Service Area on one PIP per year. Section 8.1.1.1.1 "MCO Report Cards" is added. Section 8.1.3.2 is modified to clarify the definition of and requirements for access to Qualified Mental Health Providers. Section 8.1.4 is modified to clarify licensure or

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			certification requirements for all providers. Section 8.1.4.4 is modified to add a sub-section heading for 8.1.4.4.1 Expedited Credentialing Process. Section 8.1.4.8.2 “Potentially Preventable Complications” is added. Section 8.1.4.14 is modified to add TAC reference for pharmacy. Section 8.1.5.11 “Member Eligibility” is added. Section 8.1.8 is modified to add that compensation to individuals or entities conducting UM activities cannot be structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services as required by 42 C.F.R. 438.210(e). Section 8.1.12 is modified to change “Children” to “Members”. Section 8.1.12.1 is modified to clarify use of the term CSHCN. Section 8.1.12.2 is modified to clarify use of the term CSHCN. Section 8.1.18.5 is modified to add timeframes for Nursing Facility claims and to clarify the MCO must provide a web portal at no cost to the Provider and its functionality. Section 8.1.19 is modified to require the MCOs to meet all requirements in Texas Government Code § 531.105. Section 8.1.28 Preadmission Screening and Resident Review (PASRR) Referring Entity Requirements is added.
Revision	1.14	September 1, 2014	Section 8.1.1.1 is modified to change the due date for PIP projects, and to require the MCOs to complete a mid-year review process. Section 8.1.3 is amended to clarify that the MCO may not require the Member to pay for any Medically Necessary or Functionally Necessary Covered Services, other than HHSC-specified co-payments for CHIP Members, where applicable. Section 8.1.3.2 is modified to update the mileage requirements for Outpatient Behavioral Health Service

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			Provider Access. Section 8.1.4 is modified to add a reference to utilization standards for CHIP (the Rule will be effective in December 2014). Section 8.1.4.4 is modified remove references to NCQA and URAC. Section 8.1.4.8 is modified to include language requiring compliance with Tex. Ins. Code § 1458.051 and §§ 1458.101-102. Section 8.1.4.8.1 is modified to change the name from "Provider Incentives" to "MCO Value Based Contracting." In addition, the language is clarified. Section 8.1.4.8.2 is modified to add the UMCM chapter reference and to remove the HHSC approved methodology. Section 8.1.4.15 is modified to include notice requirements for changes to the prior authorization process. Section 8.1.5.8 is modified to remove reference to Section 7. Section 8.1.12.2 is modified to add a reference to women's health and family planning programs. Section 8.1.14.1 is modified to update the requirements. Section 8.1.18 is revised to define major systems changes and to outline notice requirements. Section 8.1.18.4 is revised to clarify notice requirements. Attachment B-1, Section 8.1.18.5 is modified to clarify notice requirements. Section 8.1.19 is modified to include language related to requirements regarding a provider in the MCO's network who is under investigation by HHSC OIG. Section 8.1.24.2 is modified to require the MCOs to have an automated PA process. Section 8.1.24.7 is modified to add language prohibiting spread pricing. Section 8.1.24.11 is modified to clarify the process for making the MAC list accessible to Providers. Section 8.1.25.1 is modified to clarify requirements

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			with respect to CHIP copayments.
Revision	1.15	October 1, 2014	Section 8.1.24.17 "Second Generation Direct Acting Antivirals for Hepatitis C" is added.
Revision	1.16	March 1, 2015	After the first appearance of the term, "Uniform Managed Care Manual" is changed to "UMCM.' Section 8.1.1.1 is modified to remove the references to "annual." Section 8.1.2.1 is modified to require MCOs to clarify restrictions and limitations to their VAS and notification process when deleting a VAS. Section 8.1.2.3 is modified to clarify medical benefits coverage of some dental related services. Section 8.1.4 is modified to change an effective date. Section 8.1.4.4 is modified to add language regarding credentialing for new providers from Section 8.1.4.4.1 and to move the last sentence of the section to the end of the second paragraph. Section 8.1.4.4.1 is modified to move language regarding credentialing for new providers to Section 8.1.4.4 Section 8.1.4.6 is modified to clarify language and 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. Section 8.1.4.8 is modified to clarify requirements for requesting an across-the-board rate reduction. Section 8.1.4.8.1 MCO Value-Based Contracting (Expansion of Alternative Payment Structures for Providers) is deleted in its entirety and the requirements added as Section 8.1.7.8.2. Section 8.1.4.8.2 is modified to change "Potentially Preventable Complications" back to "Provider Preventable Conditions" and to clarify that PPC includes any hospital-acquired conditions or healthcare acquired conditions identified in the TMPPM. Section 8.1.5.1 is modified to clarify approval requirements for Member Materials. Section 8.1.5.4 is modified to clarify the format for submission to the HHSC Administrative Services

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			Contractor. Section 8.1.5.5 is revised to refer to UMCM chapters that set out general and pharmacy website requirements. Section 8.1.5.8 is modified to clarify that MCOs are responsible for reimbursing Providers for language services. Section 8.1.7.8 Network Management is modified to add sub-section heading 8.1.7.8.1 Physician Incentive Plans. Section 8.1.7.8.2 MCO Value-Based Contracting is added. Section 8.1.8.2 is added to require that MCOs offer a toll-free fax line for service authorizations. Section 8.1.9 is modified to add subsection headings and clarify the roles and responsibilities of the MCOs. Section 8.1.12.1 is modified to list groups of Members considered MSHCN and to clarify identification requirements. Section 8.1.12.2 is modified to update the section name and to clarify service management requirements. Section 8.1.12.3 Service Management for MSHCN is added. Section 8.1.13 Service Management for Certain Populations is deleted in its entirety and the section is intentionally left blank. Section 8.1.14.1 is modified to update the due date. Section 8.1.15.3 is modified to clarify that the MCO must submit separate hotline reports for BH and other routine Member calls. Section 8.1.18.5 is modified to clarify claims processing and payment requirements. Section 8.1.19 is modified to add some additional OIG commonly requested information to the current list. Section 8.1.20.2 is modified to add Dental and Pharmacy to the Claims Summary Report requirements and to add the Enrollment Denial Report and Pharmacy Quarterly Report. Section 8.1.24.1 is modified to remove the date. Section 8.1.24.2 is modified to reflect the new clinical

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			edit review process. Section 8.1.24.3 is modified to add link to CMS list of participating drug companies. Section 8.1.24.5 is modified to clarify that MCOs are not allowed to negotiate rebates on *any* drugs and to add the Government Code citation. In addition, item c. is modified to require the MCO to provide HHSC with an update on the status of a claim correction. Section 8.1.24.6 is modified to remove a report that is no longer needed. Section 8.1.24.8 is modified to require the MCO to disclose all financial terms and arrangements for their PBMs. Section 8.1.24.11 is modified to require MCOs and PBMs to use therapeutically equivalent A rated drugs when formulating MAC prices. Section 8.1.24.12 is modified to require the MCOs and PBMs to accept retail pharmacy POS claims for specialty drugs and to require MCOs to implement a process to ensure that Members receive free outpatient pharmaceutical deliveries from community retail pharmacies. In addition, it is clarified that mail order delivery is not an appropriate substitute for delivery unless requested by the Member. Section 8.1.26.2 MCO Health Home Services Evaluation is deleted in its entirety. Section 8.1.27 is modified to clarify MCO requirements related to delivery services for covered products.
Revision	1.17	May 1, 2015	Contract amendment did not revise Attachment B-1, Section 8 “Operations Phase Requirements”.
Revision	1.18	September 1, 2015	Section 8.1.1.1 is modified to clarify the requirements for collaboration. Section 8.1.2.1 is modified to change the due dates. Section 8.1.3 is modified to clarify the language. Section 8.1.3.2 is modified to remove past effective dates. Section 8.1.3.3 is modified to add requirements for a mandatory survey of Providers. Section 8.1.4 is modified to remove “when effective”

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			from the CHIP Tex. Admin. Code references. Section 8.1.4.4 is modified to clarify the requirement and to add applicability to unlicensed providers. Section 8.1.4.9 is modified to require the MCOs to notify HHSC when a Provider termination impacts more than 10% of its Members. Section 8.1.5.5 is revised to correct the UMCM chapter number for the MMC/CHIP Website Critical Elements. Section 8.1.5.8 is modified to require the MCOs to update the plan within 60 days if directed by HHSC. Section 8.1.7.7 is modified to change the section name to “Provider Credentialing and Profiling” and to add credentialing requirements. Section 8.1.9.5 is modified to reflect the new IFSP form and instructions developed by ECI. Section 8.1.15.9 Mental Health Parity is added. Section 8.1.18.1 is modified to clarify the language and to add the STAR+PLUS Handbook Appendices Section XVI and to add requirements for the Quarterly Encounter Reconciliation Report. Section 8.1.19 is modified to address issues of material misrepresentation. In addition, sub-section headings are added and the section is reorganized for clarity. Section 8.1.20.2 is modified to change the section name from “HEDIS and Other Statistical Performance Measures” to “Performance Measurement” and to remove unnecessary language. Section 8.1.21 is amended to clarify the requirement. Section 8.1.24.1 is modified to add certain LHHS and vitamins and minerals. Section 8.1.24.2 is modified to require the MCO to submit all clinical edit proposals in compliance with the required information outlined in the UMCM. Section 8.1.24.4 is deleted in its entirety. Section 8.1.24.7 is modified to comply with the requirements of SB 94. Section 8.1.24.11 is modified to clarify requirements regarding PSAOs.

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Revision	1.19	March 1, 2016	Section 8.1.1.2 is modified to require the MCO to allow HHSC access for remote monitoring. Section 8.1.2 is modified to require MCOs to monitor claims data for delivery of prior authorized acute and long-term care services and to require the MCOs to utilize evidence based medical policies. Section 8.1.4.9 is modified to clarify the timeframe. Section 8.1.6 is modified to correct the UMCM reference. Section 8.1.24.1 is modified to change “Clinical Edits” to “Clinical PAs.” Section 8.1.24.2 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. Section 8.1.24.6 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. Section 8.1.24.15 is modified to prohibit the use of extrapolation in pharmacy audits and to remove the requirement to comply with Texas Insurance Code § 843.3401. Section 8.1.24.17 “Second Generation Direct Acting Antivirals for Hepatitis C” is deleted in its entirety.
Revision	1.20	September 1, 2016	Section 8.1.4 is modified to modify Children's Hospitals/Hospitals with specialized pediatric services. 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 8.1.4.4.1 is modified to add provider types for which the MCOs must expedite credentialing. Section 8.1.4.8 is modified to align the contract language with the Texas Government Code. Section 8.1.4.8.1 Safety-net Hospital Incentives is added. Section 8.1.4.9 is modified to clarify the reporting requirement. Section 8.1.5.1 is modified to clarify delivery of hard copies of the Provider Directories.

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			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. Section 8.1.5.5 is modified to add a reference to the Online Provider Directory and to add requirements for mobile devise use. Section 8.1.11 Coordination with Texas Department of Family and Protective Services is modified to conform to language in the Uniform Managed Care Contract. Section 8.1.19 is modified to clarify MCO level of cooperation and assistance. Section 8.1.19.2 is modified to clarify and provide support to the Deliverables/Liquidated Damages Matrix. Section 8.1.20.2 is modified to update the requirements for items (d) (e) and (f); to delete item (g) and re-letter all subsequent items. Section 8.1.23 is modified to require the MCOs to educate providers on documentation for immunizations.
Revision	1.21	March 1, 2017	All references to OIG or IG will be changed to HHSC OIG. Section 8.1.1.1 is modified to align to the UMCM and to remove the reference to the NorthSTAR program. 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 8.1.4.6 is modified to require the MCOs to notify Providers of changes to provider relations

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			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. Section 8.1.5.1 is modified to remove review timeframe. Review timeframes can be found in UMCM Chapter 4.6 MCO Materials Submission Process. Section 8.1.5.6 is modified to add requirements that Member Service representatives be knowledgeable about service management and service plans and trained to assist with scheduling an appointment. Section 8.1.5.8 is modified to add CLAS requirements. Section 8.1.5.12 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. Section 8.1.12.2 is modified to clarify credentialing requirements, to update the name of the Healthy Texas Women Program, and to remove the Expanded Primary Health Care Program. Section 8.1.15.9 is modified to conform to CMS clarifying guidance regarding mental health parity. Section 8.1.18.2 is modified to remove the phrase "at the beginning of each State Fiscal Year" from the first and second paragraph. Section 8.1.19 is modified to add a reference to Texas Government Code § 531.1131. Section 8.1.19.3 is modified to add item 2 and all subsequent items are renumbered. Section 8.1.20.2 is modified to add item (l). Section 8.1.22 is modified to clarify the payment requirements. Section 8.1.29 “Continuity of Care and Out-of-Network Providers” is added.
Revision	1.22	September 1, 2017	Section 8.1.1.3 is added. Section 8.1.1.2 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

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			travel reimbursement. 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 comply with managed care access requirements to be based on distance or travel time rather than both and the addition of therapy provider reports in accordance with UMCM Chapter 5.0. Section 8.1.4 is modified to comply with 42 CFR §457.990 regarding enrollment of CHIP providers. In addition the reference to the DSHS website is changed to HHSC. 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 8.1.4.7 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 8.1.4.8.3 is added to comply with a new CMS managed care requirement in 438.602(d)(2). Section 8.1.4.9 is modified to comply with 42 CFR §438.10(f)(1), which relates to written notice of termination of a contracted provider. Section 8.1.4.11 “Provider Complaints” is renamed “Provider Complaints and Internal MCO Appeals”; and is amended to provide greater clarification regarding proper and timely dissemination of information to the noted parties. Section 8.1.4.12 "Appeal of Provider Claims" is renamed " Provider Appeal of MCO Claims Determinations" and to comply with 42 CFR §438.406 Section 8.1.5.1 is modified to comply with 42 CFR §438.10. Section 8.1.5.4.2 is modified to comply with 42 CFR

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			§438.10, which relates to provider directories, member handbooks, and formularies. 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. 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. Section 8.1.7.1 is modified to comply with 42 CFR §438.332. Section 8.1.7.8.2 "MCO Value-Based Contracting" is renamed "MCO Alternative Payment Models with Providers" and the requirements are updated to establish targets for MCOs regarding levels of payments tied to APMs with Providers. Section 8.1.7.9 is modified to clarify that MCOs using HEDIS hybrid measures are responsible for conducting chart reviews and submitting results to the EQRO. Section 8.1.9.1 is modified to add Member Handbook to the list of policies and procedures and substituting HHSC for DARS. Section 8.1.12.2 is modified to reflect the family planning program changes. Section 8.1.14.1 is modified to change the submission of the Plan for Special Populations from an annual report to an ad hoc report. 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 from HHSC staff as a requirement for travel reimbursement. Section 8.1.15.9 is modified to add specificity to the requirement. Section 8.1.17 is modified to clarify reasonable costs. Section 8.1.17.2 is modified to add item (n) "Medical Loss Ratio (MLR) Report" to comply with 42 CFR §438.8. Section 8.1.18 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct

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			MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.18.5.1 is added to ensure MCOs are completing their claims projects and submitting final claims in a timely fashion. Section 8.1.19.2 is modified to add a five business day timeframe for requests submitted to the MCO/DMO for policy guidance, interpretations or clarifications. Section 8.1.19.4 (7) clarifies how settlements under the False Claims Act will be handled. Section 8.1.20.2 is modified to change the reporting requirements for "Claims Summary Report" to by Program only, to delete "Children of Migrant Farmworkers Annual Plan" and to change the report title "Children of Migrant Farmworkers Annual Report (FWC Annual Report)" to "Migrant Farmworker Child Annual Report (FWC Annual Report) and Annual FWC Report Log" and update the requirements. Section 8.1.22 is modified to comply with a court order related to the Legacy lawsuit requiring FQHC non-emergency unauthorized out-of-network services be fully reimbursed. Section 8.1.24 is modified to comply with 42 C.F.R. §438.3(s) and the Mental Health Parity and Addiction Equality Act (MHPAEA) of 2008. Section 8.1.24.1 is modified to comply with 42 C.F.R. §438.10, which relates to provider directories, member handbooks, and formulary information. Section 8.1.24.6 is modified to comply with 42 C.F.R. §438.3(s). Section 8.1.25 is modified to update the citation to 42 C.F.R. §438.113. Section 8.1.29 modified to comply with 42 CFR §438.208(b)(3).
Revision	1.23	March 1, 2018	The following changes were made throughout the attachment: Updates to citations Removal of hyperlinks Change “patient” to “Member”

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			Change “shall” to “must” Change “Network Provider Agreement” and “Provider Agreement” to “Provider Contract” Change “day(s)” and “calendar day(s)” to “Day” Remove numeric number for those numbers under 10 Capitalized defined terms Changed order of terms Fraud, Waste and/or Abuse to consistent use of phrase Changed “Fair Hearing System” to “State Fair Hearing System” Section 8.1.1.3 is modified to remove statement regarding STAR+PLUS. Section 8.1.2.2 is modified to accommodate 42 C.F.R. 438.3(e). 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 8.1.4 “Optometrists and Ophthalmologists” is added to comply with implementation of HB 3675, 85r. Section 8.1.4.8.2 is modified to comply with 42 C.F.R. § 438.3(g). Section 8.1.4.15 is modified to state expectations related to retaliation and to withdraw MCO geo-mapping and MCO requirement to participate in HHSC’s work group. Section 8.1.5.1 is modified to remove references to potential members from requirements, to remove references to written materials, and to ensure all information provided by MCOs to Members complies with 42 C.F.R. § 438.10. Section 8.1.5.4.1 is modified to comply with 42 C.F.R. § 438.10(h)(3) and to comply with FTP submission from beginning of each state fiscal quarter to as often as needed. Section 8.1.5.4.2 is modified to add “at least” to weekly updates to online provider directories. Section 8.1.5.8 is modified to add standardized requirements for cultural competency plans and to clarify services for Competent Interpreters. Section 8.1.8.2 is modified to include “Provider portal”.

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			Section 8.1.12.1 is modified to clarify requirements regarding Service Management for Members with Special Health Care Needs (MSHCN). Section 8.1.12.3 is modified to remove language. Section 8.1.18.1 is modified to comply with 42 C.F.R. §§ 438.242 and 438.818. Section 8.1.20.2 is modified to standardize language across all MCOs. Section 8.1.21 is modified to require MCOs to submit a yearly plan/TPL process and clarify deadlines for billing & collection of TPL recoveries. Section 8.1.22 is modified to comply with a court order requiring wrap payments and that FQHC non-emergency unauthorized out-of-network services be fully reimbursed. Section 8.1.23 is modified to include “appropriate designee”. Section 8.1.24 is modified to limit HHSC and MCO liability. Section 8.1.24.2 is modified to give more flexibility to the MCOs by allowing the pharmacy to dispense a 72-hour supply of drug in emergency situations. Section 8.1.24.3 is modified to add flexibility to deny certain claims for compound medications and to add clarity to the automatic approval of compounded medications. Section 8.1.24.4 “Compounded Medications” is added. Section 8.1.24.13 is modified to require MCOs to deny retail claims of 340B drugs. Section 8.1.29 is modified to make certain MCOs ensure continuity of care of newly enrolled Members.
Revision	1.24	September 1, 2018	Section 8.1.1.1 is modified to allow health plans to collaborate with community organizations. Section 8.1.2 is modified to comply with 42 C.F.R. §457.1201 (p). 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.

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			Section 8.1.3 is modified to be in full compliance with 42 C.F.R. § 438.14. 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. It is also modified to allow geo mapping for audiology providers. In addition, this section is modified to comply with 42 C.F.R. §§ 438.68 and 457.1201(j). Lastly, this section is modified to bring contract language into alignment with current practice. Section 8.1.3.4 is added to outline requirements permitting Members to see out-of-network Indian Health Care Providers in order to comply with 42 C.F.R. 438.14. Section 8.1.4 is modified to clarify pharmacy services are included in the requirements supported by the CDC. 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. Section 8.1.4.6 is modified to clarify the responsibility of the MCO to coordinate substance use disorder services. Section 8.1.4.8 is modified to reflect the new program area name, Managed Care Compliance & Operations. Section 8.1.4.12 is modified to make consistent with other contracts. 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. Section 8.1.12.1 is modified to clarify and streamline criteria for identifying Members with Special Health Care Needs. Section 8.1.12.2 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. Section 8.1.13 is added to streamline criteria for identifying Members with Special Health Care Needs. Section 8.1.18 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as

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			opposed to only those subcontracting Behavioral Health Services for continuity. Section 8.1.18.5 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. Section 8.1.19.3 is modified to clarify language on operational processes. Section 8.1.19.4 is modified to comply with Texas Government Code § 531.102(g). Section 8.1.19.5 is modified to comply with 42 C.F.R. 438.608(d)(1)(i) and CMS MCE Checklist 1.1.6. Section 8.1.20.2 (m) is added to create a new deliverable which captures utilization data for clinician-administered drugs paid through the non-risk based model. Section 8.1.22 is modified to be in full compliance with 42 C.F.R. § 438.14. Section 8.1.24.1 is modified to comply with H.B. 1296 of the 85th Legislative Session. Section 8.1.24.2 is modified to move language regarding “prescriber authorization during a Governor-declared disaster” to new Section 8.1.29. Section 8.1.29 is modified to clarify and streamline criteria for identifying Members with Special Health Care Needs. Section 8.1.30 is added to ensure MCOs have plans in place for future disasters.
Revision	1.25	January 1, 2019	Section 8.1.15.7 is modified to identify types of court orders that are CHIP-payable. Section 8.1.21 is modified to comply with The Bipartisan Budget Act of 2018. Section 8.1.25 is modified to clarify court orders that are Medicaid-payable.
Revision	1.26	March 1, 2019	Contract amendment did not revise Attachment B-1 Section 8 “Operations Phase Requirements”.
Revision	1.27	September 1, 2019	Substance abuse is changed to substance use disorder to align with the language in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Texas Administrative Code Titles 40 and 25

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			transferring to Title 26. Section 8.1.3.1 is modified to clarify required appointment wait time for Specialty Therapy Services. Section 8.1.3.3 modified to comply with managed care Network Adequacy initiatives. Section 8.1.4 is modified to clarify pharmacy contract arrangements; and correct the terminology regarding licensing, certification and Medicaid contracting per guidance from HHSC Licensing. Section 8.1.4.8 to modified to change timeframes for fee schedule changes. Section 8.1.5.4 is modified to comply with managed care Network Adequacy initiatives Section 8.1.5.4.1 is modified to comply with managed care Network Adequacy initiatives. Section 8.1.5.4.2 is modified to comply with managed care Network Adequacy initiatives. Section 8.1.5.6 is modified to comply with managed care Network Adequacy initiatives. Section 8.1.5.8 is modified to clarify the interpreter service requirements available to MCOs, including advance notice. Section 8.1.5.9. is modified to align with MCO appeal standards. Section 8.1.7.8.2 is modified to add pharmacies and pharmacist as types of providers MCOs can work with to meet the APM requirement. 8.1.8 is modified to comply with CFR. Section 8.1.16 is modified to align the TPL language across all MCO contracts. Section 8.1.18 is modified to ensure standardized reporting of provider addresses for analytical network adequacy reporting. Section 8.1.19 is modified to ensure MCOs comply with nursing facility utilization review findings and discovery. Section 8.1.19.1 is modified to comply with Rider 152, Article II, 85th Texas Legislature. Section 8.1.19.2 is modified to add a requirement to retain certain documents for review by the OAG.

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			Section 8.1.19.2 is modified to comply with Timeframe. Section 8.1.20.2 is modified to add or modify reports. Section 8.1.21 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 8.1.24.10 is modified to clarifies MCO's must adhere Specialty Drug List. Section 8.1.30 is modified to align UMCM Chapter 15.
Revision	1.28	March 1, 2020	Section 8.1.8 is modified to comply with SB 1096. This change requires MCOs issue coverage determinations within specific timeframes for members who are hospitalized.
Revision	1.29	September 1, 2020	Global change to correct the program name from "ImmTrac" to "ImmTrac2," the new program name. Section 8.1.1.2 is modified to align review requirements across all contracts Section 8.1.2.2 is modified to specify what information is required for each authorized case-by-case service 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 and include distinguishing access standards in response to the HHSC Business Plan. Section 8.1.4.7 is modified to remove language that is no longer required by CMS. Section 8.1.5.6 is modified to remove measures that are no longer required by CMS. Section 8.1.5.8 is modified to remove reference to UMCM Chapter that do not exist. Section 8.1.7.8.1 is modified to correct citation. Section 8.1.7.8.2(5) is modified facilitate in advance to approval of MCOs APMs involving the outpatient drug benefit. Section 8.1.8 is modified to include requirement from SB 1207 related to prior authorizations.

