



**Health and Human Services Commission**

**STAR Health Contract Terms**

## DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	2.0	July 1, 2015	Initial version of Attachment A, "STAR Health Managed Care Contract Terms and Conditions" that includes all modifications negotiated by the Parties.
Revision	2.1	September 1, 2015	<p>Definition for Abuse, Neglect, or Exploitation is added.</p> <p>Definition for Consolidated FSR Report or Consolidated Basis is modified to exclude the Dual Demonstration Project.</p> <p>Definition for Court Order is modified to clarify the MCOs requirements.</p> <p>Definition for Covered Services is modified to clarify that court ordered services are not necessarily Covered Services.</p> <p>Definition for Dual Demonstration is added.</p> <p>Definition for Targeted Case Management is changed to Mental Health Targeted Case Management and clarified.</p> <p>Definition for Severe and Persistent Mental Illness (SPMI) is better defined.</p> <p>Definition for Severe Emotional Disturbance (SED) is better defined.</p> <p>Section 3.03 is modified to clarify the language.</p> <p>Section 3.07 is modified to require prior approval from HHSC.</p> <p>Section 3.08 is modified to clarify the language.</p> <p>Section 4.03 is modified to clarify the language.</p> <p>Section 4.12 "E-Verify System" is added.</p> <p>Section 5.03 is amended to clarify existing requirements and clean-up language relating to span of coverage. In addition, Section 5.03 is modified to add Enrollment Changes with Custom DME Prior Authorizations.</p> <p>Section 7.02 is modified to clarify the language.</p> <p>Section 10.08 is modified to carve-out the new Duals Demonstration Program from the "Consolidated Basis," with respect to FSR reporting, the Experience</p>

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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Rebate, and the Admin Cap.</p> <p>Section 10.08.1 is modified to conform to the other contracts and to carve-out the new Duals Demonstration Program from the "Consolidated Basis," with respect to FSR reporting, the Experience Rebate, and the Admin Cap.</p> <p>Section 11.01 is modified to clarify part (h).</p>
Revision	2.2	March 1, 2016	<p>All references to Frew v. Janek are changed to Frew v. Traylor.</p> <p>Definition for Abuse, Neglect, or Exploitation is modified to update the citations.</p> <p>Definition for Clinical Prior Authorization or Clinical PA is added.</p> <p>Definition for DFPS Texas Comprehensive CANS assessment is added.</p> <p>Definition for Self-employed Direct Provider is added.</p> <p>Definition for Texas Medicaid Provider Procedures Manual is modified to remove the publication frequency.</p> <p>Section 3.07 is modified to update the UMCM references.</p> <p>Section 4.12 "E-Verify System" is renamed "Employment Verification" and the requirements updated.</p> <p>Section 10.16 "Non-Risk Payments for Second Generation Direct Acting Antivirals for Hepatitis C" is renamed "Non-Risk Payments for Certain Drugs" and the language is clarified.</p>
Revision	2.3	September 1, 2016	<p>All references to Frew v. Traylor are changed to Frew v. Smith.</p> <p>Definition for Adaptive Aid is added.</p> <p>Definition for Breach is added.</p> <p>Definition for Change in Condition is added.</p> <p>Definition for Community Based Services is added.</p> <p>Definition for Daily Notification File (DNF) is modified to clarify the categories.</p>

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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Definition for Discovery/Discovered is added.</p> <p>Definition for DFPS Texas Comprehensive CANS assessment or CANS assessment is modified to update the name and to clarify the definition.</p> <p>Definition for Dual Eligibles is added.</p> <p>Definition for Effective Date of Coverage is modified to clarify the categories.</p> <p>Definition for Employment Assistance is added.</p> <p>Definition for Family Strengths and Needs Assessment (FNSA) is added.</p> <p>Definition for Financial Management Services is added.</p> <p>Definition for HHSC Administrative Services Contractor (or ASC) is modified to remove the FFCHE program.</p> <p>Definition for Home and Community Support Services Agency (HCSSA) is added.</p> <p>Definition for Long-Term Services and Supports (LTSS) is added.</p> <p>Definition for Main Dental Home Provider, Main Dentist, or Dental Home is modified to include RHCs.</p> <p>Definition for Medically Dependent Children Program (MDCP) is added.</p> <p>Definition for Member is modified to remove the FFCHE program.</p> <p>Definition for Minor Home Modifications is added.</p> <p>Definition for Personal Care Services (PCS) is added.</p> <p>Definition for Prescribed Pediatric Extended Care Center (PPECC) is added.</p> <p>Definition for Respite is added.</p> <p>Definition for Screening and Assessment Instrument (SAI) is added.</p> <p>Definition for Supported Employment is added.</p> <p>Definition for Target Population is modified to remove the FFCHE program.</p>

## DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Definition for Transition Planning is added.</p> <p>Definition for Transition Specialist is added.</p> <p>Definition for Wrap-Around Services is added.</p> <p>Section 5.02 is modified to remove the FFCHE program.</p> <p>Section 7.02 is modified to add item (a)(16) to require MCOs to report all Member heelpath care information upon HHSC's request and subsequent items are renumbered. Item (a)(18) is deleted as redundant.</p> <p>Section 9.04 is modified to add an explanation of reasonable notice.</p> <p>Section 10.18 Supplemental Payments for Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products is added.</p> <p>Section 11.09 MCO's Breach Notice, Reporting and Correction Requirements is added.</p>
<p><sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions</p> <p><sup>2</sup> 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.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			

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## **Article 1. Introduction**

### **Section 1.01 Purpose.**

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

### **Section 1.02 Risk-based contract.**

This is a Risk-based contract.

