TEXAS
Health and Human Services

Texas Health and Human Services Commission

Charles Smith
Executive Commissioner

Date: July 26, 2017

To: All Medicaid and CHIP Managed Care Organizations

From: Jami Snyder, Associate Commissioner, Texas Health and Human Services Commission

Subject: Guidance on Preferred Provider Arrangements and Network Access Requirements

In fiscal year (FY) 2018, the Medicaid and CHIP managed care contracts, including the Uniform Managed Care Contract (UMCC), will require that managed care organizations (MCOs) continue to transition provider payment methodologies from volume based payment approaches to quality-based alternative payment models (APMs). APMs are designed to improve health outcomes for members, improve members' experience of care and lower healthcare cost trends (see UMCC Section 8.1.7.8). One arrangement MCOs may consider to further these goals is a preferred provider arrangement. While this is an allowable arrangement, MCOs must continue to offer members choice of provider to the extent possible and appropriate (42 CFR 438.3(l)).

If an MCO enters into a preferred provider arrangement, the MCO must notify members of the arrangement in writing at least 30 days in advance of execution of the arrangement, consistent with Chapter 4 of the Uniform Managed Care Manual. The MCO must also develop and implement a process whereby members have the opportunity to opt out of the preferred provider and use another network provider. The MCO must provide clear written instructions on how a member may opt out of using the preferred provider. 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 already in effect prior to the issuance of Health and Human Services Commission (HHSC) guidance, MCOs must provide notification to impacted members and provide clear written

instructions on how the member may opt out of using the preferred provider. Furthermore, the MCO may not change a member's provider without notifying the member of the change and providing clear written instructions on how the member may opt out of using the provider.

HHSC will continue to explore the feasibility of all types of narrow network arrangements within the Texas Medicaid system as enhancements are made to value-based contracting requirements.

Please note, only those preferred provider arrangements for which some portion of the overall healthcare payment is based on quality-based performance will be considered eligible for fulfillment of the value-based contracting requirements, as stipulated in the September 1, 2017 UMCC amendment.

Sincerely,

Jami Snyder
Associate Commissioner
Texas Health and Human Services Commission