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			Section 8.1.8.1 is modified to clarify language when providing new information to providers Section 8.1.15.3 is modified to remove measures that Is no longer required by CMS. Section 8.1.16 is modified to add language to reflect the order when Medicaid is obligated pay. Section 8.1.17.2 (m) & (o) is modified to make language consistent across all contracts. Section 8.1.18.5.1 is modified to exclude Nursing Facility Daily/Unit as part of a Claims Project. Section 8.1.19.1 Is modified delete the language that allows MCOs to submit a letter in lieu of a full Fraud, Waste and Abuse compliance plan. Section 8.1.19.3 is modified to remove a report that is no longer required. Section 8.1.20.2 is modified to be consistency with other contract. Section 8.1.21 is modified to be consistent across all contracts. Section 8.1.23 is modified to be in alignment with other schedule for immunization. Section 8.1.24.1 is modified to align with TDI. Section 8.1.24.5 is modified to be consistent with current contract language. Section 8.1.24.11 Modifies language to clearly state HHSC's right to review MAC lists as they pertain to this contract.
Revision	V1.30	March 1, 2021	Section 8.1.31 is added to comply with federal law and CMS requirements. Section 8.1.31.1 is added to comply with federal law and CMS requirements.
Revision	V1.30.1	June 1, 2021	Contract amendment did not revise Attachment B-1 Section 8 "Operations Phase Requirements".
Revision	V1.31	September 1, 2021	Global change is modified to update UMCM chapter reference. Section 8.1.1.3 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

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			contract changes to VAS. Section 8.1.3.2 is modified to correct the current citation. Section 8.1.7.8.3 is added to give MCO guidance in the contract for July 2017 requirements. Section 8.1.8.1 is modified to correct language to differentiate between Medicaid and CHIP requirements for PA. Section 8.1.16 is modified to remove language specific to tort/subrogation. Section 8.1.18.5 is modified to add TDI requirement related to coordination of benefits for secondary payors Section 8.1.19.5 is modified to clarify MCO requirements for referring FWA. Section 8.1.20.2 (m) is modified to remove the section as the referenced survey is obsolete. Section 8.1.21 is modified to clarify HHSC file submission timeframe. Section 8.1.24.2 is modified to provide timeframes for MCO. Section 8.1.24.12 is modified to correct existing language. Section 8.1.24.14 is modified to establish a performance measure and clarify language consistent in each contract . Section 8.1.24.17 is added as new PA criteria requirement. Section 8.1.29.1 is added due to CMS requirement. Section 8.1.32 is added to update names of programs that provide primary and family planning services.
Revision	1.32	March 1, 2022	Section 8.1.4 is modified to add additional language to address current contract reimbursement and reporting issues. Section 8.1.4.8 is modified to clarify language used for pharmacy provider reimbursements. Section 8.1.24 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

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			HHSC. Section 8.1.24.7 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 8.1.24.8 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 8.1.24.11 is modified to add-on, proactive approach to address current MCO/PBM/Provider contract reimbursement and MCO FSRA reporting/transparency issues to HHSC. Section 8.1.29 is modified to include language to meet CMS requirements to allow single case agreements for members. Section 8.1.29.1 is deleted, language moved.
Revision	V1.33	September 1, 2022	Global Change in Section 8 change “Service Management to Service Coordination” throughout Section 8 Section 8.1.1.4 is added Section 8.1.3.1 is modified a defined term that is inclusive of substance use disorder. Section 8.1.3.5 is added Section 8.1.7.1 is modified to comply with HB 4533, 86th Legislature, 2019. Section 8.1.7.8.2 is modified new language to support a more comprehensive approach to APMs. Section 8.1.8.5 is modified to be consistent across all MCO contracts. Section 8.1.9.1 is modified to update the citation to the TAC rules for the ECI program due to it having been moved to new section Section 8.1.9.2 is modified to update the citation to the TAC rules for the ECI program due to it having

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			been moved to new section. Section 8.1.9.5 is modified to update the citation to the TAC rules for the ECI program due to it having been moved to new section. Section 8.1.11 is modified to match the terminology for this service that is used by DFPS, the agency that operates this service. Section 8.1.12.4. is added Section 8.1.15.9 is modified to provide clarification to Code of Federal Regulations references in the mental health parity. Section 8.1.16 is modified to update language due to Rider 39 from SB1, from the 87th Regular Legislative Session Section 8.1.16 is modified to add clarifying language to be consistent across all MCO contracts. Section 8.1.17.2 is modified to add clarifying language to be consistent across all MCO contracts Section 8.1.18.5 is modified to be consistent across all MCO contracts Section 8.1.19 is modified to align Compliance Plan language in one section Section 8.1.19.1 is modified to align Compliance Plan language in one section Section 8.1.19.2 is modified to update claims data due date to align with current practice Section 8.1.19.4 is modified to Update contact information with current OIG area Section 8.1.21 is modified to make word changes and/or corrections made for consistency across all MCO contracts. Section 8.1.24.2 is modified to address pharmacy related information. Section 8.1.24.11 is modified – language due to the pending withdrawal of the liquated damages for Pharmacy (PH) performance standard PH-11
Revision	1.34	March 1, 2023	Contract amendment did not revise Attachment B-1 Section 8 “Operations Phase Requirements”.
Revision	1.35	September 1, 2023	Section 8.1.3.5 is modified to help HHSC to track utilization and trends related to the use of

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			telecommunications for Covered Services in managed care. Section 8.1.4.8.1 is modified remove incentives to safety-net hospitals for exemplary performance. Section 8.1.5.3 is modified to clarify CPW carve-in language on how an MCO should notify their members and which members should be notified when there is a change in covered services. Section 8.1.8 is modified to clarify the TDI statute prohibits group health insurers from requiring the observation of psychotherapy sessions and submission of psychotherapy notes as part of utilization review. Section 8.1.12.3 is modified service plan elements are updated to align with the elements required for STAR and CHIP in the UMCC. Section 8.1.19.2 is modified to ensure OIG has access to complete, unredacted information. Section 8.1.19.3 is modified to ensure OIG has access to complete, unredacted information. Section 8.1.20 is modified to strengthen language in the reporting requirements. Section 8.1.24 is modified to clarify intent of the contract language. Section 8.1.24.11 is modified to clarify intent of the contract language. Section 8.1.25 is modified to strengthen contract requirements outline the types of allowable providers for the emergency services. Section 8.1.33 is added to clarify CHIP-P postpartum coverage.
Revision	1.36	March 1, 2024	Section 8.1.7.8.2 is modified for consistency across all contracts. Section 8.1.17.2 (c) is modified to align all contracts with current financial requirements based on MCO and OIG response. Section 8.1.21 is modified in response to federal law changes to 42 USC §1396a(a)(25), as amended by the Deficit Reduction Act of 2005 and, further, by H.R. 2471 (2022), and state law changes made by SB 1342, 88th Texas Legislature, Regular Session, 2023, by Perry, that codify the federal law changes in state law.

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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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8. OPERATIONS PHASE REQUIREMENTS

This Section describes scope of work requirements for the Operations Phase of the Contract.

This Section does not include detailed information about the CHIP or CHIP Perinatal Program requirements, such as the time frame and format for all reporting requirements. HHSC has included this information in the **Attachment A** "General Contract Terms and Conditions" and the Uniform Managed Care Manual (UMCM). HHSC reserves the right to modify these documents as it deems necessary using the procedures set forth in the **Attachment A** "General Contract Terms and Conditions".

8.1 General Scope of Work

HHSC may select up to two MCOs to provide health care services to all CHIP Rural Service Area Program Members. The MCOs must be approved by the TDI in all zip codes in the Service Area no later than 120 Days after the Contract Effective Date. Coverage for benefits will be available to enrolled Members effective on the Operational Start Date.

8.1.1 Administration and Contract Management

The MCO must comply, to the satisfaction of HHSC, with (1) all Contract requirements, and (2) all applicable provisions of state and federal laws, rules, regulations, and waivers.

8.1.1.1 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. The purpose of health care 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. (See UMCM Chapter 10).

CMS protocol describes ten steps to be undertaken 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.

HHSC will track MCO performance on PIPs. It will also track other key facets of MCO performance through the use of a Performance Indicator Dashboard for Quality Measures in accordance with UMCM Chapter 10. HHSC will compile the Performance Indicator Dashboard based on MCO submissions, data from the EQRO, and other data available to HHSC. HHSC will share the Performance Indicator Dashboard measures with high and minimum performance standards established using the methodology set forth in UMCM Chapter 10 with the MCO on an annual basis.

8.1.1.1.1 MCO Report Cards

Texas Government Code § 536.051 requires HHSC to provide information to Medicaid and CHIP Members regarding MCO performance on outcome and process measures during the enrollment process. To comply with this requirement, HHSC will develop annual MCO report cards. HHSC will develop a separate report card for each Program Service Area to allow enrollees to easily compare the MCOs on quality measures. HHSC may publish the report cards on its website and include them in the enrollment packets. HHSC will provide a copy of the report card to the MCO before publication and the MCO will have the opportunity to review and provide comments. However, HHSC reserves the right to publish the results while awaiting MCO feedback.

HHSC may charge the MCO any costs related to recalculating the report card measures if the EQRO determines the original data was valid.

8.1.1.2 Operations Phase Readiness, Operational and Targeted Reviews

HHSC may conduct desk or onsite reviews related to Contract performance. HHSC may also require MCOs to submit detailed policies and procedures to 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
4. Carve-ins of new Services.

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 received HHSC approval for an exception in writing, the MCO must provide HHSC secure access rights as an authorized guest user to all 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's or Subcontractor production environment or an environment that mirrors the production environment functionality.

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

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

For MIS Changes Only: The MCO must provider HHSC updates to the MCO's organizational chart and descriptions of MIS responsibilities at least 30 Days prior to the effective date 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** ("Transition Phase Requirements") and **Section 8.1.18** ("Management Information System Requirements") for additional information regarding Readiness Reviews. Refer to **Attachment A** ("General Contract Terms and Conditions"), **Section 4.08(c)** for information regarding Readiness Reviews of the MCO's Material Subcontractors.

8.1.1.3 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 corrective actions taken, including demonstration by the MCO that the corrective action(s) or intervention(s) included in the Corrective Action Plan (CAP) has 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 shall 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.

8.1.1.4 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.

8.1.2 Covered Services

The MCO is responsible for assessing, authorizing, arranging, coordinating, and providing Covered 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 and/or receipt of any prior health care services. 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. The MCOs must not avoid costs for Covered Services by referring Members to publicly funded health care resources. If a Member's Effective Date of Coverage occurs while the Member is confined in a Hospital, MCO is responsible for the Member's costs of Covered Services beginning on the Effective Date of Coverage. If a Member is disenrolled while the Member is confined in a Hospital, MCO's responsibility for the Member's costs of Covered Services terminates on the Date of Disenrollment.

The MCO must not practice discriminatory selection or encourage segregation among the total group of eligible Members by excluding, seeking to exclude, or otherwise discriminating against any group or class of individuals.

A description of CHIP Covered Services and exclusions is provided in **Attachment B-2** of the Contract. A description of CHIP Perinatal Program Covered Services and exclusions is provided in **Attachment B-2.1** of the Contract. CHIP MCOs are responsible for providing all Covered Services in accordance with the state plan under Title XXI and Attachments B-2, "CHIP Covered Services", and B-2.1, "CHIP Perinatal Program Covered Services. Covered Services are subject to change due to changes in federal and state law, changes in CHIP or CHIP Perinatal Program 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 (VAS) means additional services for coverage beyond those specified in **Attachments B-2** ("CHIP Covered Services"), and **B-2.1** ("CHIP Perinatal Program Covered Services"). VAS may be actual Health Care Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve health outcomes among Members. VAS that promotes healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be VAS, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered VAS.

If offered, VAS must be offered to all Members within an MCO Program that are part of an identified group or category of Members.

Any Value-added Services that the MCO elects to provide must be provided at no additional cost to HHSC. The costs of Value-added Services are not reportable as allowable medical or administrative expenses, and therefore are not factored into the rate-setting process. In addition, the MCO must not pass on the cost of the Value-added Services to Members or Providers.

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 specify the conditions and parameters regarding the delivery of each VAS 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.).

Operations Phase. During the Operations Phase, VAS can be added or removed. MCOs will be given the opportunity to add, enhance, delete or reduce VAS once per State Fiscal Year (SFY), with changes to be effective September 1. HHSC may allow additional modifications to VAS if Covered Services are amended by HHSC during a SFY. HHSC will coordinate annual

revisions to HHSC's MCO Comparison Charts for Members. The MCOs must submit requests to add, enhance, delete, or reduce a VAS 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.)

The MCO's request to add a VAS must:

a. define and describe the proposed VAS;
b. specify the MCO Programs for the proposed VAS;
c. identify the category or group of Members eligible to receive the VAS if it is a type of service that is not appropriate for all Members;
d. note any limitations or restrictions that apply to the VAS;
e. identify the Providers or entities responsible for providing the VAS;
f. describe how the MCO will identify the VAS in administrative data (Encounter Data) and/or in its Financial Statistical Report (FSR), as applicable;
g. propose how and when the MCO will notify Providers and Members about the availability of such VAS;
h. describe the process by which a Member may obtain or access the VAS, including any action required by the Member, as appropriate; and
i. include a statement that the MCO will provide such VAS for at least 12 months.

An MCO cannot include a VAS in any material distributed to Members or prospective Members until the VAS is approved by HHSC. If a VAS is deleted, the MCO must notify each Member, at a minimum of 30 Days prior to discontinuing the VAS, that the service will no longer be available as a VAS through the MCO. The MCO must also revise all materials distributed to prospective Members to reflect the change in VAS. Materials are subject to review and approval by HHSC.

8.1.2.2 Case-by-case Services

Except as provided below, the MCO may offer additional benefits that are outside the scope of services to individual CHIP Members on a case-by-case basis, based on Medical Necessity, cost-effectiveness, the wishes of the Member or the Member's Legally Authorized Representative (LAR), and the potential for improved health status of the Member. The Case-by-case Services benefit does not apply to the CHIP Perinatal Program. 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.

8.1.2.3 Dental Services

The MCO is not responsible for reimbursing dental providers for preventive and therapeutic dental services obtained by CHIP or CHIP Perinate Newborn Members. However, medical and/or Hospital charges, such as anesthesia, that are necessary in order for such Members to access standard therapeutic dental services, are Covered Services. The MCO must provide access to facilities and physician services that are necessary to support the dentist who is providing dental services to a CHIP or CHIP Perinate Newborn Member under general anesthesia or Intravenous (IV) sedation.

The CHIP medical benefit also provides limited emergency dental coverage for dislocated jaw, traumatic damage to teeth, and removal of cysts; treatment of oral abscess of tooth or gum origin; treatment and devices for craniofacial anomalies; and drugs.

The MCO must inform Network facilities, anesthesiologists, and PCPs what authorization procedures are required, and how Providers are to be reimbursed for the preoperative evaluations by the PCP and/or anesthesiologist and for the facility services. For dental-related medical Emergency Services, the MCO must reimburse in-Network and Out-of-Network providers in accordance with federal and state laws, rules, and regulations.

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 provide coverage for Emergency Services to Members 24 hours a Day and 7 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 Network or Out-of-Network. A CHIP 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 8.1.22**.

The MCO must also have an emergency and crisis Behavioral Health Services Hotline available to CHIP Members and CHIP Perinate Newborns 24 hours a Day, 7 Days a week, toll-free throughout the Service Area. The Behavioral Health Services Hotline must meet the requirements described in **Section 8.1.15.3**. The MCO may arrange Emergency Services and crisis Behavioral Health Services through mobile crisis teams.

For the CHIP Perinatal Program, refer to **Attachment B-2.1** ("CHIP Perinatal Program Covered Services") for description of emergency services for CHIP Perinates and CHIP Perinate Newborns

For CHIP and CHIP Perinate Newborns Members, MCO must require, and make best efforts to ensure, that PCPs are accessible to Members 24 hours a Day, 7 Days a week and that Network Primary Care Providers (PCPs) have after-hours telephone availability consistent with **Section 8.1.4** ("Provider Network"). The CHIP MCO is not required to establish PCP Networks for CHIP Perinate Members. 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.

For CHIP and CHIP Perinate Newborn Members, the MCO must provide that if Medically Necessary Covered Services are not available through Network physicians or other Providers, the MCO must, upon the request of a Network physician or other 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 five Business Days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider. The MCO must fully reimburse the non-network provider at the usual and customary rate defined by TDI in 28 Tex. Admin. Code. § 11.506. The MCO may not require the Member to pay for any Medically Necessary Covered Services, other than HHSC-specified co-payments for CHIP Members, where applicable.

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. Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;
2. 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;
3. Primary Routine Care must be provided within 14 Days;
4. Specialty Routine Care must be provided within 21 Days;
5. 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 submission of a signed referral;
6. Initial outpatient Behavioral Health visits must be provided within 14 Days (this requirement does not apply to CHIP Perinate);
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 for Members less than six months of age must be provided within 14 Days. Preventive health services for Members six months through age 20 must be provided within 60 Days. Members should receive preventive care in accordance with the American Academy of Pediatrics (AAP) periodicity schedule.

8.1.3.2 .....Access to Network Providers

The MCO's Network must include all of the 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 for regular and preventive pediatric care to all CHIP and CHIP Perinate Newborn 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. § 457.1201(j). The MCO must ensure that access is consistent with Tex. Admin. Code §353.411.

For each provider type, the MCO must provide access to at least 90 percent of Members in each Program and Service Area 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.

Primary Care Provider (PCP) At a minimum, the MCO must ensure that all CHIP and CHIP Perinate Newborn Members have access to a choice of age-appropriate PCPs in the Provider Network with an Open Panel

This provision does not apply to CHIP Perinates, but it does apply to CHIP Perinate Newborns.

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. **Note:** This PCP access provision does not apply to CHIP Perinates.

Obstetrician/Gynecologist (OB/GYN) CHIP Perinatal Program Provider: CHIP Program Networks must ensure that all female Members have access to an OB/GYN in the Provider Network. If the OB/GYN is acting as the Member's PCP, the MCO must follow the access requirements for the PCP.

Prenatal: Members who are pregnant must have access to a Network Provider for prenatal care.

MCO must seek to obtain the participation of Providers for CHIP Perinate Members. The MCO is encouraged to obtain the participation of OB/GYNs, Family Practice Physicians with experience in prenatal care, or other qualified health care Providers as CHIP Perinate Providers.

See **Sections 8.1.3.2** ("Access to Network Providers") and **Section 8.1.4.2** ("Primary Care Providers") regarding distinctions in the Provider Networks for CHIP Perinates and CHIP Perinate Newborns.

Mental Health - Outpatient: At a minimum, the MCO must ensure that all Members, except CHIP Perinates, have access to a covered outpatient mental health Service Provider in the Network. Outpatient mental health Service Providers must include Masters and Doctorate-level trained practitioners practicing independently or at clinics/group practices, or at outpatient Hospital departments as detailed in the UMCM 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 child psychiatrists, and outpatient mental health Service Providers who serve children and adolescents.

At a minimum, the MCO must also ensure that all CHIP Members have access to rehabilitative day treatment providers and partial hospitalization providers in the Network.

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.

Specialist Physician Access: At a minimum, the MCO must ensure that all Members except CHIP Perinates have access to a Network specialist physician. 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 Health Care Services, other than surgery, and 2) have access without a PCP referral to eye Health Care 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 Network Provider for occupational therapy, physical therapy, and speech therapy.

Acute Care Hospital: The MCO must ensure that all Members have access to an Acute Care Hospital in the Provider Network.

Pharmacy: At the minimum, the MCO must ensure that all Members must 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, specialty Hospitals, psychiatric Hospitals, diagnostic services, and single or limited service health care physicians or Providers, as applicable to each Program.

The MCO is not precluded from making arrangements with physicians or providers outside the MCO's Service Area for Members to receive a higher level of skill or specialty than the level available within the Service Area, 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 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 Health

Care 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

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 8.1.3.1** ("Waiting Times for Appointments") and **Section 8.1.3.2** ("Access to Network Providers"), and for Covered Services furnished by PCPs, the standards described in **Section 8.1.4.2** ("Primary Care Providers").

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. For each Service Area, 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 and 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 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 and 42 C.F.R. § 457.1209 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. § 457.1212. 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 a Network Provider. 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 8.1.22.

8.1.3.5 Telemedicine and Telehealth

CHIP Covered Services may be delivered by Telemedicine and Telehealth.

MCOs must contract with Providers offering these services to provide better access to healthcare for its Members.

The MCO must include information about Providers with Telemedicine or Telehealth capabilities in its hard copy and electronic provider directory.

The MCO must be able to accept and process Provider claims for Covered Services using modifier 95 (synchronous Audio-visual technology), 93 (synchronous Audio-only), or FQ modifier (BH synchronous Audio-only) when delivered by Telemedicine or Telehealth. Procedure codes that already indicate the type of remote delivery in their description do not need to be billed with the 95, 93, or FQ modifiers.

MCOs must be able to accept, and process Provider claims for Covered Services provided through Telemedicine and Telehealth.

The MCO must 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 TAC §353.7 and Behavioral Health Services providers to assure engagement of qualified Providers offering Telemedicine, Telehealth and Telemonitoring. In the outreach process, the MCO must offer trainings and supports to help establish Telemedicine, Telehealth, and Telemonitoring literacy and capabilities. In addition, the MCO must actively recruit additional rural providers in order to increase Member access to the services that can be delivered through Telemedicine and Telehealth.

CHIP MCOs are required to comply with Texas Health and Safety Code §62.1571 and Texas Government Code §531.02161.

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 provisions for services by Telecommunication located in UMCM Chapter 16.

8.1.4 Provider Network

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, contractors and Subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the Contract.

The Provider Network must be responsive to the linguistic, cultural, and other unique needs of any minority or disabled individuals, or other special population in the MCO Programs. 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 CHIP and CHIP Perinatal Program Members in the Service Area. MCOs utilizing Out-of-Network providers to render services to their Members must not exceed the utilization standards established in 1 Tex. Admin. Code § 370.604(d). HHSC may modify this requirement for MCOs that demonstrate good cause for noncompliance, as set forth in 1 Tex. Admin. Code § 370.604(d).

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 8.1.4.14. Network Providers cannot be under sanction or exclusion from the Medicaid, CHIP, or CHIP Perinatal Programs. A Provider must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D. All Providers serving only CHIP Members must be enrolled with HHSC by January 1, 2018. Additionally, the MCO will assign internal provider numbers for submitting all HHSC required data, as specified in the UMCM. All Pharmacy Providers must be enrolled with HHSC's Vendor Drug Program.

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 that Acute Care Hospitals and specialty Hospitals are available and accessible 24 hours per Day, 7 Days per week, within the MCO's Network to provide Covered Services to Members throughout the Service Area. 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's 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, so that these Covered Services are available and accessible 24 hours per Day, 7 Days per week, to Members throughout the Service Area. 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.

The MCO must make Out-of-Network reimbursement arrangements with a designated Children's Hospital and/or Hospital with specialized pediatric services in proximity to the Member's residence if the MCO does not include such Hospitals in its Provider Network. Such arrangements must be in writing.

Trauma: The MCO must ensure Member's access to DSHS designated Level I and Level II trauma centers within the State, or Hospitals meeting the equivalent level of trauma care in the Service Area or in close proximity to the Member's residence.

The MCO must make Out-of-Network 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 or Hospital in its Provider Network. Such arrangements must be in writing.

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.

The MCO must make Out-of-Network reimbursement arrangements with a designated transplant center or center meeting equivalent levels of care in proximity to the Member's residence if the MCO does not include such a center in its Provider Network. Such arrangements must be in writing.

Hemophilia centers: The MCO must ensure Member access to hemophilia centers supported by the Centers for Disease Control (CDC), which include pharmacy services provided by the centers. A list of these hemophilia centers is maintained by the CDC.

The MCO must make Out-of-Network reimbursement arrangements with a CDC-supported hemophilia center if the MCO does not include such a center in its Provider Network. Such arrangements must be in writing.

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 to comply with the access requirements throughout **Section 8.1.3** ("Access to Care") and meet the needs of Members for all Covered Services.

The MCO must ensure that an adequate number of participating physicians have admitting privileges at one or more participating Acute Care Hospitals in the Provider Network to ensure that necessary admissions are made. In no case may there be less than one Network PCP with

admitting privileges available and accessible 24 hours per Day, 7 Days per week for each Acute Care Hospital in the Provider Network.

The MCO also must ensure that an adequate number of participating specialty physicians have admitting privileges at one or more participating Hospitals in the MCO's Provider Network to ensure necessary admissions are made. The MCO shall require that all physicians who admit to Hospitals maintain Hospital access for their Members through appropriate call coverage.

Laboratory services: The MCO must ensure that in-Network reference laboratory services must be of sufficient size and scope to meet the non-emergency and emergency needs of Members and the access requirements in **Section 8.1.3** ("Access to Care"). 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 in the Service Area, strategically located specimen collection areas in the Service Area, and the use of a courier system under the management of the reference lab.

Chapter 33 of the Texas Health and Safety Code and 25 Tex. Admin. Code, Chapter 37, Subchapter D include requirements for the Texas Newborn Screening Program. In accordance with an interagency agreement between HHSC and DSHS, neither the MCO nor its providers are responsible for the costs associated with the Texas Newborn Screening Program. Pursuant to the interagency agreement, DSHS will allow the MCO's Providers to obtain Medicaid-eligible/charity care specimen collection kits ("test kits"), as described in 25 Tex. Admin. Code § 73.21(c)(1), from DSHS' lab, at no cost to the Provider, for use with CHIP and CHIP Perinatal Newborn Members. Providers will conduct blood draws for such Members, complete the test kit forms, and send the test kits to DSHS' laboratory for analysis. DSHS will notify the performing Provider of the results of the analysis. The MCO must include instructions on the requirements for the Texas Newborn Screening Program in its Provider Manual.

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 with one or more pharmacy providers for drugs listed on the HHSC specialty drug list published on the Medicaid Vendor Drug Program website. These arrangements must comply with Medicaid standards found in 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 VDP formulary, with the exception of drugs listed on the HHSC Specialty Drug List. MCOs may limit the dispensing of drugs 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 all Members in the Service Area in accordance with the access standards in

Section 8.1.3 ("Access to Care"). 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.

Home health services: The MCO must have a contract(s) with a home health Provider so that all Members living within the Service Area will have access to at least one such Provider for home health Covered Services. These services are provided as part of the Acute Care Covered Services.

Ambulance providers: The MCO must enter into a 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.

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, and providers capable of providing SUD intensive outpatient services and SUD partial hospitalization. The network must also include the following for medication assisted treatment: licensed narcotic (opioid) treatment programs, chemical dependency treatment facilities licensed by HHSC, and appropriately trained physicians and other qualified prescribers, including nurse practitioners and physician assistants.

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.

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 health care Providers must be in writing, must be in compliance with applicable federal and state laws and regulations, and must include minimum requirements specified in the RFP, **Attachment A** ("General Contract Terms and Conditions"), and UMCM. 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.

The MCO must submit model Provider contracts to HHSC for review during Readiness Review. HHSC retains the right to reject or require changes to any model Provider contract that does not comply with MCO Program requirements or the HHSC's Contract with the MCO.

8.1.4.2 Primary Care Provider

The MCO's PCP Network for CHIP and CHIP Perinate Newborn Members may include Providers from any of the following practice areas: General Practice; Family Practice; Internal Medicine; Pediatrics; Obstetrics/Gynecology (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 Obstetrics/Gynecology 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. **The MCO is not required to develop PCP Networks for CHIP Perinates.** 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. 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 PCP responsibilities for such Members in a specific age group under age 19,
2. the Provider has a history of practicing as a PCP for the specified age group as evidenced by the Provider's primary care practice including an established Member population under age 19 and within the specified age range, and
3. the Provider has admitting privileges to a local Hospital that includes admissions to pediatric units.