### **Section 1.03 Inducements.**

In making the award of this Contract, HHSC relied on MCO's assurances of the following:

(1) MCO is a health maintenance organization, Approved Non-Profit Health Corporation (ANHC), or Exclusive Provider Organization that arranges for the delivery of Healthcare Services, and either (1) has received Texas Department of Insurance (TDI) licensure or approval as one of these entities and is fully authorized to conduct business in the Service Area, or (2) will receive TDI licensure or approval as one of these entities and be fully authorized to conduct business in the Service Area no later than 60 calendar days after HHSC executes this Contract;

(2) MCO and the MCO Administrative Service Subcontractors have the skills, qualifications, expertise, financial resources and experience necessary to provide the Services and Deliverables described in the RFP, MCO's Proposal, and this Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities;

(3) MCO has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP, and has had the opportunity to review and fully understand HHSC's current Program and operating environment for the activities that are the subject of the Contract and HHSC's needs and requirements during the Contract term;

(4) MCO has had the opportunity to review and understand HHSC's stated objectives in entering into this Contract and, based on this review and understanding, MCO currently has the capability to perform in accordance with the terms and conditions of this Contract;

(5) MCO also has reviewed and understands the risks associated with the Program as described in the RFP, including the risk of non-appropriation of funds.

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

### **Section 1.04 Construction of the Contract.**

(a) Scope of Introductory Article.

The provisions of any introductory article to the Contract are intended to be a general introduction and are not intended to expand the scope of the Parties' obligations under the Contract or to alter the plain meaning of the terms of the Contract.

(b) References to the "State."

References in the Contract to the "state" mean the State of Texas unless otherwise specifically indicated and will be interpreted, as appropriate, to mean or include HHSC and other agencies of the State of Texas that may participate in the administration of the Program, provided, however, that no provision will be interpreted to include any entity other than HHSC as the contracting agency.

(c) Severability.

If any provision of this Contract is for any reason held to be unenforceable, the rest of it remains fully enforceable.

(d) Survival of terms.

Termination or expiration of this Contract for any reason will not release either Party from any liabilities or obligations set forth in this Contract that:

(1) The Parties have expressly agreed will survive any termination or expiration; or

(2) Arose prior to the effective date of termination and remain to be performed or by their nature would be intended to be applicable following any termination or expiration.

(e) Headings.

The article, section, and paragraph headings in this Contract are for reference and convenience only and may not be considered in the interpretation of this Contract.

(f) Global drafting conventions.

(1) The terms "include," "includes," and "including" are terms of inclusion and enlargement, and where used in this Contract, should be read as if followed by the phrase "without limitation."

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

(3) Any references to laws, rules, regulations, and manuals in this Contract are references to these documents as amended, modified, or supplemented from time to time during the term of this Contract.

**Section 1.05 No implied authority.**

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

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

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

**Section 1.06 Legal Authority.**

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

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

**Article 2. Definitions**

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

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

**Abuse, Neglect, or Exploitation** has the meaning assigned in 40 Tex. Admin. Code Chapter 711 (for Adult Protective Services provider investigations).

**Action** means:

- (1) the denial or limited authorization of a requested Medicaid service, including the type or level of service;
- (2) the reduction, suspension, or termination of a previously authorized service;
- (3) the denial, in whole or in part, of payment for a service;
- (4) the failure to provide services in a timely manner;
- (5) the failure of an MCO to act within the timeframes provided in the Contract and 42 C.F.R. § 438.408(b); or
- (6) for a resident of a rural area with only one MCO, the denial of a Member's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside of the Network.

An Adverse Determination is one type of Action.

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

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

**Adaptive Aid** means a device necessary to treat, rehabilitate, prevent, or compensate for a condition resulting in a disability or a loss of function. An Adaptive Aid enables an individual to perform activities of daily living or control the environment in which he or she lives.

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

**Administrative Services** see MCO Administrative Services.

**Administrative Services Contractor** see HHSC Administrative Services Contractor.

**Adverse Determination** means a determination by an MCO or Utilization Review agent that the Healthcare Services furnished, or proposed to be furnished to a patient, are not Medically Necessary or not appropriate.

**Affiliate** means any individual or entity that meets any of the following criteria: 1) owns or holds a 5.0% or greater interest in the MCO (either directly or through one or more intermediaries); 2) in which the MCO owns or holds a 5.0% or greater interest (either directly or through one or more intermediaries); 3) any parent entity or subsidiary entity of the MCO, regardless of the organizational structure of the entity; 4) any entity that has a common parent with the MCO (either directly or through one or more intermediaries); 5) any entity that directly, or indirectly through one or

Definition for Adaptive Aid added by Version 2.3

Definition for Abuse, Neglect, or Exploitation added by Version 2.1 and modified by Version 2.2

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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.

**Agreement** see Contract.

**Allowable Expenses** means all expenses related to the Contract between HHSC and the MCO that are incurred during the Contract Period, are not reimbursable or recovered from another source, and that conform with the HHSC **UMCM's Chapter 6.1** "Cost Principles For Expenses."

**AAP** means the American Academy of Pediatrics.

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

**Appeal** means the formal process by which a Member or his or her representative requests a review of the MCO's Action, as defined above.

**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** 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 (BH) Hotline** means the toll-free number operated by the MCO to handle routine behavioral-health related calls.

**Behavioral Health (BH) Services** means Covered Services for the treatment of mental, emotional, or substance abuse disorders.

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

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

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

of MIS operations after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

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

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

**Call Coverage** means arrangements made by a facility or an attending physician with an appropriate level of healthcare provider who agrees to be available on an as-needed basis to provide medically appropriate services for routine, high risk, or Emergency Medical Conditions or Emergency Behavioral Health Conditions that present without being scheduled at the facility or when the attending physician is unavailable.

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

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

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

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

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

**Case Management for Children and Pregnant Women** is a Medicaid program for children with a

Definition for  
Breach added  
by Version 2.3

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health condition/health risk, birth through 20 years of age and for women with high-risk pregnancies of all ages, in order to help them gain access to medical, social, educational and other health-related services.