The PCP for a Member with disabilities, Special Health Care Needs, or Chronic or Complex Conditions may be a specialist physician who agrees to provide PCP services to the Member. The specialty physician must agree to perform all PCP duties required in the Contract and PCP duties must be within the scope of the specialist's license. Any interested person may initiate the request through the MCO for a specialist to serve as a PCP for a Member with disabilities, Special Health Care Needs, or Chronic or Complex Conditions. The MCO must handle such requests in accordance with 28 Tex. Admin. Code Chapter 11, Subchapter J.

PCPs who provide Covered Services for Members 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 must require, through contract provisions, that PCPs are accessible to Members 24 hours a Day, 7 Days a week. The MCO is encouraged to include in its Provider Contracts 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 office telephone is answered after-hours by an answering service, which meets language requirements of the Major Population Groups and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
2. The 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 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 office telephone is only answered during office hours;
2. the office telephone is answered after-hours by a recording that tells Members to leave a message;
3. the office telephone is answered after-hours by a recording that directs Members to go to an Emergency Room for any services needed; and
4. returning after-hours calls outside of 30 minutes.

The MCO must require PCPs, through contract provisions or Provider Manual, to provide Members with preventive services in accordance with the AAP recommendations. The MCO must make best efforts to ensure that PCPs follow these periodicity requirements for children. Best efforts must include, but not be limited to, Provider education, Provider profiling, monitoring, and feedback activities.

The MCO must require PCPs, through contract provisions or Provider Manual, to assess the medical needs of Members for referral to specialty care providers and provide referrals as needed. PCPs must coordinate such Members' care with specialty care providers after referral. The MCO must make best efforts to ensure that PCPs assess Members' needs for referrals and make such referrals. Best efforts must include, but not be limited to, Provider education activities 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 Provider no later than five Business Days after the MCO receives the Enrollment File from the HHSC Administrative Services Contractor each month. 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

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 an MCO's credentialing and re-credentialing processes must be consistent with recognized CHIP industry standards and relevant state and federal regulations including 28 Tex. Admin. Code §§ 11.1902 and 11.1402(c), relating to credentialing of providers in managed care organizations. The re-credentialing process must take into consideration Provider performance data including Member Complaints and Appeals, quality of care, and utilization management.

The MCO must complete the credentialing process for a new provider and its claim systems must be able to recognize the provider as a Network Provider no later than 90 Days after receipt of a complete application.

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.

8.1.4.4.1 Expedited Credentialing Process

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.

Additionally, if a Provider qualifies for expedited credentialing, the MCO's claims system must be able to process claims from the provider as if the Provider was a Network Provider no later than 30 Days after receipt of a complete application, even if the MCO has not yet completed the credentialing process.

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 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.

The MCO must prepare and issue one or more Provider Manual(s) for the MCO Programs, including any necessary specialty manuals (e.g., Behavioral Health) to all existing Network Providers. For newly contracted Providers, the MCO must issue copies of the Provider

Manual(s) 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 sections relating to special requirements of the MCO Programs and Members.

HHSC's initial review of the Provider Manual is part of the Operational Readiness Review described in **Section 7** ("Transition Phase Requirements"). Following Operational Readiness Review, HHSC must review and approve any substantive revisions to the Provider Manual before the MCO publishes or distributes it to Providers.

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 CHIP and CHIP Perinatal Program training must be completed within 30 Days of placing a newly contracted Provider on active status. The MCO must provide on-going 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, but is not limited to, the following issues:

1. covered Services and the Provider's responsibilities for providing and/or coordinating such services. Special emphasis must be placed on areas that vary from commercial coverage rules (e.g., Early Childhood Intervention (ECI) services, therapies and Durable Medical Equipment (DME)/Medical Supplies);
2. making referrals and coordination with Non-capitated Services;
3. relevant requirements of the Contract;
4. the MCO's quality assurance and performance improvement program and the Provider's role in such a program; and
5. the MCO's policies and procedures, especially regarding in-Network and Out-of-Network referrals.
6. how to access Behavioral Health Services, including Substance Use Disorder treatment.

Provider materials produced by the MCO must comply with state and federal laws, rules and regulations, and the requirements of the **Attachment A** ("General Contract Terms and Conditions").

As described above, HHSC must approve the MCO's Provider Manual and all substantive revisions. See UMCM Chapter 3, Chapter 4, and Chapter 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.

8.1.4.7 Provider Hotline

The MCO must operate a toll-free telephone line for Provider inquiries from 8 a.m. to 5 p.m. local time throughout the Service Area, Monday through Friday, except for State-approved holidays. The Provider hotline must be staffed with personnel who are knowledgeable about Covered Services and the MCO Programs. The MCO must ensure that after regular business hours the line is answered by an automated system with the capability to provide callers with hours of operation 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 such verification prior to providing Emergency Services.

The MCO must ensure that the Provider hotline meets the following minimum performance requirements for the MCO Programs:

1. the average hold time is 2 minutes or less; and
2. the call abandonment rate is 7 percent or less.

The MCO must conduct ongoing call quality assurance to ensure these standards are met. The Provider Hotline may serve multiple managed care programs if hotline staff is knowledgeable about the MCO Programs.

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 8.1.20** ("Reporting Requirements"). If the MCO subcontracts with a Behavioral Health Organization (BHO) that is responsible for Provider hotline functions related to Behavioral Health Services, the BHO's Provider hotline must meet the requirements in **Section 8.1.4.7** ("Provider Hotline").

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 Provider Reimbursement

The MCO must make payment for all Medically Necessary Covered Services provided to Members. The MCO's Provider Contract must include a complete description of the payment methodology or amount, as described in UMCM Chapter 8.

The MCO must ensure claims payment is timely and accurate as described in **Section 8.1.18.5** "Claims Processing Requirements" and UMCM Chapter 2. The MCO must require tax identification numbers from all participating Providers. The MCO is required to do back-up withholding from all payments to Providers who fail to give tax identification numbers 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 Health Care-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 Health Care and Education Reconciliation Act as amended by PPACA, entitled "Payments to Primary Care Physicians."

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

The MCO cannot implement significant, non-negotiated, across-the-board 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 MCO Subcontractors including pharmacy provider reimbursements 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.

8.1.4.8.1 Hospital Quality Based Payment Program

HHSC collects data on potentially preventable events and uses it to improve quality and efficiency of services. MCOs and hospitals are financially accountable for potentially preventable complications (PPCs) and potentially preventable readmissions (PPRs), two quality measures used by HHSC in its Hospital Quality Based Payment (HQBP) Program. For fee-for-service, HHSC or its designee makes reimbursement adjustments to inpatient hospital claims based on performance of these measures. For the managed care programs, HHSC builds the adjustments into MCO capitation payments to reflect hospital reductions related to PPR/PPC.

HHSC provides MCOs with an annual confidential report of hospitals with poor performance on PPCs and PPRs. This report will contain the hospital's NPI, name, and level of payment reduction based on HHSC's methodology. In order to receive credit for the HQBP Program as an Alternative Payment Model according to the criteria set forth in Section 8.1.7.8.2., MCOs must pass down payment reductions to the hospitals identified by HHSC.

8.1.4.8.2 Provider Preventable Conditions

The MCO must identify Present on Admission (POA) indicators as required in the UMCM Chapter 2. and the MCO 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.

8.1.4.8.3 Provider Overpayments

The MCO must have a mechanism in place through which Network Providers report overpayments. The MCO must inform Providers of this mechanism. The mechanism must allow Providers to include a reason for the overpayment. The MCO must require that the Provider 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.

8.1.4.9 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 later than 15 Days after the MCO receives notice to terminate from the Provider.

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.

8.1.4.10 Provider Complaints and Appeals

Provider complaints and appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. The MCO must resolve provider complaints or appeals within 30 Days from the date the complaint or appeal is received**.**

8.1.4.11 MCO Internal Provider Complaints and Appeals Process

The MCO must develop, implement, and maintain a system for tracking and resolving all MCO Provider complaints. Within this process, the MCO must respond fully and completely 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 HMO 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 HMO. Please see the Uniform Managed Care Contract Terms & Conditions and Attachment B-5, Deliverables/Liquidated Damages Matrix.

HMOs must also resolve Provider Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will generally provide HMOs ten Business Days to resolve such Complaints. If an HMO 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 HMO demonstrates good cause.

Unless HHSC has granted a written extension as described above, the HMO is subject to remedies, including liquidated damages if Provider Complaints are not resolved by the timeframes indicated herein.

8.1.4.12 Provider Appeal of MCO Claims Determinations

The MCO must develop, implement, and maintain a system for tracking and resolving all MCO Provider appeals related to claims payment. Within this process, the MCO must respond fully and completely to each MCO Provider's claims payment appeal and establish a tracking mechanism to document the status and final disposition of each MCO Provider's claims payment appeal.

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.

In addition, the MCO's process must comply with Texas Government Code § 533.005(a)(19). The MCO must provide information specified in 42 C.F.R. § 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.

8.1.4.13 Provider Advisory Groups

The MCO must establish and conduct quarterly meetings with Network Providers. Membership in the Provider Advisory Group(s) must include, at a minimum, acute and pharmacy providers. The MCO must maintain a record of Provider Advisory Group meetings, including agendas and minutes, for at least three years.

8.1.4.14 Out-of-State Providers

The MCO may enroll out-of-state providers in its CHIP 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 CHIP Network under the circumstances described in Texas Government Code § 531.066.

8.1.4.15 Provider Protection Plan

The MCO must comply with the HHSC's provider protection plan requirements for reducing the administrative burdens placed on Network Providers 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, grievances, 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 (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 prior authorizations, as described in Section 8.1.8, "Utilization Management," and Section 8.1.24.2, "Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies."
7. Provide 30 Days' notice to Providers before implementing changes to policies and procedures affecting the prior authorization 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 prior authorization process without the required notice period.
8. Include other measures developed by HHSC or the provider protection plan workgroup, or measures developed by the MCO and approved by HHSC.

8.1.5 Member Services

The MCO must maintain a Member Services Department to assist Members and Members' family members or guardians in obtaining Covered Services for Members. The MCO must maintain employment standards and requirements (e.g., education, training, and experience) for Member Services Department staff and provide a sufficient number of staff for the Member Services Department to meet the requirements of this Section, including Member Hotline response times, and Linguistic Access capabilities, see **Section 8.1.5.6** ("Member Hotline") for requirements.

8.1.5.1 Member Materials

The MCO must design, print and distribute Member Identification (ID) cards and a Member Handbook to Members. Within five Business Days following the receipt of an Enrollment File from the HHSC Administrative Services Contractor, the MCO must mail a Member's ID card and Member Handbook to the Case Head or Account Name for each new Member. When the Case Head or Account Name represents two or more new Members, the MCO is only required to

send one Member Handbook. The MCO is responsible for mailing materials only to those Members for whom valid address data is contained in the Enrollment File.

The MCO must design, print and distribute one or more hard copies of the Provider Directories to the HHSC Administrative Services Contractor as described in **Section 8.1.5.4** ("Provider Directory").

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 specified by HHSC. HHSC will provide the MCO with reasonable notice when the enrolled population reaches the Major Population Group 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.

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 point. 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 to publication or distribution, including revisions to previously approved Member Materials. See UMCM Chapter 3 and UMCM Chapter 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, Evidence of Coverage, Certificate of Coverage, 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 CHIP or CHIP Perinatal Program number;
3. the effective date of the PCP assignment (excluding CHIP Perinates);
4. the PCP's name (not required for CHIP Perinates), address (optional for all products), and telephone number (excluding CHIP Perinates);
5. the MCO's name;

6. the 24-hour, 7 Day a week toll-free Member services telephone number and BH Hotline number operated by the MCO; and
7. any other critical elements identified in the UMCM.

The MCO must reissue the Member ID card if a Member reports a lost card, there is a Member name change, if the Member requests a new PCP, or for any other reason that results in a change to the information disclosed on the ID card. The MCO must issue Member ID cards to both CHIP Perinates and CHIP Perinate Newborns.

8.1.5.3 Member Handbook

HHSC must approve all Member Handbooks, 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 one or more draft Member Handbooks for approval during the Readiness Review and must submit one or more final Member Handbooks incorporating changes required by HHSC prior to the Operational Start Date.

The Member Handbooks for the CHIP and CHIP Perinatal Programs must, at a minimum, meet the Member Materials requirements specified by **Section 8.1.5.1** ("Member Materials") above and must include critical elements in the UMCM. The MCO must issue Member Handbooks to both CHIP Perinates and CHIP Perinate Newborns. If the MCO uses the same Member Handbook for both MCO Programs, it must identify any differences in the programs, including differences in Covered Services.

In addition to modifying Member Materials for new Members, the MCO must notify all existing Members of Covered Services changes. The MCO may do so by producing a revised Member Handbook, or an insert informing Members of changes to Covered Services. In addition to modifying the Member Materials for new Members, the MCO must notify all existing Members of changes to Covered Services. If HHSC notifies the MCO that the change in Covered Services is significant, the MCO must notify existing Members through a written notice, such as a mailed letter or electronic mail, during the timeframe specified in this subsection or within a timeframe approved by HHSC. If multiple Members reside within a single household, the MCO shall send only one written notice pursuant to this section. If HHSC notifies the MCO that the change in Covered Services is not significant, the MCO must notify existing Members through any method of communication during the timeframe specified in this subsection or within a timeframe approved by HHSC.

8.1.5.4 Provider Directory

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, 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 templates for approval and must submit the final Provider Directories incorporating changes required by HHSC prior to the Operational Start Date. Such draft and final Provider Directories must be submitted according to the Readiness Review deadlines established by HHSC.

The Provider Directory must comply with HHSC's marketing policies and procedures, as set forth in the UMCM Chapter 4.

The Provider Directories must, at a minimum, meet the Member Materials requirements specified by **Section 8.1.5.1** ("Member Materials") above and must include the critical elements identified in the UMCM. The Provider Directory must include only Network Providers credentialed by the MCO in accordance with **Section 8.1.4.4** ("Provider Credentialing and Re-credentialing"). If the MCO contracts with limited Provider Networks, the Provider Directory must comply with the requirements of 28 T.A.C. § 11.1600(b)(11), relating to the disclosure and notice of limited Provider Networks.

The MCO may develop separate Provider Directories for CHIP, CHIP Perinate, and CHIP Perinate Newborn Members, or combine one or more of the Provider Directories. In either event, the Provider Directories must meet all the requirements set out in the UMCM**,** Chapter 3.

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 such update available to existing Members upon request. HHSC will establish weight limits for the Provider Directories. If the MCO exceeds the weight limits, it must compensate HHSC for postage fees in excess of the weight limits.

The MCO must send the most recent Provider Directory, including any updates, to Members 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.

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 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.

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 Chapter 3.

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 Programs, 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's internet website must contain the requirements of UMCM **Chapter 3.** The MCO's pharmacy website must contain the requirements of UMCM **Chapter 3.** 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 Member Hotline

The MCO must operate a toll-free hotline that Members can call 24 hours a Day, 7 Days a week. The Member hotline must be staffed between the normal business hours of 8:00 a.m. to 5:00 p.m. local time throughout the Service Area, Monday through Friday, excluding state-approved holidays. The State-approved holiday schedule is updated annually and can be found at the Texas State Auditor's Office website.

The MCO must ensure that after hours, on weekends, and on holidays the Member Services hotline is answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in cases of emergency. All recordings must be in English, Spanish, and the languages of other Major Population Groups identified by HHSC. 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:

1. knowledgeable about the MCO Programs and Covered Services;

2. able to answer non-technical questions pertaining to the role of the PCP, as applicable;
3. able to answer non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services;
4. able to give information about Providers in a particular area;
5. knowledgeable about Fraud, Waste, and Abuse and the requirements to report any conduct that, if substantiated, may constitute Fraud, Waste, and Abuse in the MCO Programs;
6. trained regarding Cultural Competency in accordance with Section 8.1.5.8, including arranging for interpreter services;
7. trained regarding the process used to confirm the status of persons with Special Health Care Needs;
8. able to give correct cost-sharing information relating to co-pays. Cost-sharing does not apply to CHIP Perinates or CHIP Perinate Newborns;
9. trained to assist with scheduling an appointment during normal hours of operation. Hotline services staff must offer Members the opportunity to participate in a facilitated three-way call between the Member or LAR and a provider's office to schedule an appointment. If the Member does not want to participate, in the above described conference call option, the MCO must document refusal and offer the Member a list of Network Providers, including offering the Member a Provider Directory at no cost to the 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 such oral interpretation services to all Hotline callers free of charge.

The MCO must process all incoming Member 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 Member. The MCO must ensure that the toll-free Member hotline meets 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.

The Member Services hotline may serve multiple managed care programs if hotline staff is knowledgeable about the MCO Programs.

The MCO must monitor its performance regarding HHSC Member hotline standards and submit performance reports summarizing call center performance for the Member hotline as indicated in **Section 8.1.20** ("Reporting Requirements") and the UMCM**.**

If HHSC determines that it will conduct onsite monitoring of the MCO's Member hotline functions, the MCO must reimburse HHSC for all authorized reimbursable 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.

8.1.5.6.1 Nurseline

If the MCO provides a 24-hour nurse hotline, it must train hotline staff about: a) the emergency prescription process and what steps to take to immediately address Medicaid Members' problems when pharmacies do not provide a 72-hour supply of emergency medicines; and b) DME processes for obtaining services and how to address common problems. The 24-hour Nurse Hotline will attempt to respond immediately to problems concerning emergency medicines by means at its disposal, including explaining the rules to Medicaid 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 and DME processes.

8.1.5.7 Member Education

The MCO must, at a minimum, develop and implement health education initiatives that educate Members about:

1. how the MCO system operates, including the role of the PCP;
2. Covered Services, limitations and any Value-Added Services offered by the MCO;
3. the value of screening and preventive care, and
4. how to obtain Covered Services, including
    a. Emergency Services;
    b. accessing OB/GYN and specialty care;
    c. Behavioral Health Services;
    d. Disease Management programs;
    e. Service Coordination, treatment for pregnant women, Members with Special Health Care Needs, including Children with Special Health Care Needs; and other special populations;
    f. ECI Services;
    g. screening and preventive services, including well child care;
    h. Member co-payments;
    i. suicide prevention; and
    j. identification and health education related to obesity.

The MCO must provide a range of health promotion and wellness information and activities for Members in formats that meet the needs of all Members. The MCO must propose, implement, and assess innovative Member education strategies for wellness care and immunization, as well as general health promotion and prevention. 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, including information on its Service Coordination and Disease Management programs described in **Section 8.1.13** ("Service Coordination for Certain Populations") and **Section 8.1.14** ("Disease Management"). Condition and disease-specific

information must be oriented to various eligible populations, such as children, persons with disabilities, and non-English speaking Members, as appropriate.

Per Texas Health and 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. 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.

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. 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 the effective date of such changes. The Cultural Competency plan must also be made available to the MCO's Network Providers. 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 Cultural Competency plan to HHSC.

The MCO must arrange and pay for Competent Interpreter services including written, spoken, and sign language interpretation, for Members, or Medical Consenter, 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, or a Legally Authorized Representative, as applicable, and the Members' Providers can access Competent Interpreter services including written, spoken, and sign language interpretation when the Member, or Medical Consenter, 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, Legally Authorized Representative, or Provider.

Upon a Provider, Member, or Legally Authorized Representative 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, and offer alternative interpretation options, such as OPI, Video Remote Interpretation, or the earliest availability of the 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 MCO Internal Member Complaint and Appeal Process

The MCO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members or their authorized representatives. For purposes of this **Section 8.1.5.9**, 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. 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. As the Texas Department of Insurance does not require the reporting of those issues to TDI, the MCOs shall report this subcategory of Complaints to HHSC as "Initial Contact Complaints."

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.

Member Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. HHSC will require the MCO to resolve Complaints and Appeals that are not elevated to TDI within 30 Days from the date the Complaint or Appeal is received 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. Any person, including those dissatisfied with the MCO's resolution of a Complaint or Appeal, may report an alleged violation to TDI.

HMOs also must resolve Member Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will provide HMOs up to ten Business Days to resolve such Complaints, depending on the severity and/or urgency of the Complaint. HHSC may, in its reasonable discretion, grant a written extension if the HMO demonstrates good cause.

Unless the HHSC has granted a written extension as described above, the HMO is subject to remedies, including liquidated damages if Member Complaints are not resolved by the timeframes indicated herein.

8.1.5.10 Member Advisory Groups

The MCO must establish and conduct quarterly meetings with Members in each service area in which it operates. Membership in the Member Advisory Group(s) must include at least three Members attending each meeting and allow for Member advocates to participate. The MCO must maintain a record of Member Advisory Group meetings, including agendas and minutes, for at least three years.

8.1.5.11 Member Eligibility

The MCO must provide eligibility renewal assistance as allowed by federal law and CMS policy guidance for Members whose eligibility is about to expire.

8.1.5.12 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.

8.1.6 Marketing and Prohibited Practices

The MCO and its Subcontractors must adhere to the Marketing Policies and Procedures as set forth in the Contract, including the UMCM Chapter 4.

8.1.7 Quality Assurance and Performance Improvement

The MCO must provide for the delivery of quality care with the primary goal of improving the health status of Members and, where the Member’s condition is not amenable to improvement, maintain the Member’s current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO must work in collaboration with Providers to actively 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 and Providers to offer input into the MCO’s quality improvement activities.

8.1.7.1 Quality Assessment and Performance Improvement Program Overview

The MCO must develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program consistent with the Contract and TDI requirements, including 28 Tex. Admin. Code § 11.1901(a)(5) and § 11.1902. CHIP MCOs must also meet the requirements of 42 C.F.R. § 457.1240.

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 in Provider contracts a requirement securing cooperation with the QAPI.

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

1. evaluate performance using objective quality indicators;
2. foster data-driven decision-making;
3. recognize that opportunities for improvement are unlimited;
4. solicit Member and Provider input on performance and QAPI activities;
5. support continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;
6. support programmatic improvements of clinical and non-clinical processes 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 and/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 Integration into QAPI Program

The MCO must integrate Behavioral Health into its QAPI Program and include a systematic and on-going process for monitoring, evaluating, and improving the quality and appropriateness of

Behavioral Health Services provided to Members. The MCO must collect data and monitor and evaluate for improvements to physical health outcomes resulting from Behavioral Health integration into the Member's overall care.

8.1.7.6 Clinical Practice Guidelines

The MCO must adopt not less than two evidence-based clinical practice guidelines for each MCO Program. Such 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 health care 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 Members and potential Members.

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

8.1.7.7 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 such Providers.

Provider profiling activities must include, but not be limited to:

1. Developing PCP and Provider-specific reports that include a multi-dimensional assessment of a PCP or Provider's performance using clinical, administrative, and Member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population.
2. Establishing PCP, Provider, group, Service Area or regional Benchmarks for areas profiled, where applicable, including CHIP and CHIP Perinatal Program-specific Benchmarks, where appropriate.
3. Providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Provider Network.

8.1.7.8 Network Management

The MCO must:

1. Use the results of its Provider profiling activities to identify areas of improvement for individual PCPs and Providers, or 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, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures.
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.

8.1.7.8.1 Physician Incentive Plans

If the MCO implements a physician incentive plan under 42 C.F.R. § 438.3(j), 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's requirements. 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.

8.1.7.8.2 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 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 benchmarks 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 processes 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 September 1st of each year.** The reporting will be completed using the data collection tool in UMCM Chapter 8. The Alternative Payment Models Data Collection Tool (DCT). The DCT will capture APM activity for 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, pharmacies, and pharmacists. Upon request by HHSC, the MCOs shall 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 payments, shared savings, and payment 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 update a strategic plan for advancing value-based care and APMs to advance quality and efficiency.

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 shall be required to submit a corrective action plan and may be subject to additional contractual remedies, including liquidated damages.

8.1.7.8.3 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, MCOs 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 8.1.7.8.2, 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 8.1.7.8.2.

8.1.7.9 Collaboration with the External Quality Review Organization

The MCO will collaborate with HHSC's external quality review organization (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, or another vendor identified by HHSC, in a format identified by HHSC in consultation with the MCO. The MCO will also supply the EQRO, or another vendor identified by HHSC, 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 Healthcare Effectiveness Data and Information Set (HEDIS) measures that require chart reviews. 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

The MCO must have a written utilization management (UM) program description, which includes, at a minimum:

1. procedures to evaluate the need for Medically Necessary Covered Services;
2. the clinical review criteria used, the information sources, and the process used to review and approve the provision of Covered Services;
3. the method for 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, as well as requirements of the Texas Insurance Code Chapter 4201 and all related TDI regulations, as applicable. The MCO may not require, as part of UM determinations, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes, except for the Member's mental health medical record summary as defined in 1 TAC 19.1703 (b)(19).

The MCO must make coverage determinations for authorization requests according to the following timelines:

- within three Business Days after receipt of the request for authorization of services;
- within one Business Day for concurrent hospitalization decisions;
- within one hour for post-stabilization or life-threatening conditions, except that for Emergency Medical Conditions and Emergency Behavioral Health Conditions, the MCO must not require prior authorization; and
- 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.

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;
3. at the MCO's discretion, pharmacy prior authorization determinations may be made by pharmacists, subject to the limitations described in Attachment A, Section 4.04, "Medical Director;"
4. appropriate personnel are available to respond to Utilization Review inquiries 8:00 a.m. to 5:00 p.m., Monday through Friday, local time throughout the Service Area with a telephone system capable of accepting Utilization Review inquiries outside of these hours, and that the MCO responds to calls within one Business Day;
5. confidentiality of clinical information; and
6. compensation to individuals or entities conducting UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services as required by 42 C.F.R. § 457.1230(d), and quality is not adversely impacted by financial and reimbursement-related processes and decisions.

For preauthorization or concurrent review programs, qualified medical professionals must supervise preauthorization and concurrent review decisions.

The MCO UM Program must include policies and procedures to:

1. routinely assess the effectiveness and the efficiency of the UM Program;
2. evaluate the appropriate use of medical technologies, including medical procedures, drugs and devices;
3. target areas of suspected inappropriate service utilization;
4. detect over- and under-utilization;
5. routinely generate Provider profiles regarding utilization patterns and compliance with Utilization Review criteria and policies;
6. compare Member and Provider utilization with norms for comparable individuals;
7. routinely monitor inpatient admissions, emergency room use, ancillary, and out-of-area services;
8. ensure that when Members are receiving Behavioral Health Services from a Local Mental Health Authority (LMHA), the MCO is using the same UM guidelines as those prescribed for use by LMHAs by DSHS, published on the DSHS website under Utilization Management; and
9. refer suspected cases of provider or Member Fraud, Waste, or Abuse to the HHSC Office of Inspector General (HHSC OIG) as required by **Section 8.1.19.**

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 Requirements

For CHIP, 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 prior authorization of prescription drug and health care benefits no later than two years after adoption and accept PA requests submitted using in 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. 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) and require Network Providers to identify and provide ECI referral information to the Legally Authorized Representative 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 for ECI for these child find activities.

The MCO must inform the Member's LAR that ECI participation is voluntary. The MCOs is required to provide medically necessary services to a Member if the Member's LAR 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 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

The IFSP identifies the Member's disability, condition(s) or developmental delay, 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, advocates, or other persons as requested by the authorized representative. If the Member's LAR 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.

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.

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.

Members in ECI will be classified as Members with Special Healthcare Needs (MSHCN) as described in Section 8.1.12. MCOs must offer Service Coordination 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 (WIC) - 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 for Members potentially eligible for WIC. The MCO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract.

8.1.11 Coordination with Texas Department of Family and Protective Services

The MCO must cooperate and coordinate with the Texas Department of Family and Protective Services (DFPS) The MCO must cooperate and coordinate with the Texas Department of Family and Protective Services (DFPS) for a Member receiving family-based safety services or for a Member who is in DFPS conservatorship but not enrolled in the STAR Health program. Family-based safety services provided by CPS are in-home services to help stabilize the family and reduce the risk of future abuse or neglect.

For the purposes of **Section 8.1.11**, court order means an order entered by a court of continuing jurisdiction requiring participation in DFPS services or placing a child or young adult under DFPS conservatorship, including court orders consistent with the Texas Health and Safety Code Chapters 573, Subchapters B and C, Texas Health and Safety Code Chapter 574, Subchapters A through G, Texas Family code Chapter 55, Subchapter D, Texas Health and Safety Code Chapter 462, Subchapter D or as a condition of probation and in accordance with UMCM Section 16.1.

The MCO must comply with all provisions related to Covered Services, including Behavioral Health Services, in the following documents:

1. a Court Order or DFPS service plan requiring participation in DFPS services entered by a court of continuing jurisdiction;
2. a DFPS service plan requiring participation in DFPS services entered by a court of continuing jurisdiction; and
3. a DFPS service plan voluntarily entered into by DFPS and a Member receiving family-based safety services.

The MCO cannot deny, reduce, or controvert the Medical Necessity of any Covered Services, including Behavioral Health Services, included in the above-referenced Court Orders or service.

Any modification or termination of court-ordered services must be approved by the court having jurisdiction over the matter.

A Member or the parent or guardian who is subject to a Court Order or DFPS service plan, cannot use the MCO's Complaint or Appeal processes or the HHSC State Fair Hearing process to reduce the amount and scope of Services in a Court Order or DFPS service plan.

The MCO must include information in its Provider Manuals and training materials regarding:

1. providing medical records to DFPS;
2. scheduling medical and Behavioral Health Services appointments within 14 Days unless requested earlier by DFPS; and
3. recognition of abuse and neglect, and appropriate referral to DFPS.

8.1.12 Services for Members with Special Health Care Needs

Section 8.1.12 applies to CHIP and CHIP Perinate Newborn Members only. It does not apply to CHIP Perinate Members.

8.1.12.1 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. Early Childhood Intervention program participants.
2. Pregnant Members identified as high risk, including:
    a. Pregnant Members age 35 and older or 15 and younger;
    b. Pregnant Members diagnosed with preeclampsia, high blood pressure, or diabetes;
    c. Pregnant Members with mental health or Substance Use Disorder diagnoses; and
    d. Pregnant Members with a previous pre-term birth, as identified on the perinatal risk report.
3. Members with high-cost catastrophic cases or high service utilization, such a high volume of ER or hospital visits.
4. Members with mental illness and co-occurring Substance Use Disorder diagnoses;
5. Members with serious ongoing illness or a chronic complex condition that is anticipated to last for a significant period and requires ongoing therapeutic intervention and evaluation, such as:

    a. Members diagnosed with respiratory illness (such as COPD, chronic asthma, or cystic fibrosis), diabetes, heart disease, kidney disease, HIV, or AIDS;
    b. Child Members receiving ongoing therapy services which may include physical therapy, speech therapy, or occupational therapy (e.g. for longer than six months); and
    c. Members receiving PDN services.
6. Members identified by the MCO as having Behavioral Health issues, including Substance Use Disorders, or serious emotional disturbance or serious and persistent mental illness, that may affect their physical health or treatment compliance.

The MCO also may designate additional Members as MSHCN based on the MCO's assessment of the Members' needs.

The MCO must use methods such as codes in the Enrollment Files, claims data, and medical history data review to identify Members who are in one of the groups listed above and other Members who have conditions requiring special services described in **Sections 8.1.12.2** and **8.1.12.3**.

The MCO's mechanisms to evaluate MSHCN must use appropriate health care professionals. In addition to the MCO's identification of MSHCN, Members may request to be assessed by the MCO to determine if they meet the criteria for MSHCN.

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 in a format and on a timeline to be specified by HHSC in the UMCM and updated with newly identified MSHCN by the 10th Day of each month.

The MCO must submit a quarterly MSHCN report as described in UMCM Chapter 5.

8.1.12.2 Access to Care and Service Coordination

Once the MCO has identified an MSHCN it must have effective systems to ensure the provision of Covered Services to meet the special preventive, primary Acute Care, and specialty health care needs appropriate for treatment of the Member's condition(s). The MCO must provide Service Coordination to MSHCN, including the development of a Service Plan and ensuring access to treatment by a multidisciplinary team when necessary, as further described in Section 8.1.12.3, "Service Coordination for MSHCN."

The MCO must provide access to identified PCPs and specialty care Providers with experience serving MSHCN. Such Providers should be board-qualified or board-eligible in their specialty and meet MCO credentialing requirements.

The MCO must have Network PCPs and specialty care Providers that have demonstrated experience with children who have special health care needs in pediatric specialty centers such as Children's Hospitals, teaching Hospitals, and tertiary care centers.

The MCO must have a mechanism in place to allow MSHCN to have direct access to a specialist as appropriate for the Member's condition and identified needs, such as a standing referral to a specialty physician or Behavioral Health Provider. 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 8.1.12** ("Services for Members with Special Health Care Needs").

The MCO must implement a systematic process to coordinate Non-capitated Services and enlist the involvement of community organizations that may not be providing Covered Services but are otherwise important to the health and well-being of Members. The MCO also must make a best effort to establish relationships with state and local programs and community organizations, such as those listed below, in order to make referrals for MSHCN and other Members who need community services:

1. Community Resource Coordination Groups (CRCGs);
2. ECI Program;
3. local school districts (Special Education);
4. Texas Department of Transportation's Medical Transportation Program (MTP);

5. Texas Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program;
6. DSHS services, including community mental health programs, the Title V Maternal and Child Health and CSHCN Programs, and the Program for Amplification of Children of Texas (PACT);
7. other state and local agencies and programs such as food stamps, and the WIC Program;
8. family planning programs including the Healthy Texas Women, Family Planning, and Primary Health Care programs; and
9. civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy, which also work on behalf of the MSHCN population.

The MCO must provide information and education in its Member Handbook and Provider Manual about the care and treatment available to MSHCN, including the availability of Service Coordination.

In accordance with the requirements in 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.

8.1.12.3 Service Coordination for MSHCN

The MCO must have Service Coordination programs and procedures for MSHCN. The MCO must provide Service Coordination to MSHCN, including the development of a Service Plan and ensuring access to treatment by a multidisciplinary team when necessary.

As part of Service Coordination, the MCO is responsible for working with MSHCNs, their health care providers, their families and, if applicable, legal guardians to develop a seamless package of care in which primary, Acute Care, and specialty service needs are met.

The MCO must develop a service plan for MSHCN. The Service Plan must be developed with and understandable to the Member and the Member's authorized representatives. The MCO must update the service plan at least annually. The service plan may also be updated upon identifying changes in the Member's health condition or a Member's request.

The Service Plan must include, but is not limited to, the following:

1) the Member's history;
2) summary of current medical and social needs and concerns including;

   a. Behavioral Health 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;

3) short and long-term needs, personal preferences, and outcomes for the Member ;
4) a list of services required, their frequency;
5) a description of who will provide the services.
6) the Member's service preferences;
7) the Member's natural strengths and supports, such as the Member's abilities or family members; and
8) a list of non-covered services, community supports, and other resources that the Member already receives or that would be beneficial to the Member.

The 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. The Service Plan should also include information regarding non-covered services, such as Non-Capitated Services, community and other resources, and information on how to access affordable, integrated housing.

Members must have access to treatment by a multidisciplinary team as outlined in a Member's Service Plan when the Member's PCP determines the treatment is Medically Necessary, or to avoid separate and fragmented evaluations and service plans. The team must include both physician and non-physician providers that the PCP determines are necessary for the comprehensive treatment of the Member. The team must:

1. participate in Hospital discharge planning;
2. participate in pre-admission Hospital planning for non-emergency Hospitalizations;
3. develop specialty care and support service recommendations to be incorporated into the Service Plan; and
4. provide information to the Member, or when applicable, the Member's representatives concerning the specialty care recommendations.

8.1.12.4 Service Plan and the Use of Telecommunication

MCOs must adhere to provisions for services by Telecommunication located in UMCM Chapter 16, and Subchapter R of 1 Tex. Admin. Code, Chapter 353.

8.1.13 Initial Health Needs Screening

The MCO must use the initial health needs screening to gauge the need for a more comprehensive assessment, to identify MSHCN, and to prioritize Members for Service Coordination.

90 Days best effort. With the exception of the groups listed below, the MCO must make a best effort to complete an initial health needs screening of all new Members within 90 Days of either the effective date of the Member's enrollment or the date the MCO is notified of the Member's enrollment, whichever is later, in accordance with 42 C.F.R. § 457.1230(c).

30 Days best effort. For Members in the following listed groups, the MCO must make a best effort to complete an initial health needs screening within 30 Days of either the effective date of the Member's enrollment or the date the MCO is notified of the Member's enrollment, whichever is later:

1. Members identified on the enrollment file as MSHCN and
2. Pregnant Members

For the purposes of this section, best effort is attempting to make contact with the Member, Member's LAR, or Member's authorized representative, a minimum of three times within the required timeframe:

If the MCO is unable to reach the Member, Member's LAR, or Member's authorized representative, the MCO must document this in the Member's file. If the Member, Member's LAR, or Member's authorized representative declines the initial health needs screening described in this section, the MCO must document this in the Member's file.

8.1.14 Disease Management

The MCO must provide, or arrange to have provided to CHIP Members, comprehensive DM services consistent with state statutes and regulations. Such DM services must be part of person-based approach to DM and holistically address the needs of persons with multiple chronic conditions. The MCO must develop and implement DM services that relate to chronic conditions that are prevalent in MCO Program Members. In the first year of operations, the MCO must have DM Programs that address the chronic conditions identified in HHSC's UMCM. HHSC will not identify individual Members with chronic conditions. The MCO must implement policies and procedures to ensure that Members that require DM services are identified and enrolled in a program to provide such DM services. The MCO must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of participants at risk for or diagnosed with the chronic conditions identified in the UMCM. 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. DM does not apply to the CHIP Perinatal Program.

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 the UMCM.

Additional requirements related to DM Programs and activities are found in the HHSC UMCM.

The DM Program(s) must include:

1. Member self-management education;
2. Provider education;
3. evidence-based models and minimum standards of care;
4. standardized protocols and participation criteria;
5. physician-directed or physician-supervised care;
6. implementation of interventions that address the continuum of care;
7. mechanisms to modify or change interventions that are not proven effective; and
8. mechanisms to monitor the impact of the DM Program over time, including both the clinical and the financial impact.

The MCO must maintain a system to track and monitor all DM participants for clinical, utilization, and cost measures.

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.

The MCO must provide designated staff to implement and maintain DM Programs and to assist participating Members in accessing DM services. The MCO must educate Members and Providers about the MCO's DM Programs and activities. Additional requirements related to the MCO's DM Programs and activities are found in the UMCM.

8.1.14.1 Special Populations

The MCO is also 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
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 its plan for management of super-utilizers including the criteria listed above using UMCM Chapter 9. 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 8.1.14.3. 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.

8.1.14.2 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 information, including differences between recommended prevention and treatment and actual care received by Members enrolled in a DM Program, and information concerning such Members' adherence to a service plan; and
3. for Members enrolled in a DM Program, provide reports on changes in a Member's health status to their PCP.

8.1.14.3 MCO DM Evaluation

HHSC or its EQRO will evaluate the MCO's DM Program.

HHSC or its EQRO will also evaluate DM as it relates to specialized populations identified in 8.1.14.1. 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.

8.1.15 Behavioral Health (BH) Network and Services

The requirements in **Section 8.1.15** ("Behavioral Health Network and Services") apply to all CHIP and CHIP Perinate Newborn Members. **Section 8.1.15** does not apply to CHIP Perinate Members.

The MCO must provide, or arrange to have provided, to Members all Medically Necessary BH Services as described in **Attachment B-2** ("CHIP Covered Services") and **Attachment B-2.1** ("CHIP Perinatal Program Covered Services"). All BH Services must be provided in conformance with the access standards included in **Section 8.1.3** ("Access to Care"). When assessing Members for BH Services, the MCO and its Network BH Service Providers must use the Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classification in effect at the time of service. HHSC may require use of other assessment instrument/outcome measures in addition to the DSM. Providers must document DSM and assessment/outcome information in the Member's medical record.

8.1.15.1 Behavioral Health Provider Network

The MCO must maintain a BH Services Provider Network that includes psychiatrists, psychologists, and other BH Service Providers. To ensure accessibility and availability of qualified Providers to all Members, the Provider Network must include BH Service Providers with experience serving special populations among the CHIP Rural Service Area Programs, including, as applicable, children and adolescents, persons with disabilities, and cultural or linguistic minorities.

8.1.15.2 Member Education and Self-referral for Behavioral Health Services

The MCO must maintain a Member education process to help Members know where and how to obtain BH Services.

The MCO must permit Members to self-refer to any in-Network BH Services Provider without a referral from the Member's PCP. The MCO's policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such self- referral to BH services.

The MCO must permit Members to participate in the selection of the appropriate Behavioral Health individual practitioner(s) who will serve them and must provide the Member with information on accessible in-network Providers with relevant experience.

8.1.15.3 Behavioral Health Services Hotline

This Section includes Behavioral Health Services hotline functions pertaining to Members. (Requirements for Provider Hotlines are found in **Section 8.1.4.7** ("Provider Hotline")). The MCO must have an emergency and crisis BH Services hotline staffed by trained personnel 24 hours a Day, 7 Days a week, toll-free throughout the Service Area. Crisis hotline staff must include or have access to qualified BH Services professionals to assess BH emergencies. Emergency and crisis BH Services may be arranged through mobile crisis teams. It is not acceptable for an emergency intake line to be answered by an answering machine.

The MCO must operate a toll-free hotline as described in **Section 8.1.5.6** ("Member Hotline") to handle BH-related calls. The MCO may operate one hotline to handle Behavioral Health calls (including emergency and crisis Behavioral Health calls) and other routine Member calls unrelated to Behavioral Health. However, the MCO must submit hotline performance reports separately as required by UMCM Chapter 5. 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 Member. Hotline services must meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.

The BH Services Hotline may serve multiple managed care programs if hotline staff is knowledgeable about the MCO Programs. The MCO must ensure that the toll-free BH Services hotline meets 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 on-going quality assurance to ensure these standards are met.

The MCO must monitor the MCO's performance against the BH Services Hotline standards and submit performance reports summarizing call center performance as indicated in **Section 8.1.20** ("Reporting Requirements") and the UMCM**.**

If HHSC determines that it will conduct onsite monitoring of the MCO's Behavioral Health 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.

8.1.15.4 Coordination between the BH Provider and the PCP

The MCO must require, through 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. PCPs may provide any clinically appropriate BH Services within the scope of their practice.

The MCO must provide training to Network PCPs on how to screen for and identify Behavioral Health disorders, the MCO's referral process for BH Services and clinical coordination requirements for such services. The MCO must include training on coordination and quality of care such as BH screening techniques for PCPs and new models of BH interventions.

The MCO must develop and disseminate policies regarding clinical coordination between BH Service Providers and PCPs. The MCO must require that BH Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. BH Providers may only provide physical health care services if they are licensed to do so. This requirement must be specified in all Provider Manuals.

The MCO must require that BH Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' BH status to the PCP, with the Member's or the Member's legal guardian's consent, as appropriate. This requirement must be specified in all Provider Manuals.

8.1.15.5 Follow-up after Hospitalization for Behavioral Health Services

The MCO must require, through Provider contract provisions or the Provider Manual, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven Days from the date of discharge. The MCO must ensure that BH Service Providers contact Members who have missed appointments within 24 hours to reschedule appointments.

8.1.15.6 Chemical Dependency

The MCO must comply with 28 Tex. Admin. Code § 3.8001 *et seq*., regarding Utilization Review for Chemical Dependency Treatment. Chemical Dependency Treatment must conform to the standards set forth in 28 Tex. Admin. Code Part 1, Chapter 3, Subchapter HH.

8.1.15.7 Court-Ordered Services

This section does not apply to CHIP Perinate Members.

The MCO is required to pay for CHIP-Covered Services ordered by a court pursuant to the statutory citations listed below. The MCO cannot deny, reduce, or controvert the court order for inpatient mental health Covered Services provided pursuant to:

1) a court order; or
2) a condition of probation.

The MCO may not limit Substance Use Disorder treatment or outpatient mental health services 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 by a court of competent jurisdiction 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.

8.1.15.7.1 Psychiatric Services

The MCO must provide all inpatient psychiatric and outpatient Covered Services to Members, who have been ordered to receive the services by:

1) a court of competent jurisdiction under Texas Health and Safety Code Chapter 573, Subchapter B and C, Texas Health and Safety Code Chapter 574, Subchapters A through G, or Texas Family Code Chapter 55, Subchapter D relating to court-ordered impatient mental health services; or
2) a condition of probation.

This requirement is not applicable when the Member is incarcerated as defined by UMCM Section 16.1.15.2.

8.1.15.7.2 Substance Use Disorder Treatment Services

MCOs must provide CHIP-covered Substance Use Disorder treatment services, including residential treatment, required pursuant to:

1) A court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or
2) a condition of probation.

This requirement is not applicable when the Member is considered incarcerated as defined by UMCM Section 16.1.15.2.

8.1.15.8 Local Mental Health Authority (LMHA)

The MCO must coordinate with the LMHA and state psychiatric facility regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric facility.

8.1.15.9 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. §457.496, 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.

8.1.16 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 costs incurred in connection with health care rendered prior to the date of the Member’s Effective Date of Coverage with 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.

CHIP 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 8.1.21, "Third Party Liability and Recovery and Coordination of Benefits," for additional information regarding coordination of benefits and recoveries from third parties.

8.1.17 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), and the cost principles contained in the Cost Principles Document in the UMCM. The State will not recognize or pay services that cannot be properly substantiated by the MCO and verified by HHSC.

The MCO must:

1. Maintain accounting records for each applicable MCO Program separate and apart from other corporate accounting records.
2. Maintain records for all claims payments, refunds and adjustment payments to providers, capitation payments, interest income and payments for administrative services or functions and must maintain separate records for medical and administrative fees, charges, and payments.
3. Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts.

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.

8.1.17.1 General Access to Accounting Records

The MCO must provide authorized representatives of the Texas and federal government full access to all financial and accounting records related to the performance of the Contract.

The MCO must:

1. Cooperate with the State and federal governments in their evaluation, inspection, audit, and/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 the Federal government determine are relevant to the Contract. Such access is guaranteed at all times during the performance and retention period of the Contract, and will include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the MCO.
3. Make copies of any accounting records or supporting documentation relevant to the Contract, including Provider Contract, available to HHSC or its agents within seven Business Days, or as otherwise specified by HHSC, of receiving a written request from HHSC for specified records or information. If such documentation is not made available as requested, the MCO agrees to reimburse HHSC for all costs, including, but not limited to, 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 location(s) of such accounting records.

4. Pay any and all additional costs incurred by the state and 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.

8.1.17.2 Financial Reporting Requirements

HHSC will require the MCO to provide financial reports by MCO Program and by Service Area to support Contract monitoring as well as State and federal reporting requirements. HHSC will consult with the MCO regarding the format and frequency of such reporting. All financial information and reports that are not Member-specific are property of HHSC and will be public record. Any deliverable or report in **Section 8.1.17.2** ("Financial Reporting Requirements") without a specified due date is due quarterly on the last Business Day of the month. Where the due date states 30 Days, the MCO is to provide the deliverable by the last Business 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.

CHIP Perinatal Program data must be reported, and the data will be integrated into existing CHIP Program financial reports. Except for the Financial Statistical Report, no separate CHIP Perinatal Program reports are required. For all other CHIP financial reports, where appropriate, HHSC will designate specific attributes within the CHIP Program financial reports that the MCO must complete to allow HHSC to extract financial data particular to the CHIP Perinatal Program. HHSC's UMCM will govern the timing, format and content for the following reports.

(a) **Audited Financial Statement –**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 this information has changed since the last report submission. The report must contain the following:

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 as expenses in the FSR Report for services provided to the MCO by the Affiliate. Those should include financial terms, a detailed description of the services to be provided, and an estimated amount that will be incurred by the MCO for such services during the Contract Period.

(c) **Employee Bonus and/or Incentive Payment Plan –** If the 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. The written plan must include a description of the MCO's criteria for establishing bonus or incentive payments, the methodology to calculate bonus or incentive payments, the timeframe for measuring the performance (Measurement Period), and the timing of bonus and/or incentive payments. The Employee Bonus or Incentive Payment Plan and description must be submitted during the Transition Phase, no later than 60 Days before the Operational Start Date of the Contract. Thereafter, the MCO must submit the Employee Bonus or Incentive Payment Plan annually to HHSC prior to the start of the plan's Measurement Period. HHSC

reserves the right to disallow all or part of a plan that it deems inappropriate. Any such payments are subject to audit, and must comply with UMCM Chapter 6.

(d) **Claims Lag Report -** The MCO must submit 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. The report format is contained in UMCM Chapter 5. The report must disclose the amount of incurred claims each month and the amount paid each month.

(e) **Delivery Supplement Payment (DSP) Report -** The MCO must submit a monthly Delivery Supplemental Payment (DSP) Report that includes the data elements specified by HHSC in the format specified by HHSC. HHSC will consult with the MCO prior to revising the DSP Report data elements and requirements. The DSP Report must include only unduplicated deliveries and only deliveries for which the MCO has made a payment, to either a Hospital or other provider.

(f) **MCO Disclosure Statement -** The MCO must file:

1. an updated MCO Disclosure Statement by September 1st 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. after any change in control, ownership, or affiliations; or,
   c. after any 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. This report will replace, and be in lieu of, the former "Section 1318 Financial Disclosure Report" and the "Form CMS 1513," and will disclose the same information, plus other information as may be required by HHSC and/or CMS Program Integrity requirements. Minor quarterly adjustments in stock holdings for publicly-traded corporations are excluded from the reporting requirements. The reporting format is included in the UMCM.

(g) **Financial-Statistical Reports (FSR) –** The MCO must file quarterly and annual FSR in the format and timeframe specified by HHSC. HHSC will include FSR format and directions in the UMCM. The MCO must incorporate financial and statistical data of delegated networks (e.g., Individual Practice Association (IPA), Limited Provider Networks), if any, in its FSR Reports. Administrative expenses reported in the FSRs must be reported in accordance with the Cost Principles Document in the UMCM. Quarterly FSR reports 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 report 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. The MCO must provide FSRs in a comprehensive and understandable format. HHSC will post all FSRs on the HHSC website.

The MCO must submit separate FSRs for the CHIP Perinatal Program following the instructions outlined above and in the UMCM.

(h) **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 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 program efforts and a financial report reflecting payments made to HUBs. MCO must use the formats included in the UMCM for the HUB monthly reports. The MCO must comply with HHSC's standard Client Services HUB Subcontracting Plan requirements for all subcontractors.

(i) **Incurred-But-Not-Reported (IBNR) Plan -** The MCO must furnish a written IBNR Plan to manage IBNR expenses, and a description of the method of insuring against insolvency, including information on all existing or proposed insurance policies. The Plan must include the methodology for estimating IBNR. The plan and description must be submitted to HHSC no later than 60 Days after the Effective Date of the Contract. Substantive changes to an MCO's IBNR plan and description must be submitted to HHSC no later than 30 Days before the MCO implements changes to the IBNR plan.

(j) **TDI Examination Report -** 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.

(k) **TDI Filings –** The MCO must submit annual figures for controlled risk-based capital, as well as its quarterly financial statements, both as required by TDI.

(l) **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 registration statement, also known as 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.

(m) **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 and plan code. TPL/TPR reports must include total dollars cost avoided, and total dollars recovered from third party payers through the MCO's coordination of benefits efforts during the Quarter.

(n) **Report of Legal and Other Proceedings and Related Events** - The MCO must comply with the UMCM Chapter 5, regarding the disclosure of certain matters involving either the MCO, its Affiliates, and/or its Material Subcontractors. Reports are due both on an as-occurs basis and annually each September 1. The as-occurs report is due no later than 30 Days after the event that triggered the notification requirement.

(o) **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.

8.1.18 Management Information System Requirements

The MCO must maintain a 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; and
8. TPR Subsystem.

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.

HHSC will provide the MCO with pharmacy data on the MCO's Members on a weekly basis through the HHSC Vendor Drug Program, or should these services be outsourced, through the Pharmacy Benefit Manager. HHSC will provide a sample format of pharmacy data to contract awardees.

The MCO must have a system that can be adapted to changes in business practices/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 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 of Major Systems Changes and implementations, including any changes relating to Material Subcontractors. Such notice must generally be provided at least 180 Days before a change or implementation and comply with the requirements of this Contract and the **Attachment A** ("General Contract Terms and Conditions").

The MCO must notify HHSC of Major Systems Changes in writing, as well as by e-mail to HPM staff. The notification must detail the following.

1. The aspects of the system that will be changed and date of implementation

2. How these changes will affect the Provider and Member community, if applicable
3. The communication channels that will be used to notify these communities, if applicable
4. A 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.