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

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

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

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

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

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

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

- (1) 837 Professional Combined Implementation Guide;
- (2) 837 Institutional Combined Implementation Guide;
- (3) 837 Professional Companion Guide;
- (4) 837 Institutional Companion Guide; or
- (5) National Council for Prescription Drug Programs (NCPDP) Companion Guide.

The MCO may not require a physician or provider to submit documentation that conflicts with the requirements of 28 Tex. Admin. Code Chapter 21, Subchapters C and T.

**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 at <http://txvendordrug.com>. The Clinical PA is used for verifying that a Member's medical condition matches the clinical criteria for dispensing a requested drug.

**CMS** means the Centers for Medicare and Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

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

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

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

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

**Community Services Specialist (CSSP)** means a Mental Health Rehabilitative Service provider who meets the following minimum requirements: (1) high school diploma or high school equivalency, and (2) three continuous years of

Definition for  
Clinical PA  
added by  
Version 2.2

Definition for  
Community-  
Based  
Services  
added by  
Version 2.3

Definition for  
Change in  
Condition  
added by  
Version 2.3

documented full-time experience in the provisions of Mental Health Rehabilitative Services and demonstrated competency in the provision and documentation of Mental Health Rehabilitative Services.

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

**Complainant** means a Member or a treating provider or other individual designated to act on behalf of the Member who filed the Complaint.

**Complaint** means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Action. As provided by 42 C.F.R. § 438.400, possible subjects for Complaints include the quality of care of services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights.

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

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

**Confidential Information** means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) consisting of:

- (1) Confidential Member information, including HIPAA-defined protected health information;
- (2) All non-public budget, expense, payment, and other financial information;
- (3) All privileged work product;
- (4) All information designated by HHSC or any other State agency as confidential, and all information designated as confidential under the Texas Public Information Act, Texas Government Code Chapter 552;
- (5) The pricing, payments, and terms of the Contract, unless disclosed publicly by HHSC or the State; and
- (6) Information utilized, developed, received, or maintained by HHSC, the MCO, or participating State agencies for the purpose of fulfilling a duty or obligation under this Contract and that has not been disclosed publicly.

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

(1) assisting Members, Caregivers, and Medical Consenters with coordination of care needs to include the scheduling of appointments and transportation;

(2) conducting outreach efforts; and

(3) educating Members, Caregivers, Medical Consenters regarding Service Coordination services.

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

Definition for Consolidated FSR Report or Consolidated Basis modified by Version 2.1

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

**Contract** means this formal, written, and legally enforceable contract between the Parties and any amendments.

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

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

**Contractor** see MCO.

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

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

Definition for Court Order added by Version 2.1

**Court-Ordered Commitment** means a commitment of a Member to an inpatient mental health facility for treatment ordered by a court of law under Texas Health and Safety Code, Chapters 573 or 574.

**Covered Services** means Healthcare Services the MCO must arrange to provide to Members, including all services required by the Contract, state and federal law, and all Value-added Services negotiated by the Parties (see **Contract Attachment B-2** relating to "Value-added Services"). Covered Services include, without limitation, Acute Care,

Definition for Covered Services modified by Version 2.1

Behavioral Health Services, dental services, pharmacy services, and vision services.

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

**Critical Event or Incident** means an event or incident that may harm, or create the potential for harm to, an individual. Critical events or incidents include:

- Abuse, Neglect, or Exploitation
- the unauthorized use of restraint, seclusion, or restrictive interventions;
- serious injuries that require medical intervention or result in hospitalization;
- criminal victimization;
- unexplained death;
- medication errors; and
- other incidents or events that involve harm or risk of harm to a Member.

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

**Daily Notification File (DNF)** means the file used to provide notification on a daily basis to the STAR Health MCO concerning each new client that is taken into DFPS conservatorship (i.e., Members included in category 1 of the “Target Population” definition). The STAR Health MCO should begin providing STAR Health services to the Member upon receipt of the DNF. The DNF is not an official eligibility file, and does not contain information concerning Members included in category 3 of the “Target Population” definition.

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

**Day** means a calendar day unless specified otherwise.

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

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

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

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

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

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

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

**Disability-related Access** means that facilities are readily accessible to and usable by individuals with Disabilities, and that auxiliary aids and services are provided to ensure effective communication, in compliance with Title III of the Americans with Disabilities Act.

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

**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 patient self-care efforts are significant.

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

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

**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.

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

**ECI** means Early Childhood Intervention, a federally mandated program for infants and toddlers under the age of three with developmental delays or disabilities. See 34 C.F.R. § 303.1 *et seq.* and 40 Tex. Admin.Code § 108.101 *et seq.* for further clarification.

**EDI** means electronic data interchange.

Definition for Discovery/Discovered added by Version 2.3

Definition for Daily Notification File (DNF) modified by Version 2.3

Definition for Dual Demonstration added by Version 2.1

Definition for Dual Eligibles added by Version 2.3

Definition for Effective Date of Coverage modified by Version 2.3

**Effective Date** means the effective date of this Contract.

**Effective Date of Coverage** means:

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

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

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

**Emergency Behavioral Health Condition**

means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

(1) requires immediate intervention or medical attention without which Members would present an immediate danger to themselves or others, or

(2) that renders Members incapable of controlling, knowing, or understanding the consequences of their actions.

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

**Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- (1) placing the patient's health in serious jeopardy;
- (2) serious impairment to bodily functions;
- (3) serious dysfunction of any bodily organ or part;
- (4) serious disfigurement; or
- (5) serious jeopardy to the health of a pregnant woman or her unborn child.

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

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

Definition for Employment Assistance added by Version 2.3

**Encounter Data** means data elements from Fee-for-Service claims or capitated-services proxy claims that are submitted to HHSC by the MCO in accordance with HHSC's required format.