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 official points of contact for MIS issues on an on-going basis.

HHSC, or its agent, may conduct a Systems Readiness Review to validate the MCO's ability to meet the MIS requirements as described in **Section 7** ("Transition Phase Requirements"). The System Readiness Review may include a desk review and/or an onsite review and must be conducted for the following events:

1. the MCO begins business in a new Service Area;
2. the MCO changes location; or
3. the MCO changes its processing system, including changes in Material Subcontractors performing MIS or claims processing functions.

If HHSC determines that it will conduct an onsite review, the MCO must reimburse HHSC for all authorized reimbursable travel costs associated with such onsite reviews. 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.

If for any reason, the 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, including without limitation actual or liquidated damages, according to the severity of the deficiency. (Refer to **Attachment A, Article 12,** ("General Contract Terms and Conditions, Remedies and Disputes") and **Attachment B-5** ("Deliverables/Liquidated Damages Matrix") for additional information regarding remedies and damages. Refer to **Section 7** ("Transition Phase Requirements") and **Section 8.1.1.2** ("Additional MCO Readiness Review") for additional information regarding Readiness Reviews. Refer to **Attachment A, Section 4.08(c)** for information regarding Readiness Reviews of the MCO's Material Subcontractors.)

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.

8.1.18.1 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 MCOs. Encounter Data must follow the format and include the data elements 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, the submission schedule, and any other requirements in the UMCM. The MCO must submit Encounter Data transmissions monthly and include all Encounter Data and Encounter Data adjustments processed by the MCO. 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 for validation purposes. Encounter Data that do not meet quality standards must be corrected and returned within a time period specified by HHSC.

In addition to providing Encounter Data in the 837 format described above, the MCO may be requested to submit an Encounter Data file to HHSC's EQRO in the format provided in the UMCM. This additional submission requirement is time-limited and may not be required for the entire term of the Contract.

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 and fee-for-service claims submissions, as applicable.

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.

8.1.18.2 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
3. Security Plan.

The Disaster Recovery Plan and the Business Continuity Plan may be combined into one document.

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
3. Systems Quality Assurance Plan.

The MCO must submit plans and checklists to HHSC according to the format and schedule identified the UMCM. Additionally, if a Systems Readiness Review is triggered by one of the events described in Section 8.1.18, the HMO must submit all of the plans identified in this Section 8.1.18.2 in accordance with an HHSC-approved timeline.

The MCO must follow all applicable Joint Interface Plans (JIPs) and all required file submissions for HHSC's Administrative Services Contractor, External Quality Review Organization (EQRO) and HHSC Medicaid Claims Administrator. The JIPs can be accessed through the UMCM.

8.1.18.3 System-wide Functions

The MCO's MIS system must include key business processing functions and/or 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 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 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;
11. relate and extract data elements to produce report formats (provided within the UMCM) 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;
13. maintain and cross-reference all Member-related information with the MCO-assigned CHIP and/or CHIP Perinatal Program Provider number; and
14. ensure that the MIS is able to integrate pharmacy data from HHSC's Drug Vendor file (available through the Virtual Private Network (VPN)) into the MCO's Member data.

8.1.18.4 HIPAA Compliance

The MCO's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA, as amended or

modified. The MCO must comply with HIPAA Electronic Data Interchange (EDI) requirements. The MCO must be able to receive, load, and read eligibility files received from HHSC or its designee in the 834 HIPAA compliant format. Eligibility inquiries must be in the 270/271 format, with the exception of pharmacy services. Pharmacies may submit eligibility inquiries in the NCPDP E1 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 also be 5010 compliant by January 2012. The following website includes the final 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 with a privacy notice as required by HIPAA, 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.

8.1.18.5 Claims Processing Requirements

The MCO must process and adjudicate all provider claims for Medically Necessary health care Covered Services that are filed within the time frames specified in the UMCM Chapter 2. and pharmacy claims in that are filed in accordance with the timeframes specified in UMCM Chapter 2. The MCO is subject to remedies, including liquidated damages and interest, if the MCO does not process and adjudicate claims in accordance with the procedures and the timeframes listed in the UMCM Chapter 2. 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 must administer an effective, accurate, and efficient claims payment process in compliance with state and federal laws, rules, and regulations and other Contract requirements, including 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 has the capability to report each claim transaction by date and type to include interest payments. The claims system must maintain information at the claim and line detail level. The claims system must maintain adequate audit trails and report accurate claims performance measures to HHSC.

The MCO's claims system must maintain online and archived files. The MCO must keep online automated claims payment history for the most current 18 months. The MCO must retain other financial information and records, including all original claims forms, for the time period established in **Attachment A** ("General Contract Terms and Conditions"**,** "Financial Record Retention and Audit"). All claims data must be easily sorted and produced in formats as requested by HHSC.

The MCO must offer its Providers/Subcontractors the option of submitting and receiving claims information through 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 Texas Administrative Code, Title 28, Part 1, Chapter 21, Subchapters C and T.

The MCO must make an electronic funds transfer (EFT) payment process (for direct deposit) available to Network Providers.

The MCO may deny a claim submitted by a provider for failure to file in a timely manner as provided for in the UMCM Chapter 2. The MCO must withhold all or part of payment for any claim submitted by a provider:

1. excluded or suspended from the Medicare, Medicaid, CHIP, or CHIP Perinatal programs for Fraud, Waste, or Abuse;
2. on payment hold under the authority of HHSC or its authorized agent(s), or
3. with debts, settlements, or pending payments due to HHSC, or the state or federal government.

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), 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 Health and Human Services Commission Office of Inspector General (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 must notify HHSC of major claim system changes in writing no later than 180 Days prior to implementation of such change. 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 MCO Provider

Contract or Provider Manual. 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 at least 90 Days prior written notice of the MCO's implementation of changes to these claims policies and guidelines.

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 an 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 Chapter 16.1.15.1 of the UMCM. The Provider portal functionality must include the following.

1. Client eligibility verification
2. Submission of electronic claims
3. Prior Authorization requests
4. Claims appeals and reconsiderations
5. Exchange of clinical data and other documentation necessary for prior authorization and claim processing

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.

8.1.18.5.1 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) and/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.

8.1.18.6 National Correct Coding Initiative

Effective for claims filed on or after October 1, 2010, the HMO must comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (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.

8.1.19 Fraud, Waste, and Abuse

The MCO is subject to all state and federal laws, rules and regulations relating to Fraud, Waste, and Abuse in health care and the MCO 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 Fraud, Waste, or Abuse.

1. The MCO is subject to and must meet all requirements in Texas Government Code §§ 531.113 and 531.1131 and 1 Tex. Admin. Code §§ 370.501-370.505 as well as all laws specified in the Contract.
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 perform pre-payment review for identified providers as directed by HHSC OIG.
4. When requested by the HHSC OIG, the MCO will be required to provide employees to participate in administrative proceedings pursued by the HHSC OIG. Such employees must be knowledgeable about the subject matter on which they called to testify and must be available for preparatory activities and for formal testimony. The MCO must provide the employees at no cost to the State and the HHSC OIG.
5. For the purposes of Hospital Utilization Reviews, Section 8.1.19 (3) also applies to HHSC requests.
6. Failure to comply with any requirement of sections 8.1.19 and 8.1.20.2(c) and (d) 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.

8.1.19.1 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 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 §§ 370.501-370.505.
2. The MCO must maintain a full-time SIU manager dedicated solely to the Texas Medicaid and CHIP programs 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 and CHIP contracts. The investigator must hold credentials such as

certification from the Association of Certified Fraud Examiners, an accreditation from the National Health Care Anti-Fraud Association or have a minimum of three years Medicaid or CHIP Fraud, Waste and Abuse investigatory experience.

8.1.19.2 General requests for and access to data, records, and other information

The MCO and its subcontractors must allow access to all premises and provide complete and unredacted originals and/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. Each MCO must designate one primary and one secondary contact person for all HHSC OIG records requests. Each MCO must also identify a central group email inbox that will receive all HHSC OIG records requests. HHSC OIG records requests will be sent to the central group email inbox and also may be sent to the designated MCO contact person(s) in writing by e-mail, fax, or mail, and will provide the specifics of the information being requested (see below).
2. The MCO must respond to the appropriate HHSC OIG staff member within the timeframe designated in the request. If the MCO is unable to provide all of the requested information within the designated timeframe, the MCO may request an extension in writing (e-mail) to the HHSC OIG requestor no less than two Business Days prior to the due date.
3. The MCO's response must include complete, unredacted and accurate 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, but are not limited to:

1. 1099 data and other financial information – three Business Days.
2. Claims data for sampling and recipient investigations – ten Business Days.
3. Urgent claims data requests – three Business Days (with HHSC OIG manager's approval).
4. Provider education information – ten Business Days.
5. Files associated with an investigation conducted by an MCO – 15 Business Days.
6. Provider profile, UR summary reports, and associated provider education activities and outcomes – as indicated in the request.
7. Member and/or pharmacy data as required by HHSC OIG.
8. Requests submitted to the MCO/DMO for interpretations or clarifications of the MCO/DMO policy and procedure- five Business Days.
9. The basis for providing specific authorized services, including Case-by-case Services, Value-Added Services, and Comprehensive Care Program (CCP) services provided through Texas Health Steps-as needed.
10. Other time-sensitive requests – as needed.

8.1.19.3 Claims Data Submission Requirements

The MCO and its subcontractors must submit complete unredacted and accurate Adjudicated Claims data per the frequency and scope prescribed by the HHSC OIG. This data must include submission of complete, unredacted 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, unredacted 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 complete unredacted and accurate processed claims data according to standards and formats as defined by HHSC OIG, complying with standard code sets and maintaining integrity with all reference data sources including provider and Member data. All data submissions by the MCO and its subcontractors will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing.
4. Any batch submission from an MCO or its subcontractors which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the MCO and its subcontractors for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted shall be completed within five Business Days. Due to the need for timely data and to maintain integrity of processing sequence, should the MCO or its subcontractors fail to respond in accordance with this Section, 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 complete, unredacted and accurate 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.

8.1.19.4 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.

8.1.19.5 Treatment of Recoveries by the MCO for Fraud, Waste and Abuse

Pursuant to 42 C.F.R. § 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.

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 subsection shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims. The MCO must not engage in any reprocessing, recoupments, and other payment recovery efforts or claims adjustments of any kind based on the parameters set by HHSC OIG.
        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 HHSC OIG.

8.1.20 Reporting Requirements

The MCO must provide and must require its Subcontractors to provide at no cost to the Texas Health and Human Services Commission (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 hereunder 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 time frames and formats reasonably acceptable to both parties; and

3. Ad hoc reports as requested by HHSC.

All information must be provided in accordance with the timelines, definitions, formats, and instructions as specified by HHSC. Where practicable, HHSC may consult with the MCO to establish timelines and formats reasonably acceptable to both Parties.

Any Deliverable or report not listed UMCM Chapter 5 but referenced in **Section 8.1.20** ("Reporting Requirements") without a specified due date is due quarterly on the last day of the month following the end of the reporting period. Where the due date states 30 Days, the MCO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 Days, the MCO is to provide the deliverable by the 15th Day of the 2nd month following the end of the reporting period. See UMCM Chapter 5.

The MCO must provide the reports specified in UMCM Chapter 5. This chapter includes a list of required reports and a description of the format, content, file layout, and submission deadlines for each report.

Pursuant to CFR §438.606 and UMCM Chapter 5, Data Certification Instructions, the MCO's chief executive officer (CEO); and chief financial officers (CFO); or an individual who reports directly to those position with delegated authority to sign for them so that the CEO or CFO is ultimately responsible for the certification, must certify that financial data, Encounter Data, and other data, as specified by CFR §438.604, has been reviewed and is true and accurate to the best of the certifying person's knowledge. Such certification may not be delegated.

8.1.20.1 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.

8.1.20.2 Reports

The MCO must provide the following reports, in addition to the Financial Reports described in **Section 8.1.17** ("Accounting and Financial Reporting Requirements") and those reporting requirements listed elsewhere in the Contract. The UMCM will include a list of all required reports, and a description of the format, content, file layout, and submission deadlines for each report.

For the following reports, CHIP Perinatal Program data will be integrated into CHIP Program reports. Generally, no separate CHIP Perinatal Program reports are required. Where appropriate, HHSC will designate specific attributes within the CHIP Program reports that the MCO must complete to allow HHSC to extract data particular to the CHIP Perinatal Program.

(a) **Claims Summary Report** - The MCO must submit one Claims Summary Report each month by Program to HHSC using the text file layout located in UMCM Chapter 5.

(b) **QAPI Program Annual Summary Report** - The MCO must submit a QAPI Program Annual Summary in a format and timeframe as specified in the UMCM.

(c) **Fraudulent Practices Referral** - Utilizing the HHSC OIG Fraud referral form, through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS), the MCO's assigned officer or director must report and refer all possible acts of Fraud, Waste, or

Abuse to the HHSC OIG within 30 Business Days of receiving the reports of possible acts of Fraud, Waste, or Abuse from the MCO's Special Investigative Unit (SIU). This requirement applies to all referrals of possible acts of Fraud, Waste, or Abuse. Additional guidance is provided in UMCM Chapter 5.

Additional reports required by the HHSC OIG relating to Fraud, Waste, or Abuse are listed in the UMCM Chapter 5.

(d) **Provider Termination Report -** The MCO must submit one Provider Termination Report each quarter by Program that identifies all Network Providers who cease to participate in the MCO's Provider 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.

(e) **Network & Capacity Report: -** Each CHIP 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 30 Days after the end of the reporting quarter.

(f) **Provider Complaints, Member Complaints, and Member Appeals** - The MCO must submit monthly Complaints and Member Appeals reports. The MCO must include in its reports Complaints, including Initial Contact Complaints and Appeals submitted to the MCO and/or any Subcontractor delegated to provide a service for the MCO. All Member or Provider 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 complaint 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.

(g) **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 Provider Hotline and Nurseline where applicable to measure the MCO's compliance in accordance with the performance standards set out in **Sections 8.1.5.6** Member Hotline, **8.1.15.3** Behavioral Health Services Hotline, and **8.1.4.7** Provider Hotline using the text file layout located in UMCM Chapter 5..

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.

(h) **Audit Reports** – the MCO must comply with the UMCM's requirements regarding notification and/or submission of audit reports.

(i) **Drug Utilization Review (DUR) Reports** – MCOs must submit the DUR reports in accordance with the requirements of HHSC's UMCM.

(j) **MCO Pharmacy Quarterly Report** – MCOs must complete and submit a MCO Pharmacy Quarterly Report for each Program 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).

(k) **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 the UMCM Chapter 5.

(l) **TPR Report for Pharmacy TPL** – MCOs must complete and submit a TPR Report for Pharmacy TPL for each Program 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.

(m) **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.

8.1.21 Third Party Liability and Recovery and Coordination of Benefits.

CHIP is the payer of last resort for Covered Services when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under CHIP will pay benefits for Covered Services that remain unpaid after all other insurance coverage has been paid. For Network Providers and Out-of- Network providers with written reimbursement arrangements with the MCO, the MCO must pay the unpaid balance for Covered Services up to the agreed rates. For Out-of-Network providers with no written reimbursement arrangement, the MCO must pay the unpaid balance for Covered Services in accordance with 1 Tex. Admin. Code § 370.604 regarding Out-of-Network payment and TDI's rules regarding usual and customary payment.

The MCO is authorized to engage in Third Party Recovery (TPR) actions for claims resulting from the care and/or treatment of CHIP Members, CHIP Perinatal Members, and CHIP Perinatal Newborn Members. 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.

Each 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 all TPR reports to OIG-TPR at the frequency and in accordance with UMCM Chapter 5.

MCOs must communicate to liable third parties their responsibilities under Texas Human Resources Code §32.0424, to include:

1. responding to an MCO inquiry within 60 Days regarding a claim for payment for Covered Services submitted to the liable third party no later than the third anniversary after the date the Covered Services were provided;

2. except as provided in §32.0424(b-2), accepting authorization from the MCO for Covered Services that require prior authorization and were previously paid by the MCO as if the MCO's authorization is a prior authorization made by the liable third party for Covered Services; and

3. the prohibition of denying a claim submitted by the MCO for which payment was made solely on the basis of:

    a. the date of submission of the claim;
    b. the type or format of the claim form;
    c. a failure to present proper documentation at the point of service that is the basis of the claim; or
    d. except as provided in §32.0424(b-2), a failure to obtain prior authorization for Covered Services.

The prohibition on denying a claim under this subsection is limited to claims submitted by the MCO no later than the third anniversary of the date the Covered Services were provided and any action by the MCO to enforce HHSC's right to the claim is commenced not later than the sixth anniversary of the date the MCO submits the claim.

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 and/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 the 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 the 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.

8.1.22 Payment of 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, HHSC 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 Health Care 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 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.

8.1.23 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 AAP Periodicity Schedule. The MCO must educate Providers that the screening provider or appropriate designee is responsible

for administration of the immunization and should not refer children to Local Health Departments or other entities to receive immunizations.

The MCO must educate Providers about the importance of including documentation for immunizations in the Member's medical record, and the necessity of the Provider's documentation to support a qualification for reimbursement for appropriate provision of immunizations to eligible Members.

The MCO must educate Providers about, and require Providers to comply with, the requirements of Tex. Health and Safety Code, Chapter 161, relating to the Texas Immunization Registry (ImmTrac2), to include parental consent on the Vaccine Information Statement.

The MCO must notify CHIP 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.

8.1.24 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 prior authorization 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 Provider Contract 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 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 and 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 negotiation between the PBM and pharmacy provider. The MCO, or its Subcontractor, as applicable, must disclose to pharmacy providers the reimbursement rates and payment methodology used to develop the rates specific to the pharmacy provider during the contract negotiation 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.

8.1.24.1 Formulary and Preferred Drug List

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 Member, the prescribing physician or health care provider, and a pharmacist may jointly approve a medication synchronization plan. A medication synchronization plan may be used only for prescribed drugs that treat chronic illnesses and that otherwise comply 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.

8.1.24.2 Prior Authorization 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 or as required under the Contract. 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 PA 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 Vendor Drug Program are available on HHSC's Vendor Drug Program 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 Vendor Drug Program website, HHSC will notify MCOs.

The MCO must provide access to a toll-free call center for prescribers to call to request drugs requiring prior authorization.

MCOs must comply with the prior authorization requirements applicable to the CHIP Program in Texas Insurance Code Chapter 4201 and peer-to-peer requirements as required in 28 TAC §19.1710 (unless the time period is inappropriate to the Member's circumstances and condition, in which case the MCO has one hour to respond).

The MCO must allow the pharmacy to dispense a 72-hour supply of the drug, if the MCO is unable to provide a PA response within the timeframe specified in Texas Insurance Code Chapter 4201 or the prescriber cannot 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'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 MCOs 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 prior authorization request. This

process must automatically evaluate whether a submitted pharmacy claim meets Prior Authorization criteria for both PDL and Clinical PAs. (See UMCM, Chapter 2.2., Section V for the definition of an Automated Prior Authorization 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 8.1.4.7, "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 8.1.5.9.

If a Member changes Medicaid or CHIP health plans, the MCO must provide the new health plan information about the Member's PA and medication history at no cost and upon request. The MCO, in consultation with HHSC, will develop a standard process and timeline for implementing a standard format for sharing Member medication and PA history. HHSC expects the former MCO to respond with the requested information within 72 hours of the new MCO's request.

8.1.24.3 Coverage Exclusions

In accordance with 42 U.S.C. § 1396r-8, the MCO must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. The MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product. A list of participating drug companies can be found on the CMS website under "Medicaid Drug Rebate Program," "Contact Information."

An MCO may restrict some compounded medications available through the pharmacy benefit. MCO's coverage of compounded medications must follow the same requirements as outlined in this section and must be listed on the Texas Medicaid or CHIP Formulary. MCOs may not reimburse pharmacies for compounding powders since these are not included on the Texas Medicaid or CHIP formulary.

8.1.24.4 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 medications, 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 pend a claim for compounded medication for $200 or more for further review to determine if the product is safe and effective.

The MCO may reject a claim for a compound medication if the active ingredients and the use of the compound prescriptions do not have a medically accepted use supported by the compendia or peer review literature. The MCO may select and use from 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 compounded medication.

For auditing purposes, an MCO may request prescription compounding logs from a pharmacy to verify NDCs, quantities, and calculations.

The MCO may pend a claim for compounded medication for $200 or more for further review to determine if the product is safe and effective.

8.1.24.5 Pharmacy Rebate Program

The MCO may not negotiate rebates with drug companies for pharmaceutical products. HHSC or its designee will negotiate rebate agreements. If the MCO or its PBM has an existing rebate agreement with a manufacturer, all Medicaid and CHIP outpatient drug claims, including provider-administered drugs, must be exempt from such rebate agreements. 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.

The MCO must implement a process to timely support HHSC's Medicaid and CHIP rebate dispute resolution processes.

1. 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.
2. The MCO must establish a single point of contact where HHSC's designee can send information or request clarification.
3. HHSC will notify the MCO of claims submitted with incorrect information. The MCO mush 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.

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.

8.1.24.6 Drug Utilization Review Program

The MCO must have a drug utilization review program (DUR) 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 CFR 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 CFR § 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 must also determine whether services were delivered as prescribed and consistent with the MCO's payment policies and procedures.

The MCO's Drug Utilization Review should specifically assess prescribing patterns for psychotropic medications. If the MCO identifies patterns outside of the MCO's parameters for psychotropic medications, or if HHSC notifies the MCO of outlier prescribing patterns, then the MCO must conduct a peer-to-peer discussion on the appropriateness of the drug regimen with the prescriber. The MCO must model its parameters on DFPS's "Psychotropic Medication Utilization Parameters for Foster Children."

8.1.24.7 Pharmacy Benefit Manager

The MCO must use a Pharmacy Benefit Manager 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 these Subcontractors. These assurances and procedures must be submitted for HHSC's review during Readiness Review (see Section 3, "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 under Section 8.1.4.8;
- reconciliation methodologies that include Medicaid or CHIP claims;

- mechanisms that facilitate "spread pricing," including pharmacy provider reimbursement clawbacks or discounts, which is described below in this section;
- PBM restrictions that are greater than those required by HHSC for Medicaid/CHIP participation; or

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.

8.1.24.8 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 & 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 the information is confidential under state or federal law.

8.1.24.9 Limitations Regarding Registered Sex Offenders

HHSC's CHIP formulary does not include sexual performance enhancing medications. If such medications are added to the CHIP formulary, then the 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.

8.1.24.10 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.

8.1.24.11 Maximum Allowable Cost Requirements

The MCO must develop maximum allowable cost (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 the same market basket, 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 specified 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 drug price on the MAC list, 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 on the MAC list, 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 MCOs or PBMs, as applicable, must provide a process for each of its Network pharmacies to readily access the MAC list specific to that pharmacy directly from the MCO or PBM, even if the pharmacy is contracted with a PSAO. At a minimum, MCOs and PBMs 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, MCOs or PBMs 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 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.

8.1.24.12 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. In Medicaid fee-for-service, the Vendor Drug Program pays qualified community retail pharmacies for pharmaceutical delivery services. 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.

In Medicaid fee-for-service, the Vendor Drug Program pays qualified community retail pharmacies for pharmaceutical delivery services. 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.

8.1.24.13 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 in Medicaid managed care must 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 covered entity may contract with the MCO 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.

8.1.24.14 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 Sections 8.2.1 (Medicaid) and 8.4.3 (CHIP) regarding payment of out-of-network 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/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 Joint Interface Plan are loaded into the pharmacy claims adjudication system within two Days of receipt.

8.1.24.15 Pharmacy Audits

The MCO and its PBM are prohibited from using extrapolation in pharmacy audits.

8.1.24.16 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.

8.1.24.17 This Section Intentionally Left Blank

8.1.25 Payment by Members

Except for costs associated with unauthorized non-emergency services provided to a Member by Out-of-Network providers and for non-covered services, the copayments outlined in the CHIP Cost Sharing Table in UMCM Chapter 6. are the only amounts that an MCO may impose and a provider may collect from a CHIP-eligible family. As required by 42 C.F.R. § 457.515, this includes, without limitation, Emergency Services that are provided at an Out-of-Network facility. Cost sharing for such Emergency Services is limited to the copayment amounts set forth in the

CHIP Cost Sharing Table. If the MCO would have paid a lesser amount than the CHIP copayment in the absence of a CHIP copayment, then the copayment amount will be capped at the lesser amount.

The MCO cannot require prior authorization as a condition for payment for an Emergency Medical Condition, an Emergency Behavioral Health Condition, 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, or labor and delivery. The MCO cannot limit what constitutes an Emergency Medical 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 Days of presentation for Emergency Services. The MCO may not hold the Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. The MCO must accept the emergency physician or provider's determination of when the Member is sufficiently stabilized for transfer or discharge.

8.1.25.1 Cost Sharing

CHIP Network Providers and Out-of-Network Providers may collect copayments authorized in the CHIP State Plan from CHIP Members.

CHIP families that meet the enrollment period cost share limit requirement must report it to the HHSC Administrative Services Contractor. The HHSC Administrative Service Contractor notifies the MCO that a family's cost share limit has been reached. Upon notification from the HHSC Administrative Services Contractor that a family has reached its cost-sharing limit for the term of coverage, the MCO will generate and mail to the CHIP Member a new Member ID card within five Days, showing that the CHIP Member's cost-sharing obligation for that term of coverage has been met. No cost-sharing may be collected from these CHIP Members for the balance of their term of coverage.

Providers are responsible for collecting all Member copayments at the time of service. Copayments that families must pay vary according to their income level.

Copayments do not apply, at any income level, to Covered Services that qualify as well-baby and well-child care services, preventive services, or pregnancy-related services as defined by 42 C.F.R. § 457.520 and SSA § 2103(e)(2).

Except for costs associated with unauthorized non-emergency services provided to a Member by Out-of-Network providers and for non-covered services, the copayments outlined in the CHIP Cost Sharing Table in UMCM Chapter 6 are the only amounts that an MCO may impose and a provider may collect from a CHIP-eligible family. If the cost of a Covered Service is less than the Member's CHIP copayment for that Covered Service, the copayment amount the Member pays will be capped at the cost of the Covered Service.

Federal law prohibits charging premiums, deductibles, coinsurance, copayments, or any other cost-sharing to Members of Native Americans or Alaskan Natives. The HHSC Administrative Services Contractor will notify the MCO of Members who are not subject to cost sharing requirements. The MCO is responsible for educating Providers regarding the cost sharing waiver for this population.

An MCO's monthly Capitation Payment will not be adjusted for a family's failure to make its CHIP premium payment. There is no relationship between HHSC's Capitation Payment to the MCO for coverage provided during a month and the family's payment of its CHIP premium obligation for that month.

Cost sharing does not apply to CHIP Perinatal Program Members. The exemption from cost sharing applies through the end of the enrollment period.

8.1.26 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 Health and Human Services. 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 Members with multiple chronic 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. evidence-based models 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 unless HHSC enters into a Dual Eligible Demonstration Project with the CMS.

8.1.26.1 Health Home Services and Participating Providers

HHSC encourages MCOs to develop provider incentive programs for designated Providers who meet the requirements for Member-centered medical 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; and
4. provide reports on changes in a Member's health status to his or her PCP for Members enrolled in a Health Home Services program.

8.1.27 Cancellation of Product Orders

If a Network Provider offers delivery services for covered products, such as durable medical equipment (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 Texas Administrative Code § 291.34. The Member or Member's LAR must have the option to withdraw from an automated refill delivery program at any time.

8.1.28 Preadmission Screening and Resident Review (PASRR) Referring Entity Requirements

The MCO must follow any PASRR requirements when acting as a referring entity for Members as required by 26 Tex. Admin. Code §§ 303.101 and 303.301.

8.1.29 Continuity of Care and Out-of-Network Providers

The MCO must ensure continuity of care such that the care of newly enrolled Members is not disrupted or interrupted. The MCO must ensure that the care of newly enrolled Members whose health or Behavioral Health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Medically Necessary Covered Services is not disrupted or interrupted. Upon notification from a Member or Provider of the existence of a prior authorization, the new MCO must ensure Members receiving services through a prior authorization from another CHIP MCO, Medicaid MCO, or fee-for-service 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. See Section 8.1.14, "Disease Management." for specific requirements for new Members transferring to the MCO's Disease Management Program.

For instances in which a newly enrolled Member was receiving a service that did not require a prior authorization in FFS or the previous MCO, 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 is also required to ensure that clients being transferred to a new MCO as part of an HHSC initiative, receiving acute care services through a prior authorization as of the Operational Start Date receive continued authorization of those services for the shorter period of one of the following: (1) 90 Days after Operational Start Date, or (2) until the expiration date of the prior authorization. During transition, an HHSC's Administrative Services Contractor or an HHS

Agency will provide the MCO with files identifying Members with prior authorizations for acute care services. The MCO must describe the process it will use to ensure continuation of these services in its Transition/Implementation Plan as noted in Section 7.2.1 Contract Start-Up and Planning. The MCO is also required to ensure that Providers in the Service Areas are educated about and trained regarding the process for continuing these services prior to the Operational Start Date (see Section 8.3.6.1 Training).

As described in Section 8.1.3.2, the MCO must allow pregnant Members past the 24th week of pregnancy to remain under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the provider is Out-of-Network. 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 Out-of-Network providers for Medically Necessary Covered Services until the Member's records, clinical information and care can be transferred to a Network Provider, or until such time as the Member is no longer enrolled in that MCO, whichever is shorter. Payment to Out-of-Network providers must be made within the time period required for Network Providers. The MCO must comply with Out-of-Network rules as described in T.A.C. 370.604.

With the exception of pregnant Members who are past the 24th week of pregnancy, this Article does not extend the obligation of the MCO to reimburse the Member's existing Out-of-Network providers for ongoing care for more than 90 Days after a Member enrolls in the MCO's Program.

The MCO's obligation to reimburse the Member's existing Out-of-Network 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.

If a Member moves out of a Service Area, the MCO must provide or pay Out-of-Network providers in the new Service Area who provide Medically Necessary Covered Services to Members through the end of the period for which the MCO received a Capitation Payment for the Member.

If Covered Services are not available within the MCO's Network, the MCO must provide Members with timely and adequate access to Out-of-Network services for as long as those services are necessary and not available in 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 Out-of-Network services if such services become available and within acceptable appointment availability timeframes described in this Contract from a Network Provider.

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), applicable to CHIP through 42 C.F.R. § 457.1230. 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.

8.1.30 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 is 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.

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 emergencies that are 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.

When directed by HHSC, by authority of waivers available through the State Plan, the MCO must be able to require Network Providers to waive all cost-sharing requirements for children of families living in FEMA or State of Texas Governor-declared disaster areas, or areas in which internal, man-made, or natural disasters have occurred, at the time of the disaster event.

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.

8.1.31 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. § 457.1233(d) and the Provider Directory API requirements in 42 C.F.R. § 457.1233, 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.

8.1.31.1 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 CFR § 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 CFR § 170.213.

8.1.32 Education for CHIP Members and Providers

The MCO must have procedures in place to educate Members about family planning programs, including the Healthy Texas Women program, the HHSC Family Planning Program, and the HHSC Primary Health Care program.

The MCO must also have procedures in place to educate Providers about eligibility criteria and program services available under the Healthy Texas Women Program, including Healthy Texas Women Plus services, the HHSC Family Planning Program, and the HHSC Primary Health Care Program.

8.1.33 Perinatal Services in CHIP Perinatal

The MCO must provide CHIP Perinatal Covered Services, including postpartum visits, to the mother of a CHIP Perinatal unborn child beginning on the Member's date of enrollment up to 60 Days after the end of pregnancy.

If provided within 60 Days after the end of pregnancy, the MCO cannot deny a Provider's claims for Covered Services provided to the mother of a CHIP Perinatal Newborn or former CHIP Perinatal unborn child on the basis that the mother's CHIP Perinatal ID number has expired in accordance with HHSC's claims processing requirements in UMCM Chapter 2. The MCO may Adjudicate claims using a proxy ID number, newborn's State-issued Medicaid ID number or newborn's CHIP Perinatal ID number.

The MCO must have a procedure to prevent duplication of payment to Providers submitting bundled payment claims for CHIP Perinatal Covered Services, including postpartum visits.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	January 1, 2010	Initial version of Attachment B-1, Section 9 that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2010	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.2	September 1, 2010	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.3	December 1, 2010	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.4	March 1, 2011	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.5	September 1, 2011	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.6	March 1, 2012	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.7	June 1, 2012	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.8	September 1, 2012	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.9	March 1, 2013	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.10	June 1, 2013	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.11	September 1, 2013	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.12	January 1, 2014	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.13	February 1, 2014	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.14	September 1, 2014	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.15	October 1, 2014	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.16	March 1, 2015	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.17	May 1, 2015	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.18	September 1, 2015	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.
Revision	1.19	March 1, 2016	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.20	September 1, 2016	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.21	March 1, 2017	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.22	September 1, 2017	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.
Revision	1.23	March 1, 2017	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.24	September 1, 2018	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.25	January 1, 2019	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.26	March 1, 2019	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.
Revision	1.27	September 1, 2019	Contract amendment did not revise Attachment B-1, Section 9 “Turnover Requirements”.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.28	March 1, 2020	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.29	September 1, 2020	Section 9.1 is modified to clarify language to include expectations required of contracted MCO. Section 9.2 is modified to be consistent with other contracts. Section 9.4 is modified to be consistent with other contracts. Section 9.5 is modified to be consistent with other contracts.
Revision	1.30	March 1, 2021	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".
Revision	1.30.1	June 1, 2021	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".
Revision	1.31	September 1, 2021	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".
Revision	1.32	March 1, 2022	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".
Revision	1.33	September 1, 2022	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".
Revision	1.34	March 1, 2023	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".
Revision	1.35	September 1, 2023	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".
Revision	1.36	March 1, 2024	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".

[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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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 Effective Date 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.

The Turnover Plan must describe the MCO's policies and procedures that will assure:

1. The least disruption in the delivery of Covered Services to Members during the transition to a subsequent contractor.
2. Cooperation with HHSC and a subsequent contractor in notifying Members of the transition, as requested and in the form required or approved by HHSC.
3. Cooperation with HHSC and a subsequent contractor in transferring information to HHSC or a subsequent contractor, as requested and in the form required or approved by HHSC.

The Turnover Plan must be approved by HHSC, and include at a minimum:

1. The MCO's approach and schedule for the transfer of data and information, as described below.
2. The quality assurance process that the MCO will use to monitor Turnover activities.
3. The MCO's approach to training HHSC or a subsequent contractor's staff in the operation of its business processes.

HHSC is not limited or restricted in the ability to require additional information from the MCO or modify the Turnover Plan as necessary.

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: data and reference tables; data entry software; license agreements for third-party software and modifications if required by HHSC; documentation relating to software and interfaces; functional business process flows; and operational information, including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and 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 such documentation exists at the

expiration or termination of the Contract. See **Attachment A, Section 15.03** for additional information concerning intellectual property rights.

In addition, the MCO will provide to HHSC the following:

1. Data, information and services necessary and sufficient to enable HHSC to map all MCO 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 defiPgned by HHSC.
2. All necessary data, information and services will be provided in the format defined by HHSC and must be HIPAA compliant.
3. All of the data, information and services mentioned in this section shall be provided and performed in a manner by the MCO 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 pursuant to this section shall be provided at no additional cost to HHSC.

All relevant data and information must be received and verified by HHSC or the subsequent contractor. 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 reasonable cost of providing these services will be the responsibility of the MCO.

9.4 Turnover Services

Twelve 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 propose the Turnover Plan sooner than twelve months prior to the termination date. In such cases, HHSC's notice of termination will include the date the Turnover Plan is due.

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. Turnover will not be considered complete until the turnover activities are complete, and the Turnover Plan is approved by HHSC.

If the MCO does not provide the required data or information necessary for HHSC or the subsequent contractor to assume the operational activities successfully, the MCO must reimburse HHSC for all authorized reimbursable travel costs and expenses 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

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	Version 1.0	January 1, 2010	Initial version of Attachment B-2, "CHIP Covered Services" that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2010	Contract amendment did not revise Attachment B-2, "CHIP Covered Services".
Revision	1.2	September 1, 2010	Inpatient General Acute and Inpatient Rehabilitation Hospital Services is modified to add "services for a mastectomy and breast reconstruction". Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center is modified to add "services for a mastectomy and breast reconstruction". Physician/Physician Extender Professional Services is modified to add "services for a mastectomy and breast reconstruction".
Revision	1.3	December 1, 2010	CHIP Hospice Care Services is modified to require concurrent CHIP and hospice care services to comply with the federal requirements from Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148). By law, CHIP health plans were required to provide concurrent hospice care services effective August 1, 2010.
Revision	1.4	March 1, 2011	Inpatient Mental Health Services is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as applied to CHIP by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). Also modified to clarify the court-ordered service requirement. Outpatient Mental Health Services is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as applied to CHIP by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). Also modified to clarify the court-ordered service requirement. Inpatient Substance Abuse Treatment Services is modified to comply with the federal requirements of the Mental Health Parity and

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Addiction Equity Act of 2008 (MHPAEA), as applied to CHIP by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). Outpatient Substance Abuse Treatment Services is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as applied to CHIP by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).
Revision	1.5	September 1, 2011	Contract amendment did not revise Attachment B-2, "CHIP Covered Services".
Revision	1.6	March 1, 2012	"Birthing Center Services" is added as a clarification item. **"**Prenatal care and prepregnancy family services and supplies" is added as a clarification item**.** "Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center" is added as a clarification item. "Drug Benefits" is added as a clarification item. CHIP Exclusions from Covered Services is modified to clarify that over the counter drugs, contraceptives, and medications prescribed for weight loss or gain are not a covered benefit.
Revision	1.7	June 1, 2012	Contract amendment did not revise Attachment B-2, "CHIP Covered Services".
Revision	1.8	September 1, 2012	Contract amendment did not revise Attachment B-2, "CHIP Covered Services".
Revision	1.9	March 1, 2013	CHIP Exclusions from Covered Services is modified to clarify coverage while traveling outside of the U.S. Territories.
Revision	1.10	June1, 2013	Contract amendment did not revise Attachment B-2, "CHIP Covered Services".
Revision	1.11	September 1, 2013	Contract amendment did not revise Attachment B-2, "CHIP Covered Services".
Revision	1.12	January 1, 2014	Contract amendment did not revise Attachment B-2, "CHIP Covered Services".

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.13	February 1, 2014	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.14	September 1, 2014	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.15	October 1, 2014	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.16	March 1, 2015	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.17	May 1, 2015	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.18	September 1, 2015	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.19	March 1, 2016	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.20	September 1, 2016	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.21	March 1, 2017	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.22	September 1, 2017	CHIP Covered Services is modified to comply with 42 CFR §438.210. CHIP Exclusions from Covered Services is modified to comply with a court order requiring FQHC non-emergency unauthorized out-of-network services to be fully reimbursed.
Revision	1.23	March 1, 2018	CHIP Exclusions From Covered Services is modified to comply with court order related to Legacy lawsuit.
Revision	1.24	September 1, 2018	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.25	January 1, 2019	CHIP Covered Services is modified to clarify court orders that are CHIP-payable. “CHIP Exclusions from Covered Services” is modified to clarify when treatment tor evaluation required by a court are excluded.
Revision	1.26	March 1, 2019	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.27	September 1, 2019	Substance abuse is changed to substance use disorder to align with the language in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.
Revision	1.28	March 1, 2020	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”..
Revision	1.29	September 1, 2020	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.30	March 1, 2021	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.30.1	June 1, 2021	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.31	September 1, 2021	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.32	March 1, 2022	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.33	September 1, 2022	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.34	March 1, 2023	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.35	September 1, 2023	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.
Revision	1.36	March 1, 2024	Contract amendment did not revise Attachment B-2, “CHIP Covered Services”.

[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.

CHIP Covered Services

Covered CHIP services must meet the CHIP definition of Medically Necessary Covered Services as defined in this **RFP**. The services supporting Members with ongoing or chronic conditions must be authorized in a manner that reflects the Member's ongoing need for such services and supports. There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays apply until a family reaches its specific cost-sharing maximum.

Covered Benefit	Description

Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following:
	▪ Hospital-provided Physician or Provider services
	▪ Semi-private room and board (or private if medically necessary as certified by attending)
	▪ General nursing care
	▪ Special duty nursing when medically necessary
	▪ ICU and services
	▪ Patient meals and special diets
	▪ Operating, recovery and other treatment rooms
	▪ Anesthesia and administration (facility technical component)
	▪ Surgical dressings, trays, casts, splints
	▪ Drugs, medications and biologicals
	▪ Blood or blood products that are not provided free-of-charge to the patient and their administration
	▪ X-rays, imaging and other radiological tests (facility technical component)
	▪ Laboratory and pathology services (facility technical component)
	▪ Machine diagnostic tests (EEGs, EKGs, etc.)
	▪ Oxygen services and inhalation therapy
	▪ Radiation and chemotherapy
	▪ Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care
	▪ In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
	▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care
	▪ Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
	  ▪ dilation and curettage (D&C) procedures;
	  ▪ appropriate provider-administered medications;
	  ▪ ultrasounds, and
	  ▪ histological examination of tissue samples.
	▪ Surgical implants
	▪ Other artificial aids including surgical implants

Covered Benefit	Description

	▪ Inpatient services for a mastectomy and breast reconstruction include:
	  ▪ all stages of reconstruction on the affected breast;
	  ▪ external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
	  ▪ surgery and reconstruction on the other breast to produce symmetrical appearance; and
	  ▪ treatment of physical complications from the mastectomy and treatment of lymphedemas.
	▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit
	▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
	  ▪ cleft lip and/or palate; or
	  ▪ severe traumatic, skeletal and/or congenital craniofacial deviations; or
	  ▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.

Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility services ▪ Drugs, medications and biologicals ▪ Casts, splints, dressings ▪ Preventive health services ▪ Physical, occupational and speech therapy ▪ Renal dialysis ▪ Respiratory services ▪ Radiation and chemotherapy ▪ Blood or blood products that are not provided free-of-charge to the patient and the administration of these products ▪ Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.

Covered Benefit	Description
	▪ Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ▪ dilation and curettage (D&C) procedures; ▪ appropriate provider-administered medications; ▪ ultrasounds, and ▪ histological examination of tissue samples. ▪ Surgical implants ▪ Other artificial aids including surgical implants ▪ Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: ▪ all stages of reconstruction on the affected breast; ▪ external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed ▪ surgery and reconstruction on the other breast to produce symmetrical appearance; and ▪ treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ▪ cleft lip and/or palate; or ▪ severe traumatic, skeletal and/or congenital craniofacial deviations; or ▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
Physician/Physician Extender Professional Services	Services include, but are not limited to, the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) ▪ Physician office visits, in-patient and out-patient services ▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation ▪ Medications, biologicals and materials administered in Physician's office ▪ Allergy testing, serum and injections ▪ Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care

Covered Benefit	Description
	- Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations ▪ Hospital-based Physician services (including Physician-performed technical and interpretive components) ▪ Physician and professional services for a mastectomy and breast reconstruction include: ▪ all stages of reconstruction on the affected breast; ▪ external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed ▪ surgery and reconstruction on the other breast to produce symmetrical appearance; and ▪ treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: ▪ dilation and curettage (D&C) procedures; ▪ appropriate provider-administered medications; ▪ ultrasounds, and ▪ histological examination of tissue samples. ▪ Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ▪ cleft lip and/or palate; or ▪ severe traumatic, skeletal and/or congenital craniofacial deviations; or ▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery)

Covered Benefit	Description
Prenatal care and prepregnancy family services and supplies	Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services. Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.
Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center	Covers prenatal services and birthing services rendered in a licensed birthing center.
Drug Benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetic devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: ▪ Orthotic braces and orthotics ▪ Dental devices ▪ Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses ▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease ▪ Hearing aids ▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A.)
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.)

Covered Benefit	Description
	▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and occupational therapies. ▪ Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker ▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services ▪ Services are not intended to replace 24-hour inpatient or skilled nursing facility services
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: ▪ Neuropsychological and psychological testing. • When inpatient psychiatric services are ordered by: • 1) a court of competent jurisdiction, pursuant to the Texas Health and Safety Code Chapters 573, Subchapters B and C, or 574, Subchapters A through G, Texas Family Code Chapter 55, Subchapter D;, or • 2) as a condition of probation, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • These requirements are not applicable when the Member is considered incarcerated as defined by UMCM Section 16.1.15.2. ▪ Does not require PCP referral
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility ▪ Neuropsychological and psychological testing ▪ Medication management ▪ Rehabilitative day treatments ▪ Residential treatment services ▪ Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development) ▪ When outpatient psychiatric services are ordered by a court of competent jurisdiction, pursuant to: ▪ 1) the Texas Health and Safety Code Chapters 573, Subchapters B and C, or 574, Subchapters A through G, Texas Family Code Chapter 55, Subchapter D: or ▪ 2) a condition of probation

Covered Benefit	Description
	the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. ▪ These requirements are not applicable when the Member is considered incarcerated as defined by UMCM Section 16.1.15.2. ▪ A Qualified Mental Health Provider – Community Services (QMHP-QS), defined by and credentialed through the Texas Department of State Health Services (DSHS)-in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services ▪ Does not require PCP referral
Inpatient and Residential Substance Use Disorder Treatment Services	Inpatient substance use disorder treatment services include, but are not limited to: • Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • When inpatient and residential substance use disorder treatment services are required: • 1) as a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code: or • 2) as a condition of probation, the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • These requirements are not applicable when the Member is considered incarcerated as defined by UMCM Section 16.1.15.2. • Does not require PCP referral
Outpatient Substance Use Disorder Treatment Services	Outpatient substance use disorder treatment services-include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized non-residential service providing structured group and

Covered Benefit	Description
	individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training • When outpatient substance use disorder treatment services are required: • 1) as a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code: or • 2) as a condition of probation, the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • These requirements are not applicable when the Member is considered incarcerated as defined by UMCM Section 16.1.15.2. • Does not require PCP referral
Rehabilitation Services	Services include, but are not limited to, the following: ▪ Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: ▪ Physical, occupational and speech therapy ▪ Developmental assessment
Hospice Care Services	Services include, but are not limited to: ▪ Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death ▪ Treatment services, including treatment related to the terminal illness ▪ Up to a maximum of 120 days with a 6 month life expectancy ▪ Patients electing hospice services may cancel this election at anytime ▪ Services apply to the hospice diagnosis
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	HMO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers

Covered Benefit	Description
	▪ Medical screening examination ▪ Stabilization services ▪ Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services ▪ Emergency ground, air and water transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.
Transplants	Services include, but are not limited to, the following: ▪ Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: ▪ One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization ▪ One pair of non-prosthetic eyewear per 12-month period
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation
Tobacco Cessation Program	Covered up to $100 for a 12- month period limit for a plan- approved program ▪ Health Plan defines plan-approved program. ▪ May be subject to formulary requirements.
[Value-added services]	See **Attachment B-3**

CHIP EXCLUSIONS FROM COVERED SERVICES

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e., cannot be prescribed for family planning)
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
- Experimental or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court other than a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters Band C, 574, Subchapter D or 462, Subchapter D and Texas Family Code Chapter 55, Subchapter D.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care services provided by an FQHC, as provided for in Section 8.1.22 of the contract, and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses, or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a

parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.

- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)

CHIP DME/SUPPLIES

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for treatment of craniofacial anomalies requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: •Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: •For members who could be sustained on an age-appropriate diet. •Traditionally used for infant feeding •In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) •For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	January 1, 2010	Initial version of Attachment B-2.1, "CHIP Perinatal Covered Services" that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2010	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.2	September 1, 2010	Attachment B-2.1 is modified to clarify the 12-month enrollment period is for the CHIP Perinate Newborn beginning with the month of enrollment as a CHIP Perinate. CHIP Perinatal Covered Services "Inpatient General Acute and Inpatient Rehabilitation Hospital Services" is modified to remove the CHIP Perinate Newborn 0% to 185% category and to add outpatient services and orthodontic services to conform to CHIP Covered Services in Attachment B-2. CHIP Perinatal Covered Services "Inpatient General Acute and Inpatient Rehabilitation Hospital Services" is modified to remove the CHIP Perinate Newborn 0% to 185% category. CHIP Perinatal Covered Services "Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center" for Perinate Newborns is modified to add outpatient services and orthodontic services to conform to CHIP Covered Services in Attachment B-2. CHIP Perinatal Covered Services "Physician / Physician Extender Professional Services" for Perinate Newborns is modified to add outpatient services and orthodontic services to conform to CHIP Covered Services in Attachment B-2. CHIP Perinatal Covered Services "Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies" for Perinate Newborns is modified to add dental devices and external breast prostheses to conform to CHIP Covered Services in Attachment B-2. Chip Perinatal Program Exclusions From Covered Services For Chip Perinates is modified to clarify the first bullet. Chip Perinatal Program Exclusions From Covered Services For Chip Perinate Newborns is modified to remove the first bullet. "Dental Devices solely for

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			cosmetic purposes" is added to conform to CHIP Covered Services in Attachment B-2. "CHIP & CHIP Perinatal Program DME/Supplies" is modified to add "Dental Devices" to conform to CHIP Covered Services in Attachment B-2.
Revision	1.3	December 1, 2010	CHIP Hospice Care Services is modified to require concurrent CHIP and hospice care services to comply with the federal requirements from Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148). By law, CHIP health plans were required to provide concurrent hospice care services effective August 1, 2010.
Revision	1.4	March 1, 2011	Inpatient Mental Health Services is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applied CHIP by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). Outpatient Mental Health Services is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applied CHIP by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). Inpatient Substance Abuse Treatment Services is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applied CHIP by the CHIP Reauthorization Act of 2009 (P.L. 111-3). Outpatient Substance Abuse Treatment Services is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applied CHIP by the CHIP Reauthorization Act of 2009 (P.L. 111-3). CHIP Perinatal Program Exclusions from Covered Services for CHIP Perinates is modified to clarify that CHIP does not provide coverage for members traveling outside of the U.S. CHIP Perinatal Program Exclusions from Covered Services for CHIP Perinate Newborns is modified to clarify that CHIP does not provide coverage for members traveling outside of the U.S.
Revision	1.5	September 1, 2011	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.6	March 1, 2012	"Birthing Center Services" is added as a clarification item. "Prenatal care and prepregnancy family services and supplies" is modified as a clarification item. "Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center" is added as a clarification item. "Drug Benefits" is added as a clarification item. CHIP Exclusions from Covered Services for CHIP Perinates is modified to clarify that over the counter drugs, contraceptives, and medications prescribed for weight loss or gain are not a covered benefit. CHIP Exclusions from Covered Services for CHIP Perinate Newborns is modified to clarify that over the counter drugs, contraceptives, and medications prescribed for weight loss or gain are not a covered benefit.
Revision	1.7	June 1, 2012	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.8	September 1, 2012	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.9	March 1, 2013	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.10	June 1, 2013	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.11	September 1, 2013	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.12	January 1, 2014	Inpatient General Acute and Inpatient Rehabilitation Hospital Services (CHIP Perinatal Coverage) is modified to clarify the eligibility thresholds. Birthing Center Services (CHIP Perinatal Coverage) is modified to clarify the eligibility thresholds. Exclusions for CHIP Perinatal is modified to clarify the eligibility thresholds.
Revision	1.13	February 1, 2014	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.14	September 1, 2014	Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies is modified

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			to add a limited set of disposable medical supplies when they are obtained from an authorized pharmacy provider. CHIP Perinatal Program Exclusions From Covered Services For CHIP Perinates is modified to add a limited set of disposable medical supplies when they are obtained from an authorized pharmacy provider. CHIP & CHIP Perinatal Program DME/Supplies is modified to add a limited set of disposable medical supplies when they are obtained from an authorized pharmacy provider.
Revision	1.15	October 1, 2014	Contract amendment did not revise Attachment B-2.1, “CHIP Perinatal Covered Services”.
Revision	1.16	March 1, 2015	Contract amendment did not revise Attachment B-2.1, “CHIP Perinatal Covered Services”.
Revision	1.17	May 1, 2015	Contract amendment did not revise Attachment B-2.1, “CHIP Perinatal Covered Services”.
Revision	1.18	September 1, 2015	Contract amendment did not revise Attachment B-2.1, “CHIP Perinatal Covered Services”.
Revision	1.19	March 1, 2016	Contract amendment did not revise Attachment B-2.1, “CHIP Perinatal Covered Services”.
Revision	1.20	September 1, 2016	Contract amendment did not revise Attachment B-2.1, “CHIP Perinatal Covered Services”.
Revision	1.21	March 1, 2017	Contract amendment did not revise Attachment B-2.1, “CHIP Perinatal Covered Services”.
Revision	1.22	September 1, 2017	Contract amendment did not revise Attachment B-2.1, “CHIP Perinatal Covered Services”.
Revision	1.23	March 1, 2018	Exclusions From Covered Services for CHIP Perinatal is modified to comply with a court order related to Legacy lawsuit. Exclusions From covered Services for CHIP Perinate Newborns is modified to comply with a court order related to Legacy lawsuit.
Revision	1.24	September 1, 2018	Contract amendment did not revise Attachment B-2.1, “CHIP Perinatal Covered Services”.
Revision	1.25	January 1, 2019	Contract amendment did not revise Attachment B-2.1, “CHIP Perinatal Covered Services”.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.26	March 1, 2019	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.27	September 1, 2019	Substance abuse is changed to substance use disorder to align with the language in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.
Revision	1.28	March 1, 2020	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.29	September 1, 2020	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.30	March 1, 2021	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.30.1	March 1, 2021	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.31	September 1, 2021	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.32	March 1, 2022	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.33	September 1, 2022	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.34	March 1, 2023	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.35	September 1, 2023	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".
Revision	1.36	March 1, 2024	Contract amendment did not revise Attachment B-2.1, "CHIP Perinatal Covered Services".