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

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

**Exclusive Provider Benefit Plan (or EPP)**

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

**Experience Rebate** means the portion of the MCO's Net Income Before Taxes that is returned to the State in accordance with **Section 10.09** (Experience Rebate).

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

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

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

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

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

**Family Partner** means a Mental Health Rehabilitative Service provider who meets the following minimum requirements: (1) high school

diploma or high school equivalency, and (2) one cumulative year of participating in mental health services as the parent or legally authorized representative of a child receiving mental health services.

Definition for Family Strengths and Needs Assessment added by Version 2.3

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

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

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

Definition for Financial Management Services added by Version 2.3

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

**Financial Statistical Report** see FSR.

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

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

**Former Foster Care Child (FFCC) Member** means a young adult who has aged out of the foster care system and has previously received Medicaid while in foster care. FFCC Members may be enrolled in the STAR or STAR Health Program. The FFCC

Member may be enrolled until the last day of the month of his or her 26th birthday.

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

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

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

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

**FSR Reporting Period 16** means the twelve-month period beginning on September 1, 2015, and ending on August 31, 2016.

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

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

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

**Healthcare Services** means the Acute Care, Behavioral Healthcare, and health-related services that an enrolled population might reasonably require in order to be maintained in good health, including, at

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a minimum, Emergency Services and inpatient and outpatient services.

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

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

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

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

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

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

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

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

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

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

**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)** means an Intermediate Care Facility for individuals with Intellectual Disability or related conditions that

provides residential care and services for those individuals based on their functional needs.

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

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

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

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

**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**.

**Licensed Medical Personnel** means, in the context of Mental Health Rehabilitative Services day programs, the following provider types: physician; advanced practice registered nurse (APRN); physician assistant (PA); registered nurse (RN); licensed vocational nurse (LVN); or pharmacists.

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

- (1) a physician;
- (2) a licensed professional counselor;
- (3) a licensed clinical social worker;
- (4) a licensed psychologist;
- (5) an advanced practice nurse; or
- (6) a licensed marriage and family therapist.

**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 Health Department** means a local health department established under Health and Safety

Definition for  
HHSC  
Administrative  
Services  
Contractor  
modified by  
Version 2.3

Definition for  
Home and  
Community  
Support  
Services  
Agency  
added by  
Version 2.3

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Code § 121.031, Local Public Health Reorganization Act.

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

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

**Main Dental Home Provider, Main Dentist, or Dental Home** means a provider who provides a Dental Home to Members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as Main Dental Home Providers are FQHCs, RHCs, and individuals who are general dentists or pediatric dentists.

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

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

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

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

- (1) enroll with the MCO; or
- (2) not enroll in, or to disenroll from, another MCO.

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

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

- the other entity is an Affiliate of the MCO;
- the Subcontract is considered by HHSC to be for a key type of service or function, including
  - Administrative Services (including third party administrator, Network administration, and claims processing);
  - delegated Networks (including behavioral health, dental, pharmacy, and vision);

- management services (including management agreements with parent)
- reinsurance or retrocession agreements;
- Disease Management;
- pharmacy benefit management (PBM) or pharmacy administrative services; or
- call lines (including nurse and medical consultation); or
- any other Subcontract that exceeds, or is reasonably expected to exceed, the lesser of:
  - a) \$500,000 per year, or b) 1% of the MCO's annual Revenues under this Contract. Any Subcontracts between the MCO and a single entity that are split into separate agreements by time period, Program, or Service Area, etc., will be consolidated for the purpose of this definition.

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

**Material Subcontractor (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.

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

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

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

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

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

Definition for Long-Term Services and Supports added by Version 2.3

Definition for Main Dental Home Provider, Main Dentist, or Dental Home modified by Version 2.3

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

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

**Medically Dependent Children Program (MDCP)** means a program that provides Home and Community-Based LTSS for individuals under the age of 21 with complex medical needs as a cost-effective alternative to living in a Nursing Facility.

**Medically Necessary** has the meaning defined in 1 Tex. Admin. Code § 353.2.

**Member** means a person who:

(1) is entitled to benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included in the Program, and is enrolled in the Program and MCO; or

(2) is entitled to benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included as a voluntary participant in the Program, and is enrolled in the Program and the MCO.

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

**Member Materials** means all written materials produced or authorized by the MCO and distributed to Members or potential members containing information concerning the MCO Program. Member Materials include Member ID cards and Member Handbooks and Provider Directories.

**Member Month** means one Member enrolled with the MCO during any given month. The total Member Months for each month of a year comprise the annual Member Months.

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

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

(1) has a serious ongoing illness, a Chronic or Complex Condition, or a Disability that has lasted or is anticipated to last for a significant period of time, and

(2) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained healthcare personnel.

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

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

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

**MIS** means Management Information System.

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

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

**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** see Provider.

**Non-capitated Services** means the Texas Medicaid programs and services that are excluded from MCO Covered Services, but Members may be eligible to receive from Texas Medicaid providers on a Fee-for-Service basis. Non-capitated Services are identified in **Section 8** of the Contract.

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

Definition for Medically Dependent Children Program added by Version 2.3

Definition for Member modified by Version 2.3

Definition for Mental Health Targeted Case Management modified by Version 2.1

Definition for Minor Home Modifications added by Version 2.3

**Non-Urban County (Rural County)** means any county with fewer than 50,000 residents.

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

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

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

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

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

**Out-of-Network (or 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.

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

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

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

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

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

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

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

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

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

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

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

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

**Pre-Appeal** means the process by which the MCO seeks to resolve disagreements with Medical Consenters, Caregivers, DFPS Staff, SSCC staff, and Members regarding potential denial or limited authorization of a requested service that does not appear to meet criteria for medical necessity.

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

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

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

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

**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 under which this Contract was awarded.

**Provider** means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the MCO for

the delivery of Covered Services to the MCO's Members.