[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.

CHIP Perinatal Program Covered Services

Covered CHIP Perinatal Program services must meet the definition of Medically Necessary Covered Services as defined in this **Contract**. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinatal Program Members. CHIP Perinate Newborns are eligible for 12-months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: ▪ Hospital-provided Physician or Provider services ▪ Semi-private room and board (or private if medically necessary as certified by attending) ▪ General nursing care ▪ Special duty nursing when medically necessary ▪ ICU and services ▪ Patient meals and special diets ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) ▪ Surgical dressings, trays, casts, splints ▪ Drugs, medications and biologicals ▪ Blood or blood products that are not provided free-of-charge to the patient and their administration ▪ X-rays, imaging and other radiological tests (facility technical component) ▪ Laboratory and pathology services (facility technical component) ▪ Machine diagnostic tests (EEGs, EKGs, etc.) ▪ Oxygen services and inhalation therapy ▪ Radiation and chemotherapy ▪ Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalentlevels of care	For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with income above the Medicaid eligibility threshold (Perinates who do not qualify for Medicaid once born), benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy. Services include: ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate

	▪ In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
	▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care
	▪ Surgical implants
	▪ Other artificial aids including surgical implants
	▪ Outpatient services provided at an outpatient hospital or ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:
	  ▪ all stages of reconstruction on the affected breast;
	  ▪ surgery and reconstruction on the other breast to produce symmetrical appearance; and
	  ▪ treatment of physical complications from the mastectomy and treatment of lymphedemas.
	▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit
	▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
	  ▪ cleft lip and/or palate; or
		viable pregnancy include, but are not limited to:
		▪ dilation and curettage (D&C) procedures;
		▪ appropriate provider-administered medications;
		▪ ultrasounds, and
		▪ histological examination of tissue samples.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	▪ severe traumatic skeletal and/or congenital craniofacial deviations; or ▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility	Not a covered benefit.

Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:
	▪ X-ray, imaging, and radiological tests (technical component)
	▪ Laboratory and pathology services (technical component)
	▪ Machine diagnostic tests
	▪ Ambulatory surgical facility services
	▪ Drugs, medications and biologicals
	▪ Casts, splints, dressings
	▪ Preventive health services
	▪ Physical, occupational and speech therapy
	▪ Renal dialysis
	▪ Respiratory services
	▪ Radiation and chemotherapy
	▪ Blood or blood products that are not provided free-of-charge to the patient and the administration of these products
	▪ Facility and related medical services, such as anesthesia, associated with dental care,
		Services include, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:
		▪ X-ray, imaging, and radiological tests (technical component)
		▪ Laboratory and pathology services (technical component)
		▪ Machine diagnostic tests
		▪ Drugs, medications and biologicals that are medically necessary prescription and injection drugs.
		▪ Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
		  ▪ dilation and curettage (D&C) procedures;
		  ▪ appropriate provider-administered medications;
		  ▪ ultrasounds, and
		  ▪ histological examination of tissue samples.
		
		(1) Laboratory and radiological services are limited to services that

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate

	when provided in a licensed ambulatory surgical facility.
	▪ Surgical implants
	▪ Other artificial aids including surgical implants
	▪ Outpatient services provided at an outpatient hospital or ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:
	  ▪ all stages of reconstruction on the affected breast;
	  ▪ surgery and reconstruction on the other breast to produce symmetrical appearance; and
	  ▪ treatment of physical complications from the mastectomy and treatment of lymphedemas.
	▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.
	▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
	  ▪ cleft lip and/or palate; or
	  ▪ severe traumatic skeletal and/or congenital craniofacial deviations; or
	  ▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
		directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth.
		(2) Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation, or miscarriage or non-viable pregnancy.
		(3) Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis.
		(4) Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.
		(5) Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
		expired in utero) are a covered benefit.
Physician/ **Physician** **Extender Professional Services**	Services include, but are not limited to, the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) ▪ Physician office visits, in-patient and out-patient services ▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation ▪ Medications, biologicals and materials administered in Physician's office ▪ Allergy testing, serum and injections ▪ Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations ▪ Hospital-based Physician services (including Physician-performed technical and interpretive components) ▪ Physician and professional services for mastectomy and breast reconstruction include:	Services include, but are not limited to the following: ▪ Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth ▪ Physician office visits, in-patient and out-patient services ▪ Laboratory, x-rays, imaging and pathology services including technical component and /or professional interpretation ▪ Medically necessary medications, biologicals and materials administered in Physician's office ▪ Professional component (in/outpatient) of surgical services, including: o Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. o Administration of anesthesia by Physician (other than surgeon) or CRNA o Invasive diagnostic procedures directly related to the labor-with delivery of the unborn child. o Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) ▪ Hospital-based Physician services (including Physician performed technical and interpretive components) ▪ Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	▪ all stages of reconstruction on the affected breast; ▪ surgery and reconstruction on the other breast to produce symmetrical appearance; and ▪ treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ▪ cleft lip and/or palate; or ▪ severe traumatic skeletal and/or congenital craniofacial deviations; or ▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	▪ Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT. ▪ Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: ▪ dilation and curettage (D&C) procedures; ▪ appropriate provider-administered medications; ▪ ultrasounds, and ▪ histological examination of tissue samples.
Birthing Center Services	Covers services rendered to a newborn immediately following delivery.	Covers birthing services provided by a licensed birthing center. Limited to facility services related to labor with delivery.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
		Applies only to CHIP Perinate Members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services. Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.	Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: (1) One visit every four weeks for the first 28 weeks or pregnancy; (2) one visit every two to three weeks from 28 to 36 weeks of pregnancy; and (3) one visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: ▪ interim history (problems, marital status, fetal status); ▪ physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and ▪ laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
		women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center	Covers services rendered to a newborn immediately following delivery.	Covers prenatal services and birthing services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: (1) One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; (2) one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and (3) one (1) visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. Visits after the initial visit must include: ▪ interim history (problems, marital status, fetal status); ▪ physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinanalysis for protein and glucose every visit;

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
		hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Drug Benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting. Services must be medically necessary for the unborn child.
Durable Medical Equipment (DME), Prosthetic Devices and **Disposable Medical Supplies**	$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: ▪ Orthotic braces and orthotics ▪ Dental devices ▪ Prosthetic devices such as artificial eyes, limbs, braces,	Not a covered benefit, with the exception of a limited set of disposable medical supplies, published at http://www.txvendordrug.com and only when they are obtained from a CHIP-enrolled pharmacy provider.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	and external breast prostheses ▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease ▪ Hearing aids ▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See **Attachment A**)	
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and occupational therapies. ▪ Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker ▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services ▪ Services are not intended to replace 24-hour inpatient or skilled nursing facility services	Not a covered benefit.
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	facilities, including, but not limited to: ▪ Neuropsychological and psychological testing. ▪ When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination ▪ Does not require PCP referral	
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination ▪ A Qualified Mental Health Provider – Community Services (QMHP-QS), is defined by and credentialed through the Texas Department of State Health Services (DSHS) Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services ▪ Does not require PCP referral	
Inpatient Substance Use Disorder Treatment Services	Services include, but are not limited to: ▪ Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs ▪ Does not require PCP referral	Not a covered benefit.
Outpatient Substance Use Disorder Treatment Services	▪ Services include, but are not limited to, the following: ▪ Prevention and intervention services that are provided by	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training ▪ Does not require PCP referral	
Rehabilitation Services	Services include, but are not limited to, the following: ▪ Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: ▪ Physical, occupational and speech therapy ▪ Developmental assessment	Not a covered benefit.
Hospice Care Services	Services include, but are not limited to: ▪ Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death ▪ Treatment services, including treatment related to the terminal illness	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	▪ Up to a maximum of 120 days with a 6 month life expectancy ▪ Patients electing hospice services may cancel this election at anytime ▪ Services apply to the hospice diagnosis	
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	HMO cannot require authorization as a condition for payment for emergency conditions labor and delivery. Covered services include, but are not limited to, the following: ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers ▪ Medical screening examination ▪ Stabilization services ▪ Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services ▪ Emergency ground, air and water transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.	HMO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. ▪ Stabilization services related to the labor with delivery of the covered unborn child. ▪ Emergency ground, air and water transportation for labor and threatened labor is a covered benefit ▪ Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Services include, but are not limited to, the following: ▪ Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: ▪ One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization ▪ One pair of non-prosthetic eyewear per 12-month period	Not a covered benefit.
Chiropractic Services	▪ Services do not require physician prescription and are limited to spinal subluxation.	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12-month period limit for a plan- approved program ▪ Health Plan defines plan-approved program. ▪ May be subject to formulary requirements.	Not a covered benefit.
Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination and community referral.	Covered benefit.
Value-added services	See **Attachment B-3.1**	

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES

- For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born) inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies, with the exception of a limited set of disposable medical supplies, published at http://www.txvendordrug.com, when they are obtained from an authorized pharmacy provider.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance use disorder treatment services and residential substance use disorder treatment services.
- Outpatient substance use disorder treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the labor with delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to the labor or threatened labor, miscarriage or non-viable pregnancy, and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or post partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community

- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor with delivery of the covered unborn child and services provided by an FQHC, as provided in 8.1.22.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ

- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATE NEWBORNS

All the following exclusions match those found in the CHIP Program.

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental Devices solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section and services provided by an FQHC, as provided in Section 8.1.22 of the contract.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of

nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)

- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

CHIP & CHIP PERINATAL PROGRAM DME/SUPPLIES

Note: DME/SUPPLIES are not a covered benefit for CHIP Perinate Members (Unborn Child), with the exception of a limited set of disposable medical supplies, published at http://www.txvendordrug.com, when they are obtained from an authorized pharmacy provider; but are a benefit for CHIP Perinate Newborns.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for treatment of craniofacial anomalies requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Urostomy supplies			See Ostomy Supplies.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	January 1, 2010	Initial version of Attachment B-5, “Deliverables/Liquidated Damages Matrix” that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2010	Contract amendment did not revise Attachment B-5, “Deliverables/Liquidated Damages Matrix”.
Revision	1.2	September 1, 2010	Item 3 is modified to conform to language in Attachment A, Sections 4.08(b)(3) and (4). Item 9 is added to add liquidated damages for timely HMO response to Provider complaints. Item 11 is modified to make the liquidated damages conform to those in the UMCC for timely HMO response to Member complaints.
Revision	1.3	December 1, 2010	Contract amendment did not revise Attachment B-5, “Deliverables/Liquidated Damages Matrix”.
Revision	1.4	March 1, 2011	Attachment B-5 Item 11 is modified to add liquidated damages for failing to submit timely HMO response to Provider complaints.
Revision	1.5	September 1, 2011	Attachment B-5 Item 9 is modified to clarify liquidated damages for timely HMO response to complaints.
Revision	1.6	March 1, 2012	Item 8 is added to require MCOs to submit or comply with the requirements of the HHSC-approved Fraud and Abuse Compliance Plan. All subsequent items are renumbered. Item 22 is added to require that MCOs must respond to Office of Inspector General request for information in the manner and format requested. Item 24 is added to require MCOs to submit a Fraudulent Practices Report within 30 days of receiving a report of possible Waste, Abuse, or Fraud and to submit quarterly SIU Reports.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.7	June 1, 2012	Contract amendment did not revise Attachment B-5, “Deliverables/Liquidated Damages Matrix”.
Revision	1.8	September 1, 2012	Contract amendment did not revise Attachment B-5, “Deliverables/Liquidated Damages Matrix”.
Revision	1.9	March 1, 2013	Item 18 is modified to clarify liquidated damage assessments and variance percentages.
Revision	1.10	June 1, 2013	Contract amendment did not revise Attachment B-5, “Deliverables/Liquidated Damages Matrix”.
Revision	1.11	September 1, 2013	Items 4, 6, 7, 16, 22, 23, 24, 25, 26, and 27 are modified to add “not submitted” to the LD. Item 9 is modified to include pharmacy requirements. Items 20 and 21 are modified to include pharmacy claims. Item 24 is modified to change the name of the report. Items 25-28 are added to include pharmacy requirements. All subsequent items are renumbered.
Revision	1.12	January 1, 2014	Contract amendment did not revise Attachment B-5, “Deliverables/Liquidated Damages Matrix”.
Revision	1.13	February 1, 2014	Item 9 “Geo-Mapping” is added. All subsequent items are renumbered.
Revision	1.14	September 1, 2014	Item 6 is modified to add “Security Plan.” Items 10, 12, and 16 “Hotlines” are modified to add busy signal standard for consistency with the Dental contract. Item 10.1 is added to conform to the other contracts. Item 13 is modified to conform to the other contracts.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Item 13.1 is added to conform to the other contracts. Item 24 is modified to conform to the other contracts.
Revision	1.15	October 1, 2014	Contract amendment did not revise Attachment B-5, “Deliverables/Liquidated Damages Matrix”.
Revision	1.16	March 1, 2015	After the first appearance of the term, “Uniform Managed Care Manual” is changed to “UMCM.’ Item 4.1 is added. Item 13.1 is modified to increase the amount commensurate with the amount assessed for Clean Claims processing. Item 16 is modified to add standard for Busy Signal Call Rate. Items 17.5, 17.6, and 17.9 are modified to remove the cross reference in the performance Standard. Item 19 is modified to remove “per Financial Arrangement Code” from the liquidated damages (a)(1) and (a)(2). Item 21 is modified to clarify the standard Item 27 is modified to clarify the standard.
Revision	1.17	May 1, 2015	Contract amendment did not revise Attachment B-5, “Deliverables/Liquidated Damages Matrix”.
Revision	1.18	September 1, 2015	Item 8 is modified to increase the LD from $250 to $1,000 per calendar day of noncompliance. Item 9.1 is added. Item 17.4 is modified to change 30 days to 10 days to match language in 8.1.17.2

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Item 19 is modified to separate certain Pharmacy requirements from non-pharmacy requirements and to change “TED” to “Vision 21”. Item 22 is modified to add pharmacy requirements. Item 23 is modified to increase the LD from $250 to $1,000 per calendar day of noncompliance. Item 23.1 is added. Item 23.2 is added. Item 23.3 is added. Item 25 is modified to increase the LD from $250 to $1,000 per calendar day of noncompliance. Item 26 is modified to change the LD from $5,000 to $10,000. Item 26.1 is added. Item 27 is modified to clarify the standard. Item 31 is modified to change from six months to twelve months.
Revision	1.19	March 1, 2016	Item 3.1 is added. Item 3.2 is added. Item 3.3 is added. Item 15 is modified. Item 15.1 is added. Item 26 is modified.
Revision	1.20	September 1, 2016	Item 23.4 is added.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.21	March 1, 2017	Item 9 is modified to correct the Service/Component reference and to add "per county" to the Measurement Assessment and Liquidated Damages.
Revision	1.22	September 1, 2017	Item 14 is modified to apply LDs to any appeal timeframe. Item 15.2 is added. Item 20.1 is added. Item 23.1 is added. Item 27 is modified to change the report from quarterly to monthly and to remove Service Areas from the measurement assessment.
Revision	1.23	March 1, 2018	Changes were made throughout the attachment for consistency purposes. Item 25 is modified to replace Report with Referral and change from quarterly to monthly submission. Item 27 is modified to remove instruct and add allow.
Revision	1.24	September 1, 2018	Item 13.1 is modified to comply with monthly reporting requirements. Item 22 is modified to comply with the claims processing requirements.
Revision	1.25	January 1, 2019	Contract amendment did not revise Attachment B-5, “Deliverables/Liquidated Damages Matrix”.
Revision	1.26	March 1, 2019	Contract amendment did not revise Attachment B-5, “Deliverables/Liquidated Damages Matrix”.
Revision	1.27	September 1, 2019	Contract amendment did not revise Attachment B-5, “Deliverables/Liquidated Damages Matrix”.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.28	March 1, 2020	Contract amendment did not revise Attachment B-6, “CHIP Rural Service Area County Listing”.
Revision	1.29	September 1, 2020	Attachment B-5, “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, 6, and 7 respectively. Items GA-1 to GA-4 were Items 1, 2, 4, and 4.1 respectively. Items GA-3 and GA-4 were modified to add monthly and annual to the reporting timeframes. 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. Items MS-1 to MS-4 were in Item 3. Items CL-1 to CL-9 were Items 24, 13.1, 22.1, 22, and 21. Items CL-4 and CL-7 were in Item 21, and Items CL-5, CL-6, CL-8 and CL-9 were in Item 22. The performance standards for CL-2, CL-3, CL-5, CL-6, CL-8, and CL-9 were clarified. Items CL-2 and CL-4 to CL-9 were modified to change the reporting timeframe to monthly. Items ED-1 to ED-6 were the Items 19 and 19.1. Items ED-1 and ED-4 were in Item 19.1. Items ED-2, ED-3, ED-5, and ED-6 were in Item 19. Item HL-1 was in Items 10 and 12. Item HL-2 is a new item. Item HL-3 to HL-5 were in Items 10, 12, and 16. HL-6 and HL-7 were in Item 16. Call pickup rate and busy signal performance standards were removed, the reporting time was modified to monthly, and measurement by Service Area was removed. The liquidated damages amount for Item HL-7 was modified to match with the amount in the new Item HL-2. Items CA-1 and CA-2 were in Item 13. Items CA-3 and CA-4 were Items 14 and 11 respectively. Items CA-1 to CA-3 were modified to change the reporting time to monthly and remove measurement by Service Area.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Items PN-1 and PN-2 were Items 9 and 15.2 respectively. Items PN-3 to PN-5 were in Item 9.1. PN-6 is a new item. Items MM-1 to MM-3 were Items 15, 15.1, and 10.1 respectively. Item MM-3 was modified to clarify performance standard. Items MI-1 and MI-2 were Items 18 and 20 respectively. Items FR-1 to FR-4 were Items 17, 17.1, 17.3, and 17.8 respectively. Items FR-5, FR-11, and FR-12 were in Item 17.9. Items FR-6 to FR-10 were Items 17.2, 17.4, 17.5, 17.6, and 17.7 respectively. Items FR-4 and FR-6 were modified to update deliverable due date information. Items IG-1 to IG-3 were Items 8, 23.4, and 23 respectively. Items IG-4 and IG-5 were in Item 25. Items IG-6 to IG-8 were Items 23.1, 23.3, and 23.2 respectively. Items TO-1 to TO-3 were Items 32, 31, and 30 respectively. Items PH-1, PH-2, and PH-5 were Items 26, 26.1, and 28 respectively. Items PH-3 and PH-4 were in Item 27. 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 29 was removed. 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.
Revision	1.30	March 1, 2021	Contract amendment did not revise Attachment B-6, “CHIP Rural Service Area County Listing”.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.30.1	June 1, 2021	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.31	September 1, 2021	CL-10 is added. PH- 8 is modified to comply with TIC and TAC requirements. PH-9 is modified to comply with TIC and TAC requirements.
Revision	1.32	March 1, 2022	CL-1 is modified to remove assessment by "per claim type." CL-10 is modified to add the contract reference to the performance standard and capitalize "Day" in the measurement assessment. PH-3 and PH-4 are combined, and PH-4 is marked as "Reserved." PH-8 is not applicable to CHIP; however, the PH-8 item cannot be removed to keep consistent numbering across the contract matrices for TexConnect. PH-9 is not applicable to CHIP; however, the PH-9 item cannot be removed to keep consistent numbering across the contract matrices for TexConnect. The standards that were in PH-9 for this contract were modified to become CHPH-1 and CHPH-2 to keep consistency with the UMCC. PH-10 is modified to remove the sentence for allowing Network pharmacies to challenge a MAC price for the performance standard.
Revision	1.33	September 1, 2022	PN-2 is modified added is language to support a more comprehensive approach to APMs. PH-7 is Deleted PH-11 is Deleted FR-5 is modified
Revision	1.34	March 1, 2023	CL-5 and CL-6 modified performance standard language for the claims LDs, per leadership request.
Revision	1.35	September 1, 2023	IG-7 modified Performance Standard language is modified to ensure OIG has access to complete, unredacted information.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			PH-6 is deleted PDL policies are not applicable to CHIP program
Revision	1.36	March 1, 2024	PN-2 is modified for consistency across all matrices to match the standards and measurement timeline in UMCM 8.10