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

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

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

**Provider Network** See Network.

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

**Psychiatric Hospital** means a Hospital that provides inpatient mental health services to individuals with mental illness or with a substance use disorder except that, at all times, a majority of the individuals admitted are individuals with a mental illness. Such services include psychiatric assessment and diagnostic services, physician services, professional nursing services, and monitoring for patient safety provided in a restricted environment. See [Title 25, Texas Administrative Code, Chapter 134](#).

**Public Health Entity** means an HHSC Public Health Region, a Local Health Department, or a Hospital district.

**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.

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

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

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

**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 the assurances made by a selected MCO and the examination conducted by HHSC, or its agents, of the MCO's ability, preparedness, and availability to fulfill its obligations under the Contract.

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

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

**Revenue** means all revenue received by the MCO under this Contract, including retroactive adjustments made by HHSC. Revenue includes any funds earned on Medicaid or CHIP managed care funds such as investment income and earned interest. Revenue excludes any reinsurance recoveries, which must be shown as a contra-cost, or reported offset to reinsurance expense. Revenues are reported at gross, and are not netted for any reinsurance premiums paid. See also **UMCM Chapter 6.1** "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.

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

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

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

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

**Screening and Assessment Instrument (SAI)** means the electronic assessment and screening tool that the MCO must administer to help determine a Member's eligibility for MDCP and CFC enrollment.

Definition for Respite added by Version 2.3

Definition for Rate Cell Removed by Version 1.2

Definition for Screening and Assessment Instrument added by Version 2.3

**SDX** means State Data Exchange.

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

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

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

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

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

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

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

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

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

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

**Significant Traditional Provider (or STP)** means Primary Care Providers, long-term care providers, and pharmacy providers identified by HHSC as having provided a significant level of care to Fee-for-Service clients in Substitute Care. Disproportionate Share Hospitals (DSH) are also Medicaid STPs.

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

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

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

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

See [Title 25, Texas Administrative Code, Chapter 133](#).

**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 Health Liaison** means the designated MCO staff person who will serve as the point-of-contact to answer questions and resolve issues with DFPS regarding STAR Health. The STAR Health Liaison will coordinate with the MCO and DFPS to ensure effective and efficient response by the MCO to operational issues and other concerns of DFPS.

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

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

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

**Subcontractor** means any individual or entity, including an Affiliate, that has entered into a Subcontract with MCO.

Definition for Self-employed Direct Provider added by Version 2.2

Definition for Severe and Persistent Mental Illness (SPMI) modified by Version 2.1

Definition for Severe Emotional Disturbance (SED) modified by Version 2.1

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

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

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

**Supplemental Security Income (SSI)** means the federal cash assistance program of direct financial payments to the aged, blind, and disabled administered by the SSA under Title XVI of the Social Security Act. All persons who are certified as eligible for SSI in Texas are eligible for Medicaid. Local SSA claims representatives make SSI eligibility determinations. The transactions are forwarded to the SSA in Baltimore, who then notifies the states through the SDX.

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

**Supported Employment** means assistance provided, in order to sustain competitive employment, to an MDCP enrolled Member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported Employment includes employment adaptations, supervision, and training related to a Member's assessed needs. Individuals receiving supported employment earn at least minimum wage (if not self-employed). Supported Employment is not available to Members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. For any Member receiving one of those waiver services, the MCO must document that the Employment Assistance service is not available to the Member in the Member's HCSP.

**Systems Quality Assurance Plan** means the written plan developed by the MCO, and approved by HHSC, that describes the processes, techniques, and

tools that the MCO will use for assuring that the MIS systems meet the Contract requirements.

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

- (1) DFPS conservatorship,
- (2) young adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement, and
- (3) young adults aged 18 through the month of their 21st birthday, who are FFCC Members or who are participating in the MTFYC Program.

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

**TDI** means the Texas Department of Insurance.

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

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

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

**Texas Medicaid Provider Procedures Manual** means the policy and procedures manual published by or on behalf of HHSC that contains policies and procedures required of all healthcare providers who participate in the Texas Medicaid Program.

**Texas Medicaid Service Delivery Guide** means an attachment to the Texas Medicaid Provider Procedures Manual.

**Third Party Liability (TPL)** means the legal responsibility of another individual or entity to pay for

Definition for Target Population modified by Version 2.3

Definition for DFPS Texas Comprehensive CANS assessment added by Version 2.2 and modified by Version 2.3

Definition for Supported Employment added by Version 2.3

Definition for Texas Medicaid Provider Procedures Manual modified by Version 2.2

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all or part of the services provided to Members under the Contract (see 1 Tex. Admin. Code § 354.2301 *et seq.*, relating to Third Party Resources).

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

**TJC (formerly JCAHO)** means The Joint Commission.

**Transition Phase** includes all activities the MCO is required to perform between the Contract Effective Date and the Operational Start Date for the Service Area.

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

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

**Turnover Phase** includes all activities the MCO is required to perform in order to close out the Contract or transition Contract activities and operations to HHSC or a subsequent contractor.

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

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

**URAC (Utilization Review Accreditation Commission dba American Accreditation HealthCare Commission, Inc.)** means the independent organization that accredits Utilization Review functions and offers a variety of other accreditation and certification programs for healthcare organizations.

**Urban County** means any county with 50,000 or more residents.

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

**Urgent Condition** means a health condition, including an Urgent Behavioral Health Situation, that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the

average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

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

**Value-added Services** means additional services for coverage beyond those specified in Attachment B-2. Value-added Services may be actual Healthcare Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve health outcomes among Members. Value-added Services that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra Home Health Services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

**Waste** means practices that are not cost-efficient.

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

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

### **Article 3. General Terms**

#### **Section 3.01 Contract elements.**

- (a) Contract documentation.

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

- (b) Order of documents.

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

- (1) The final executed **STAR Health Managed Care Contract signature document**, and all amendments;
- (2) **Attachment A** of the STAR Health Managed Care Contract document– “STAR Health Contract Terms,” and all amendments;
- (3) **Attachment B** of the STAR Health Managed Care Contract document, RFP “Scope

Definition for Transition Planning added by Version 2.3

Definition for Transition Specialist added by Version 2.3

Definition for Wrap-Around Services added by Version 2.3

of Work/Performance Measures,” and all attachments and amendments;

(4) The **HHSC Uniform Managed Care Manual (UMCM)**, and all attachments and amendments;

(5) **Attachment C** of the STAR Health Managed Care Contract document, “The MCO’s Proposal and all attachments and amendments.

**Section 3.02 Term of the Contract.**

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

**Section 3.03 Funding.**

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

**Section 3.04 Delegation of authority.**

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

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

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

**Section 3.06 Force majeure.**

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

**Section 3.07 Publicity.**

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

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

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

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

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

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

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

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

**Section 3.08 Assignment.**

(a) Assignment by MCO.

Section 3.07 modified by Versions 2.1 and 2.2

Section 3.03 modified by Version 2.1

Section 3.08 modified by Version 2.1

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

(b) Assignment by HHSC.

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

(c) Assumption.

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

**Section 3.09 Cooperation with other vendors and prospective vendors.**

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

**Section 3.10 Renegotiation and reprocurement rights.**

(a) Renegotiation of Contract terms.

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

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

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

(c) Termination rights upon reprocurement.

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

**Section 3.11 RFP errors and omissions.**

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

**Section 3.12 Attorneys' fees.**

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

**Section 3.13 Preferences under service contracts.**

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

**Section 3.14 Ensuring timely performance.**

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

**Section 3.15 Notice**

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

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

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

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

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

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

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

**Article 4. Contract Administration and**

## Management

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

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

### **Section 4.02 MCO's Key Personnel.**

#### (a) Designation of Key Personnel.

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

- (1) Member Services;
- (2) Management Information Systems;
- (3) Health Passport Management;
- (4) Claims Processing;
- (5) Provider Network Development and Management;
- (6) Benefit Administration and Prior Authorization;
- (7) Service Management;
- (8) Service Coordination;
- (9) Quality Improvement;
- (10) Behavioral Health Services;
- (11) Dental Services;
- (12) Financial Functions;
- (13) Reporting;
- (14) Executive Director as defined in **Section 4.03** (Executive Director);
- (15) Medical Director as defined in **Section 4.04** (Medical Director); and
- (16) STAR Health Liaison Director as defined in **Section 4.05** (STAR Health Liaisons).

#### (b) Support and Replacement of Key Personnel.

The MCO must maintain, throughout the Contract Term, the ability to supply its Key Personnel with the required resources necessary to meet Contract requirements and comply with applicable law. The MCO must ensure project continuity by timely replacement of Key Personnel, if necessary,

with a sufficient number of persons having the requisite skills, experience, and other qualifications. Regardless of specific personnel changes, the MCO must maintain the overall level of expertise, experience, and skill reflected in the Key MCO Personnel job descriptions and qualifications included in the MCO's proposal.

#### (c) Notification of replacement of Key Personnel.

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

#### d) Dedicated Staff

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

##### (1) Regional staff:

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

#### e) Training for dedicated staff

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

- (1) differences and similarities between managing the care for a child in foster care and managing the care for the other Medicaid populations;
- (2) vital timelines in the evaluation and delivery of services to Members;
- (3) the roles and responsibilities of MCO staff in interfacing with DFPS Staff, SSCC staff, and the court system;
- (4) the legacy foster care medical and behavioral health management system and how it changed with the STAR Health Program;

(5) Foster Care Redesign and the roles and responsibilities of the SSCC generally and each specific SSCC with an awarded contract within the different designated areas; and

(6) symptoms and treatment of childhood medical and behavioral health conditions commonly seen in the foster care population, such as the effect of abuse and neglect on the developing brain, fetal alcohol syndrome, and shaken baby syndrome.

**Section 4.03 Executive Director.**

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

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

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

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

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

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

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

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

(7) meeting with HHSC at the time and place requested by HHSC, if HHSC determines that

the MCO is not in compliance with the requirements of the Contract.

**Section 4.04 Medical Director.**

(a) The MCO must have a qualified individual to serve as the Medical Director for its HHSC MCO Program(s). The Medical Director must be currently licensed in Texas by the Texas Medical Board as an M.D. or D.O. with no restrictions or other 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, seven days a week, for Utilization Review decisions. The Medical Director, and his or her designee, must either possess expertise with Behavioral Health Services, or have ready access to that expertise to ensure timely and appropriate medical decisions for Members, including after regular business hours.

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

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

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

**Section 4.05 This Section is Intentionally Left Blank**

**Section 4.06 Responsibility for MCO personnel and Subcontractors.**

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

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

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

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

(e) MCO agrees to be responsible for the following in respect to its employees:

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

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

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

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

***Section 4.07 Cooperation with HHSC and state administrative agencies.***

(a) Cooperation with Other MCOs.

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

other HHSC contractors reasonably cooperate with the MCO.

(b) Cooperation with state and federal administrative agencies.

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

(1) The investigation and prosecution of fraud, abuse, and waste in the HHSC Programs;

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

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

***Section 4.08 Conduct of MCO personnel.***

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

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

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

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

(1) Removing the employee from the project;

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

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

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

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

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

**Section 4.09 Subcontractors and Agreements with Third Parties.**

(a) MCO remains fully responsible for the obligations, services, and functions performed by its Subcontractors to the same extent as if these obligations, services, and functions were performed by MCO's employees, and for purposes of this Contract, any work is deemed work performed by MCO. HHSC reserves the right to require the replacement of any Subcontractor that HHSC finds unacceptable and unable to meet the requirements of the Contract. HHSC may also object to the selection of any Subcontractor.