[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

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Operations Readiness (OR)					
OR-1	Contract Attachment, B-1 §7.3 Transition Phase Schedule and Tasks Contract Attachment B-1, §7.3.1.1 Transition Phase Planning Contract Attachment B-1, §8.1 General Scope of Work	The MCO must be operational no later than the 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
OR-2	Contract Attachment B-1, §7.3.1.5 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: • Joint Interface Plan; • Disaster Recovery Plan; • Business Continuity Plan; • Risk Management Plan; • Systems Quality Assurance Plan; and • Security 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, §7.3.1.7 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, "General Contract Terms & Conditions" Contract Attachment B-1, §§ 6, 7, 8 and 9	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, or (2) materially affects HHSC's ability to administer the Program(s).	Ongoing	Per Day, per each incident of noncompliance.	HHSC may assess up to $5,000 per Day for each incident of noncompliance.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
GA-2	General Requirement: Failure to Provide a Covered Service Contract Attachment A, "General Contract Terms & Conditions" Contract Attachment B-1, §§ 6, 7, 8 and 9	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.	Ongoing	Each Day of noncompliance, per each incident of noncompliance.	HHSC may assess up to $7,500 per Day of noncompliance for each incident of noncompliance.
GA-3	Contract Attachment B-1, §§ 6, 7, 8 and 9 UMCM	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 HHSC's UMCM. (Specific reports or Deliverables listed separately in this matrix are subject to the specified liquidated damages.)	Transition Phase and Operations Phase	Per each Day of noncompliance.	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.
GA-4	Contract Attachment B-1, §§ 6, 7, 8 and 9 UMCM	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.	Transition Phase and Operations Phase	Per incident of noncompliance.	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.
Privacy/ Security (PS)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PS-1	Contract Attachment A, "General Contract Terms & Conditions" Section 7.07 HIPAA and Article 11 Disclosure & 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, "General Contract Terms & Conditions" Section 7.07 HIPAA and Article 11 Disclosure & 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, "General Contract Terms & Conditions" Section 7.07 HIPAA and Article 11 Disclosure & Confidentiality of Information	The MCO must meet all confidentiality 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 privacy/security incident.	HHSC may assess up to $5,000 per quarterly reporting period for each breach by MCO scenario as required by HHSC.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PS-4	Contract Attachment A, "General Contract Terms & Conditions" Section 7.07 HIPAA and Article 11 Disclosure & Confidentiality of Information	The MCO must meet the privacy breach notification and/or breach response standard required by applicable federal and state law and HHSC contract requirements.	Transition Phase and Quarterly during Operations Phase	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.	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.
Material Subcontractors (MS)					
MS-1	Contract Attachment A, “General Contract Terms & Conditions” Section 4.08 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, Measured Quarterly during the Operations Phase	Each Day of noncompliance.	HHSC may assess up to $5,000 per Day of noncompliance.
MS-2	Contract Attachment A, “General Contract Terms & Conditions” Section 4.08 Subcontractors and Agreements with Third Parties	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.	Transition Phase, Measured Quarterly during the Operations Phase	Each Day of noncompliance.	HHSC may assess up to $5,000 per Day of noncompliance.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
MS-3	Contract Attachment A, "General Contract Terms & Conditions" Section 4.08 Subcontractors and Agreements with Third Parties	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.	Transition Phase, Measured Quarterly during the Operations Phase	Each Day of noncompliance.	HHSC may assess up to $5,000 per Day of noncompliance.
MS-4	Contract Attachment A, "General Contract Terms & Conditions" Section 4.08 Subcontractors and Agreements with Third Parties	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.	Transition Phase, Measured Quarterly during the Operations Phase	Each Day of noncompliance.	HHSC may assess up to $5,000 per Day of noncompliance.
Claims (CL)					
CL-1	Contract Attachment B-1, §8.1.20.2 Reports UMCM Chapter 5	Claims Summary Report: The MCO must submit monthly Claims Summary Reports to HHSC by the last Day of each month following the reporting period.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-2	Contract Attachment B-1, §8.1.4.12 Provider Appeal of MCO Claims Determinations UMCM Chapter 2	The MCO must resolve at least 98% of appealed claims within 30 Days from the date the appealed claim is filed with the MCO.	Operations Phase and Turnover Phase	Per month, per claim type.	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.
CL-3	Contract Attachment B-1, §8.1.18.5.1 Claims Project UMCM Chapters 2 and 5	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.	Operations Phase	Per incident of noncompliance.	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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-4	Contract Attachment B-1, §8.1.18.5 Claims Processing Requirements UMCM Chapter 2	For a Clean Claim not adjudicated within 30 Days of receipt by the MCO, 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 30-Day claims processing deadline. Interest owed to the provider must be paid on the same date as the claim.	Operations Phase	Per month, per claim.	HHSC may assess up to $1,000 per month and per claim if the MCO fails to pay interest timely.
CL-5	Contract Attachment B-1, §8.1.18.5 Claims Processing Requirements UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Section 8.1.18.5 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.	Operations Phase	Per month, per claim type.	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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-6	Contract Attachment B-1, §8.1.18.5 Claims Processing Requirements UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Section 8.1.18.5 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 99% Clean Claims within 90 Days of the claim being submitted to the MCO.	Operations Phase	Per month, per claim type.	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.
CL-7	Contract Attachment B-1, §8.1.18.5 Claims Processing Requirements Contract Attachment B-1, §8.1.24.14 Pharmacy Claims and File Processing UMCM Chapter 2	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.	Operations Phase	Per month, per claim.	HHSC may assess up to $1,000 per month and per claim if the MCO fails to pay interest timely.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-8	Contract Attachment B-1, §8.1.18.5 Claims Processing Requirements Contract Attachment B-1, §8.1.24.14 Pharmacy Claims and File Processing UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Sections 8.1.18.5 and 8.1.24.14 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.	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-9	Contract Attachment B-1, §8.1.18.5 Claims Processing Requirements Contract Attachment B-1, §8.1.24.14 Pharmacy Claims and File Processing UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Sections 8.1.18.5 and 8.1.24.14 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-10	Contract Attachment B- 1, §8.1.18.5 Claims Processing Requirements Contract Attachment B-1, §8.1.24.14 Pharmacy Claims and File Processing UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Sections 8.1.18.5 and 8.1.24.14 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
Encounter Data (ED)					
ED-1	Contract Attachment B-1, § 8.1.18.1 Encounter Data	The MCO must submit complete and accurate non-pharmacy Encounter Data transmissions in accordance with Section 8.1.18.1.	Measured Quarterly during Operations Phase	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 MCO fails to submit complete and accurate non-pharmacy Encounter Data in a quarter. 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
ED-2	Contract Attachment B-1, §8.1.18.1 Encounter Data	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.	Operations Phase	Per quarter, per incident of noncompliance.	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. 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.
ED-3	Contract Attachment B-1, §8.1.18.1 Encounter Data	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.	Measured Quarterly during Operations Phase	Per month, per incident of noncompliance.	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. For each subsequent quarter: HHSC may assess up to $5,000 per month and per incident of noncompliance for each month in any subsequent quarter that the MCO fails to submit monthly non-pharmacy Encounter Data.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
ED-4	Contract Attachment B-1, § 8.1.18.1 Encounter Data	The MCO must submit complete and accurate pharmacy Encounter Data transmissions in accordance with Section 8.1.18.1.	Measured Quarterly during Operations Phase	Per Day, per incident of noncompliance.	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.
ED-5	Contract Attachment B-1, §8.1.18.1 Encounter Data	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.	Operations Phase	Per quarter, per incident of noncompliance.	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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
ED-6	Contract Attachment B-1, §8.1.18.1 Encounter Data	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.	Operations Phase	Per quarter, per incident of noncompliance.	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 the MCO fails to submit pharmacy Encounter Data in a timely manner.
Hotlines (HL)					
HL-1	Contract Attachment B-1, §8.1.5.6 Member Hotline Contract Attachment B-1, §8.1.4.7 Provider Hotline	The MCO must operate toll-free Member and Provider hotlines from 8 AM – 5 PM local time for the Service Area, 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 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
HL-2	Contract Attachment B-1, §8.1.5.6 Member Hotline Contract Attachment B-1, §8.1.15.3 Behavioral Health Services Hotline	Call hold rate: At least 80% of calls must be answered by hotline staff within 30 seconds.	Operations Phase and Turnover Phase	Per each percentage point below the standard, per hotline, per monthly reporting period.	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.
HL-3	Contract Attachment B-1, §8.1.5.6 Member Hotline Contract Attachment B-1, §8.1.4.7 Provider Hotline Contract Attachment B-1, §8.1.15.3 Behavioral Health Services Hotline	Call abandonment rate: Call abandonment rate must be 7% or less.	Operations Phase and Turnover Phase	Per each percentage point above the standard, per hotline, per monthly reporting period.	HHSC may 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.
HL-4	Contract Attachment B-1, §8.1.5.6 Member Hotline Contract Attachment B-1, §8.1.4.7 Provider Hotline Contract Attachment B-1, §8.1.15.3 Behavioral Health Services Hotline	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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
HL-5	Contract Attachment B-1, §8.1.15.3 Behavioral Health Services Hotline	The MCO must have an emergency and crisis Behavioral Health Services Hotline available 24 hours a Day, seven Days a week, toll-free throughout Service Area.	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.
HL-6	Contract Attachment B-1, §8.1.15.3 Behavioral Health Services Hotline	Crisis hotline staff must include or have access to qualified Behavioral Health Services' professionals to assess behavioral health emergencies.	Operations Phase and Turnover Phase	Per each incident of noncompliance.	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.
Complaints/ Appeals (CA)					
CA-1	Contract Attachment B-1, §8.1.5.9 MCO Internal Member Complaint and Appeal Process	The MCO must resolve at least 98% of Member Complaints within 30 Days from the date the Complaint is received by the MCO.	Operations Phase	Per monthly reporting period.	HHSC may assess up to $250 per monthly reporting period if the MCO fails to meet the performance standard.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CA-2	Contract Attachment B-1, §8.1.4.11 MCO Internal Provider Complaints and Appeals Process	The MCO must resolve at least 98% of Provider Complaints within 30 Days from the date the Complaint is received by the MCO.	Operations Phase	Per monthly reporting period.	HHSC may assess up to $250 per monthly reporting period if the MCO fails to meet the performance standard.
CA-3	Contract Attachment B-1, §8.1.5.9 MCO Internal Member Complaint and Appeal Process	The MCO must resolve at least 98% of Member Appeals within the specified timeframes for standard and expedited appeals.	Operations Phase	Per monthly reporting period.	HHSC may assess up to $500 per monthly reporting period if the MCO fails to meet the performance standard.
CA-4	Contract Attachment B-1, §8.1.5.9 MCO Internal Member Complaint and Appeal Process Contract Attachment B-1, §8.1.4.11 MCO Internal Provider Complaints and Appeals Process UMCM Chapter 3	MCOs must resolve Provider and Member Complaints received by HHSC and referred to the MCOs 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, email, etc.).	Measured Quarterly	Per Day, per each incident of non-compliance.	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.
Provider Networks (PN)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PN-1	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	The MCO must comply with the contract's mileage and/or time standards and benchmarks for Member access.	Quarterly	Per quarter, per incident of noncompliance, per plan code, per county, and per Provider type.	HHSC may assess up to $1,000 per quarter, per incident of noncompliance, per plan code, per county, and per Provider type.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PN-2	Contract Attachment B-1, §8.1.7.8.2 MCO Alternative Payment Models with Providers 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 Risk-Based APM Ratio +25% • Measurement Year 3: ○ Minimum Overall APM Ratio: Year 2 Risk-Based APM Ratio +25% ○ Minimum Risk-Based APM Ratio: Year 2 Overall APM Ratio +25% • Measurement Years 4, 5, and 6: ○ Minimum Overall APM Ratio: >=50% ○ Minimum Risk-Based APM Ratio: >=25%	Measured on September 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PN-3	Contract Attachment B-1, §8.1.4 Provider Network UMCM Chapter 5	No more than 20% of total dollars billed to an MCO for "other outpatient services" may be billed by Out-of-Network providers.	Quarterly	Per quarter.	HHSC may assess up to $25,000 per quarter.
PN-4	Contract Attachment B-1, §8.1.4 Provider Network UMCM Chapter 5	No more than 15% of an MCO's total hospital admissions may occur in Out-of-Network facilities.	Quarterly	Per quarter.	HHSC may assess up to $25,000 per quarter.
PN-5	Contract Attachment B-1, §8.1.4 Provider Network UMCM Chapter 5	No more than 20% of an MCO's total emergency room visits may occur in Out-of-Network facilities.	Quarterly	Per quarter.	HHSC may assess up to $25,000 per quarter.
PN-6	Contract Attachment B-1, §8.1.4 Provider Network UMCM Chapter 5	No more than 20% of total dollars billed to an MCO for residential substance use disorder (SUD) treatment may be billed by Out-of-Network residential SUD treatment providers.	Quarterly	Per quarter.	HHSC may assess up to $25,000 per quarter.
Marketing and Member Materials (MM)					
MM-1	Contract Attachment B-1, §8.1.6 Marketing & 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
MM-2	Contract Attachment B-1, §8.1.6 Marketing & 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.
MM-3	Contract Attachment B-1, §8.1.5.1 Member Materials	No later than the 5th 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 Account Name or Case Head for each new Member. When the Account Name or Case Head represents two or more new Members, the MCO is only required to send one Member Handbook.	Transition Phase, Operations Phase, and Turnover Phase	Per each incident of noncompliance.	HHSC may assess up to $500 per each incident of the MCO's failure to mail Member Materials to the Account Name or Case Head for each new Member.
Management Information Systems (MI)					
MI-1	Contract Attachment B-1, §8.1.18 Management Information System (MIS) Requirements	The MCO's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.	Measured 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, §8.1.18.3 System-wide Functions	The MCO's MIS system must meet all requirements in Section 8.1.18.3 of Attachment B-1.	Measured Quarterly during the Operations Phase	Per Day of noncompliance.	HHSC may assess up to $5,000 per Day of noncompliance.
Financial Reporting (FR)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-1	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements UMCM Chapter 5	Financial Statistical Reports (FSR**)**: For each CHIP Rural Service Area Program, 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 report is due no later than 120 Days after the end of each Contract Year and the second annual report is due no later than 365 Days after the end of each Contract Year.	Quarterly during the Operations Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance a quarterly or annual report is not submitted or is late, inaccurate, or incomplete.
FR-2	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements UMCM Chapter 5	Claims Lag Report must be submitted by the last Day of the month following the reporting period.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-3	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements	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.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-4	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements UMCM Chapter 5	Report of Legal and Other Proceedings and Related Events: The MCO must comply with UMCM requirements regarding the disclosure of certain matters involving the MCO, its Affiliates, and/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	Transition Phase and Operations Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-5	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements	Third Party Liability and Recovery (TPL/TPR) Reports: The MCO must submit reports TPL/TPR reports quarterly, by MCO Program and plan code, as described in UMCM Chapter 5.	Operations Phase	Per Day of noncompliance, per TPL/TPR report.	HHSC may assess up to $500 per Day of noncompliance per TPL/TPR report that is not submitted or is late, inaccurate, or incomplete.
FR-6	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements	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.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-7	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements	TDI Examination Report: The MCO must furnish HHSC with a full and complete copy of any TDI Examination Report issued by TDI no later than ten Days after receipt of the final version from TDI.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-8	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements	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.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-9	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements	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.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-10	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements UMCM Chapter 5	Audit Reports: The MCO must comply with UMCM requirements regarding notification and/or submission of audit reports.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-11	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements	Employee Bonus and/or Incentive Payment Plan must be submitted no later than 30 Days after the Effective Date of the Contract.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-12	Contract Attachment B-1, §8.1.17.2 Financial Reporting Requirements	Registration Statement (aka "Form B") must be submitted by ten Days after the MCO's submission of the item to TDI.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
HHSC Office of the Inspector General (IG)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
IG-1	Contract Attachment B-1, §7.3.1.7 Operations Readiness Contract Attachment B-1, §8.1.19 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, §8.1.19 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, §8.1.19.2 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	Each 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 fourth and each subsequent occurrence within a 12-month period.
IG-4	Contract Attachment B-1, §8.1.20.2 Reports UMCM Chapter 5	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).	Transition Phase, Operations Phase, and Turnover Phase	Per Day of noncompliance.	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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
IG-5	Contract Attachment B-1, §8.1.19.4 Payment Holds and Settlements UMCM Chapter 5	The MCO must submit monthly MCO Open Case List Reports.	Transition Phase, Operations Phase, and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance that the report 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.
IG-6	Contract Attachment B-1, §8.1.19.4 Payment Holds and Settlements	The MCO must respond to HHSC OIG requests for payment hold amounts accurately and, in the manner, and format requested.	Transition Phase, Operations Phase, and Turnover Phase	Per incident of noncompliance.	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.
IG-7	Contract Attachment B-1, §8.1.19.2 General requests for and access to data, records, and other information	The MCO fails to submit complete, unredacted and accurate claims data as prescribed by the HHSC OIG.	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 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.
IG-8	Contract Attachment B-1, §8.1.19.4 Payment Holds and Settlements	The MCO must impose payment suspensions or lift payment holds as directed by the HHSC OIG.	Transition Phase, Operations Phase, and Turnover Phase	Per incident of noncompliance, per MCO.	HHSC may assess up to the amount not held or released improperly per incident of noncompliance and per MCO.
Turnover (TO)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
TO-1	Contract Attachment B-1, §9.5 Post-Turnover Services	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.	Measured 30 Days after the turnover of operations	Per Day of noncompliance.	HHSC may assess up to $250 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
TO-2	Contract Attachment B-1, §9.4 Turnover Services	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.	Measured at twelve months prior to the end of the Contract Period, or any extension thereof, and ongoing until satisfactorily completed	Each Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the Turnover Plan is not submitted or is late, inaccurate, or incomplete.
TO-3	Contract Attachment B-1, §9.3 Transfer of Data and Information	The MCO must transfer all data regarding the provision of Covered Services to Members to HHSC or a new MCO at the sole discretion of HHSC and as directed by HHSC. All transferred data must comply with the Contract requirements, including HIPAA.	Measured at time of transfer of data and ongoing after the transfer of data until satisfactorily completed	Per Day, per incident of noncompliance (failure to provide data and/or failure to provide data in required format).	HHSC may assess up to $10,000 per Day, per incident of noncompliance the data is not submitted, is not provided in the required format, or is late, inaccurate, or incomplete.
Pharmacy (PH)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PH-1	Contract Attachment B-1, §8.1.24.1 Formulary and Preferred Drug List (PDL) Contract Attachment B-1, §8.1.24.2 Prior Authorization 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, §8.1.24.1 Formulary and Preferred Drug List Contract Attachment B-1, §8.1.24.10 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 up to $10,000 per incident of noncompliance.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PH-3	Contract Attachment B-1, §8.1.24.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies	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.	Ongoing	Per incident of noncompliance.	HHSC may assess up to $5,000 per incident of noncompliance.
PH-4	RESERVED				
PH-5	Contract Attachment B-1, §8.1.24.5 Pharmacy Rebate Program UMCM Chapter 2	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.	Ongoing	Per month, per incident of noncompliance.	HHSC may assess up to $500 per month for each incident of noncompliance.
PH-6	RESERVED				
PH-7	RESERVED				

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PH-8	Intentionally left blank and not subject to future revisions.				
PH-9	Intentionally left blank and not subject to future revisions.				
PH-10	Contract Attachment B-1, §8.1.24.11 Maximum Allowable Cost Requirements	The MCO must ensure at least 98% of MAC challenge requests are resolved by the 15th Day after the MCO receives the request.	Ongoing, Quarterly during Operations Phase	Per incident of noncompliance below percentage rate.	HHSC may assess up to $1000 per incident of noncompliance below the percentage rate each quarter.
PH-11	RESERVED				
CHPH-1	Contract Attachment B-1, §8.1.24.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies	The MCO must ensure at least 98% of all PA request denial notices are provided within three Business Days after the MCO receives the request.	Ongoing, Quarterly during Operations Phase	Per each percentage point below the standard.	HHSC may assess up to $100 per each percentage point below the standard each quarter.
CHPH-2	Contract Attachment B-1, §8.1.24.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies	The MCO must ensure at least 98% of all PA request approval notices are transmitted not later than the second Business Day after the MCO receives the request.	Ongoing, Quarterly during Operations Phase	Per each percentage point below the standard.	HHSC may assess up to $100 per each percentage point below the standard each quarter.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	Version 1.0	January 1, 2010	Initial version of Attachment B-6, "CHIP Rural Service Area County Listing," that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2010	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.2	September 1, 2010	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.3	December 1, 2010	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.4	March 1, 2011	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.5	September 1, 2011	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.6	March 1, 2012	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.7	June 1, 2012	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.8	September 1, 2012	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.9	March 1, 2013	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.10	June1, 2013	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.11	September 1, 2013	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.12	January 1, 2014	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.13	February 1, 2014	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.14	September 1, 2014	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.15	October 1, 2014	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.16	March 1, 2015	Contract amendment did not revise Attachment

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			B-6, "CHIP Rural Service Area County Listing".
Revision	1.17	May 1, 2015	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.18	September 1, 2015	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.19	March 1, 2016	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.20	September 1, 2016	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.21	March 1, 2017	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.22	September 1, 2017	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.23	March 1, 2018	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.24	September 1, 2018	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.25	January 1, 2019	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.26	March 1, 2019	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.27	September 1, 2019	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.28	March 1, 2020	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.29	September 1, 2020	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.30	March1, 2021	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.30.1	June 1, 2021	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.31	September 1, 2021	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.32	March 1, 2022	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.33	September 1, 2022	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.34	March 1, 2023	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.35	September 1, 2023	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".
Revision	1.36	March 1, 2024	Contract amendment did not revise Attachment B-6, "CHIP Rural Service Area County Listing".

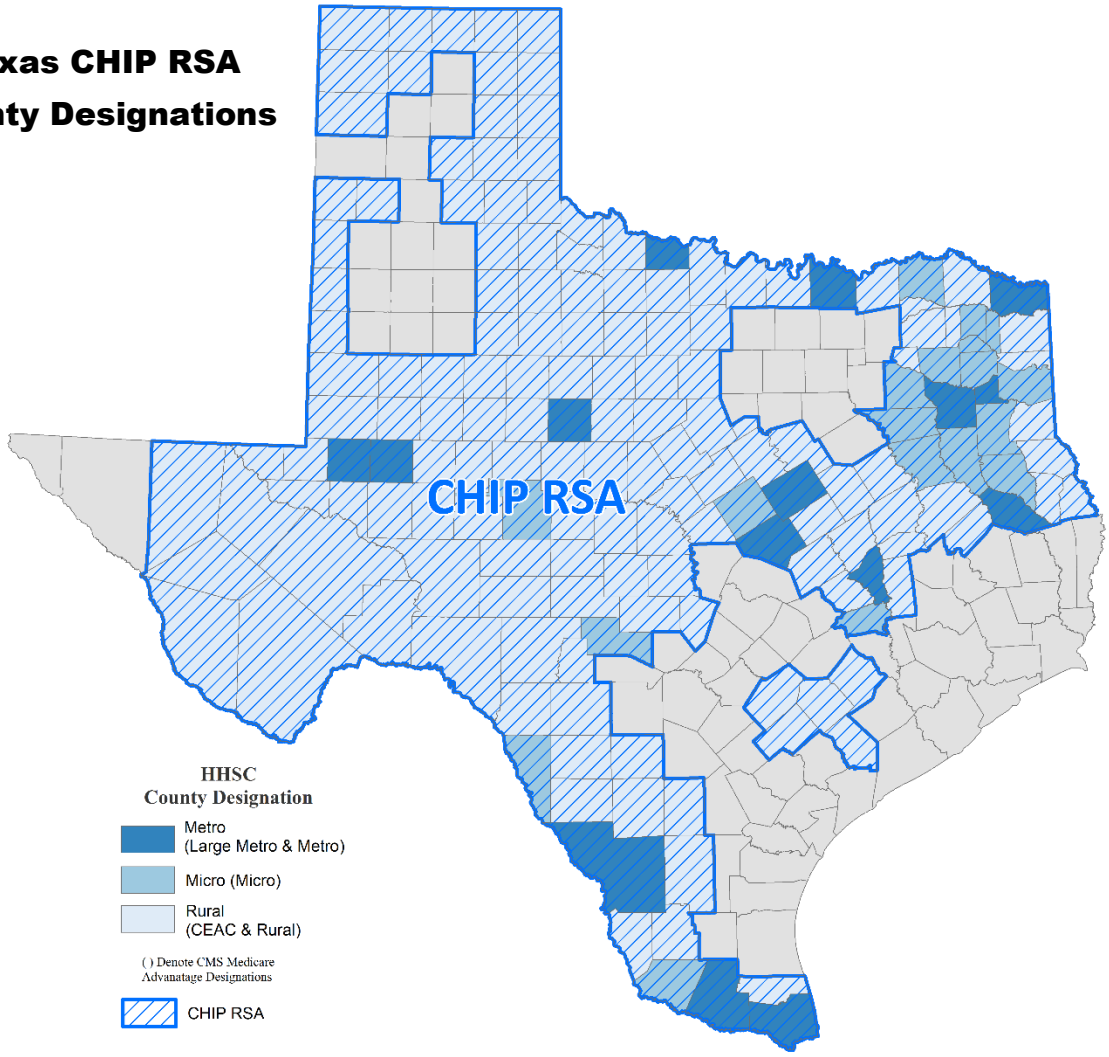
[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

CHIP Rural Service Area County Listing (174 Counties)

Anderson	Donley	King	Robertson
Andrews	Duval	Kinney	Runnels
Angelina	Eastland	Knox	Rusk
Archer	Ector	La Salle	Sabine
Armstrong	Edwards	Lamar	San Augustine
Bailey	Erath	Lampasas	San Saba
Baylor	Falls	Lavaca	Schleicher
Bell	Fannin	Leon	Scurry
Blanco	Fisher	Limestone	Shackelford
Borden	Foard	Lipscomb	Shelby
Bosque	Franklin	Llano	Sherman
Bowie	Freestone	Loving	Smith
Brazos	Frio	Madison	Somervell
Brewster	Gaines	Marion	Starr
Briscoe	Gillespie	Martin	Stephens
Brown	Glasscock	Mason	Sterling
Burleson	Gonzales	Maverick	Stonewall
Callahan	Gray	McCulloch	Sutton
Cameron	Grayson	McLennan	Taylor
Camp	Gregg	McMullen	Terrell
Cass	Grimes	Menard	Throckmorton
Castro	Hall	Midland	Titus
Cherokee	Hamilton	Milam	Tom Green
Childress	Hansford	Mills	Trinity
Clay	Hardeman	Mitchell	Upshur
Cochran	Harrison	Montague	Upton
Coke	Hartley	Moore	Uvalde
Coleman	Haskell	Morris	Val Verde
Collingsworth	Hemphill	Motley	Van Zandt
Colorado	Henderson	Nacogdoches	Ward
Comanche	Hidalgo	Nolan	Washington
Concho	Hill	Ochiltree	Webb
Cooke	Hopkins	Oldham	Wheeler
Coryell	Houston	Palo Pinto	Wichita
Cottle	Howard	Panola	Wilbarger
Crane	Irion	Parmer	Willacy
Crockett	Jack	Pecos	Winkler
Culberson	Jackson	Presidio	Wood
Dallam	Jeff Davis	Rains	Yoakum
Dawson	Jim Hogg	Reagan	Young
Delta	Jones	Real	Zapata
DeWitt	Kent	Red River	Zavala
Dickens	Kerr	Reeves	
Dimmit	Kimble	Roberts	

Attachment B-7

Texas CHIP RSA County Designations



HHSC County Type	MA County Type	Population	Density
Metro	***Large Metro***	≥ 1,000,000	≥ 1,000/mi²
---	---	500,000 – 999,999	≥ 1,500/mi²
---	---	Any	≥ 5,000/mi²
---	***Metro***	≥ 1,000,000	10 – 999.9/mi²
---	---	500,000 – 999,999	10 – 1,499.9/mi²
---	---	200,000 – 499,999	10 – 4,999.9/mi²
---	---	50,000 – 199,999	100 – 4,999.9/mi²
---	---	10,000 – 49,999	1,000 – 4,999.9/mi²
Micro	***Micro***	50,000 – 199,999	10 – 99.9 /mi²
---	---	10,000 – 49,999	50 – 999.9/mi²
Rural	***Rural***	10,000 – 49,999	10 – 49.9/mi²
---	---	<10,000	10 – 4,999.9/mi²
---	***CEAC***	Any	<10mi²

A county must meet both the population and density thresholds for inclusion in a given designation.

Data Source: CMS Medicare Advantage

Designation	Counties
Metro	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
Micro	Anderson, Aransas, Bastrop, Caldwell, Camp, Chambers, Cherokee, Coryell, Hardin, Harrison, Henderson, Kendall, Kerr, Lamar, Liberty, Maverick, Morris, Nacogdoches, Rusk, San Patricio, Starr, Titus, Tom Green, Upshur, Van Zandt, Walker, Waller, Washington, Wilson, Wise, Wood
Rural	Andrews, Archer, Armstrong, Atascosa, Austin, Bailey, Bandera, Baylor, Bee, Blanco, Borden, Bosque, Brewster, Briscoe, Brooks, Brown, Burleson, Burnet, Calhoun, Callahan, Carson, Cass, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Colorado, Comanche, Concho, Cooke, Cottle, Crane, Crockett, Crosby, Culberson, Dallam, Dawson, Deaf Smith, Delta, DeWitt, Dickens, Dimmit, Donley, Duval, Eastland, Edwards, Erath, Falls, Fannin, Fayette, Fisher, Floyd, Foard, Franklin, Freestone, Frio, Gaines, Garza, Gillespie, Glasscock, Goliad, Gonzales, Gray, Grimes, Hale, Hall, Hamilton, Hansford, Hardeman, Hartley, Haskell, Hemphill, Hill, Hockley, Hopkins, Houston, Howard, Hudspeth, Hutchinson, Irion, Jack, Jackson, Jasper, Jeff Davis, Jim Hogg, Jim Wells, Jones, Karnes, Kenedy, Kent, Kimble, King, Kinney, Kleberg, Knox, La Salle, Lamb, Lampasas, Lavaca, Lee, Leon, Limestone, Lipscomb, Live Oak, Llano, Loving, Lynn, Madison, Marion, Martin, Mason, Matagorda, McCulloch, McMullen, Medina, Menard, Milam, Mills, Mitchell, Montague, Moore, Motley, Navarro, Newton, Nolan, Ochiltree, Oldham, Palo Pinto, Panola, Parmer, Pecos, Polk, Presidio, Rains, Reagan, Real, Red River, Reeves, Refugio, Roberts, Robertson, Runnels, Sabine, San Augustine, San Jacinto, San Saba, Schleicher, Scurry, Shackelford, Shelby, Sherman, Somervell, Stephens, Sterling, Stonewall, Sutton, Swisher, Terrell, Terry, Throckmorton, Trinity, Tyler, Upton, Uvalde, Val Verde, Ward, Wharton, Wheeler, Wilbarger, Willacy, Winkler, Yoakum, Young, Zapata, Zavala

Notes

The County Designations in Attachment B-7 are for purposes of assessing access to network providers. 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.