(b) MCO must:

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

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

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

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

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

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

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

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

(4) the MCO must demonstrate that a Material Subcontractor assuming delegated functions satisfies all requirements of a pre-

delegation audit before the applicable functions can be delegated. The MCO must conduct the audit, which must include: a standard audit tool approved by HHSC, site visit, file review (if applicable), staff interviews, and scoring to ensure compliance is achieved.

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

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

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

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

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

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

(6) a Readiness Review is requested by HHSC.

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

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

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

(f) Except as provided in this section, all Subcontracts must be in writing and must provide HHSC the right to examine the Subcontract and all Subcontractor records relating to the Contract and the

Subcontract. This requirement does not apply to agreements with non-Affiliate utility or mail service providers.

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

For any third-party agreements not in writing valued under \$200,000 per State Fiscal Year that are reported as Allowable Expenses, the MCO still must maintain standard financial records and data sufficient to verify the accuracy of those expenses in accordance with the requirements of **Article 9**, "Audit and Financial Compliance." Any agreements that are, or could be interpreted to be, with a single party, must be in writing if the combined total is more than \$200,000. This would include payments to individuals or entities that are related to each other.

(g) A Subcontract or any other agreement in which the MCO receives rebates, recoupments, discounts, payments, incentives, fees, free goods, bundling arrangements, retrocession payments (as described in **UMCM Chapter 6.1**, "Cost Principles for Expenses") or any other consideration from a Subcontractor or any other third party (including without limitation Affiliates) as related to this Contract must be in writing and the MCO must allow HHSC and the Office of the Attorney General to examine the Subcontract or agreement and all related records.

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

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

(j) Network Provider Contracts must include the mandatory provisions included in the **UMCM Chapter 8.1**, "Provider Contract Checklist."

(k) HHSC reserves the right to reject any Subcontract or require changes to any provisions that

do not comply with the requirements or duties and responsibilities of this Contract or create significant barriers for HHSC in monitoring compliance with this Contract.

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

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

(n) The MCO and its Subcontractors must provide all information required under **Section 4.09** to HHSC, or to the Office of the Attorney General, if requested, at no cost.

**Section 4.10 HHSC's ability to contract with Subcontractors.**

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

**Section 4.11 Prohibition Against Performance Outside the United States.**

(a) Findings.

(1) HHSC finds the following:

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

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

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

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

(2) In view of these obligations, and to ensure accountability, integrity, and the security of the information maintained by or for HHSC and the work performed on behalf of HHSC, HHSC determines that it is necessary and appropriate to require that:

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

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

(3) Further, HHSC finds it necessary and appropriate to forbid the performance of any work or the maintenance of any information relating or obtained under this Agreement to occur outside of the United States except as specifically authorized or approved by HHSC.

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

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

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

(c) Maintenance of Confidential Information.

(1) MCO and all Subcontractors, vendors, agents, and service providers of or for MCO must not allow any Confidential Information that MCO

receives from or on behalf of HHSC to be moved outside the United States by any means (physical or electronic) at any time, for any period of time, for any reason.

(2) MCO and all Subcontractors, vendors, agents, and service providers of or for MCO must not permit any person to have remote access to HHSC information, systems, or Deliverables from a location outside of the United States.

(d) Performance of Work under Agreement.

(1) Unless otherwise approved in advance by HHSC in writing, and subject to the exceptions specified in paragraph (d) 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 all Services, including 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) Unless otherwise approved in advance by HHSC in writing, and subject to the exceptions specified in paragraph (d) 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.

(3) HHSC Prior Approval. The foregoing requirements will not preclude MCO from performing work outside the United States that HHSC has approved in writing and that HHSC has confirmed will not involve the sharing of Confidential Information outside the United States.

(f) Disclosure.

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

(g) Remedy.

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

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

**Section 4.12 Employment Verification**

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.

**Article 5. Member Eligibility and Enrollment**

**Section 5.01 Eligibility Determination**

The State or its designee will make eligibility determinations for each potential enrollee for the Program.

**Section 5.02 Member Enrollment and Disenrollment.**

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

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

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

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

(e) Members will be enrolled in the MCO on the Effective Date of Coverage. Individuals already eligible for Texas Medicaid managed care or Fee-for-Service Programs or CHIP on the Effective Date of Coverage with the MCO will be disenrolled from the applicable Texas Medicaid Program or CHIP, effective the day prior to the Effective Date of Coverage with the MCO.

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

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

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

Section 4.12 added by Version 2.1 and modified by Version 2.2

Section 5.02 modified by Version 2.3

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

**Section 5.03 Span of Coverage**

(a) General

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

(b) Inpatient Hospital.

If a Member's Effective Date of Coverage occurs while the Member is confined in a Hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, the MCO is responsible for the Member's costs of Covered Services as follows:

(1) If the Member is receiving services through Texas Medicaid Fee-for-Service prior to the Effective Date of Coverage, then the Texas Medicaid Fee-for-Service Program will pay all facility charges until the Member is discharged from the Hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, or until the Member loses Medicaid eligibility, whichever occurs earlier. For purposes of **Section 5.03**, the date of discharge from a Hospital for behavioral health stay includes extended stay days, as described in the Texas Medicaid Provider Procedures Manual. The STAR Health MCO will be responsible for all other Covered Services on the Effective Date of Coverage with the STAR Health MCO.

(2) If the Member is receiving services through a STAR, STAR Kids, or STAR+PLUS MCO prior to the Effective Date of Coverage, then the STAR, STAR Kids, or STAR+PLUS MCO will pay all facility charges until the Member is discharged from the Hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, or until the Member loses eligibility, whichever occurs earlier. The STAR Health MCO will be responsible for all other Covered Services on the Effective Date of Coverage with the STAR Health MCO.

(3) If the Member is receiving services through a commercial insurer, Texas Children's Health Insurance Program (CHIP) MCO or CHIP exclusive provider organization prior to the Effective Date of Coverage, then the STAR

Health MCO will be responsible for all facility charges and all other Covered Services on the Effective Date of Coverage with the STAR Health MCO.

(4) If a Member is disenrolled from STAR Health and enrolled in FFS or in a STAR, STAR Kids, or STAR+PLUS MCO during an Inpatient Stay, then the STAR Health MCO will pay all facility charges until the Member is discharged from the Hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, or until the Member loses Medicaid eligibility, whichever occurs earlier. FFS or the STAR, STAR Kids, or STAR+PLUS MCO will be responsible for all other Covered Services on the Effective Date of Coverage with FFS or the STAR, STAR Kids, or STAR+PLUS MCO.

(c) Nursing Homes.

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

(d) Custom DME and Augmentive Devices

(1) If the Member has an existing prior authorization in place for custom DME from Texas Medicaid Fee-For Service, Texas Children's Health Insurance Program (CHIP) MCO or exclusive provider organization, or commercial insurer at the time of the Effective Date of Coverage with the STAR Health MCO, but prior to the delivery of the product, the STAR Health MCO is responsible for payment.

(2) If the Member has an existing prior authorization in place for custom DME from a STAR, STAR Kids, or STAR+PLUS MCO at the time of the Effective Date of Coverage with the STAR Health MCO, but prior to the delivery of the product, the STAR, STAR Kids, or STAR+PLUS MCO is responsible for payment.

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

(e) Verification of Member Eligibility.

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

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vendors must contract with the State and obtain eligibility information from the State.

(f) Effective Date of SSI Status:

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

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

**Article 6. Service Levels and Performance Measurement**

**Section 6.01 Performance measurement.**

Satisfactory performance of this Contract will be measured by:

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

**Section 6.02 Service Management and Coordination Staffing.**

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

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

reasonable adjustments in staffing, including increasing, reallocating, or reassigning MCO staff.

**Article 7. Governing Law and Regulations**

**Section 7.01 Governing law and venue.**

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

**Section 7.02 MCO responsibility for compliance with laws and regulations.**

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

- (1) Title XIX of the Social Security Act;
- (2) Tex. Gov't Code Chapters 531 and 533;
- (3) 42 C.F.R. Parts 417 and 457, as applicable;
- (4) 45 C.F.R. Parts 74 and 92;
- (5) 48 C.F.R. Part 31, and 2 C.F.R. Part 200;
- (6) 1 Tex. Admin. Code Chapters 361, 370, 371, 391, and 392;
- (7) consent decree and Corrective Action Orders, *Frew, et al. v. Smith, et al.*;
- (8) partial settlement agreements, *Alberto N., et al. v. Smith, et al.*;
- (9) Texas Human Resources Code Chapters 32 and 36;
- (10) Texas Penal Code Chapter 35A (Medicaid Fraud);
- (11) 1 Tex. Admin. Code Chapter 353;
- (12) 1 Tex. Admin. Code Chapter 354, Subchapters B, J, and F, with the exception of the following provisions in Subchapter F: 1 Tex. Admin. Code § 354.1865, § 354.1867, § 354.1873, and Division 6, "Pharmacy Claims; and § 354.3047;
- (13) 1 Tex. Admin. Code Chapter 354, Subchapters I and K, as applicable;
- (14) The Patient Protection and Affordable Care Act ("PPACA"; Public Law 111-148);

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(15) The Health Care and Education Reconciliation Act of 2010 ("HCERA"; Public Law 111-152) 42 CFR Part 455;

(16) 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");

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

(18) all administrative rules governing the Program that are adopted in the Texas Administrative Code.

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

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

(d) 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, or has proper permits to perform any activity related to the Services or Deliverables.

(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 law, regulation, code, ordinance, or policy.

**Section 7.03 TDI status and solvency.**

(a) TDI Status

MCO must be an exclusive provider benefit plan approved by TDI in accordance with 28 Tex. Admin. Code §§ 3.9201–3.9212.

(b) Solvency

MCO must maintain compliance with the Texas Insurance Code and rules promulgated and administered by the TDI requiring a fiscally sound operation. 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 benefits, until the time of discharge, to Members who are confined on the date of insolvency in a Hospital or other inpatient facility;

(2) payment to unaffiliated healthcare providers and affiliated healthcare providers whose agreements do not contain member "hold harmless" clauses acceptable to TDI, and

(3) continuation of benefits for the duration of the Contract period for which HHSC has paid a Capitation Payment.

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.

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

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

(1) Title VI of the Civil Rights Act of 1964 ([42 U.S.C. § 2000d](#) *et seq.*);

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794);

(3) Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 *et seq.*);

(4) Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107);

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(5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688);

(6) Food Stamp Act of 1977 (7 U.S.C. § 200 *et seq.*); and

(7) HHSC's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

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

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

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

(d) Upon request, MCO will provide HHSC with copies of all of the MCO'S civil rights policies and procedures.

(e) MCO must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must

be delivered no more than 10 calendar days after receipt of a complaint. For this section's purposes, notice must be directed to:

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

**Section 7.05 Environmental protection laws.**

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

(a) Pro-Children Act of 1994.

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

(b) National Environmental Policy Act of 1969.

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

(c) Clean Air Act and Water Pollution Control Act regulations.

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

(d) State Clean Air Implementation Plan.

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

(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 7.06 HIPAA.**

(a) MCO must comply with applicable provisions of HIPAA. This includes the requirement that the MCO's MIS system comply with applicable certificate of coverage and data specification and reporting

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requirements promulgated under HIPAA. MCO must comply with HIPAA EDI requirements.

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

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

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

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

#### **Section 7.07 Historically Underutilized Business Participation Requirements.**

(a) Definitions.

For purposes of this Section:

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

(2) "**HSP**" means a HUB Subcontracting Plan.

(b) HUB Requirements.

(1) In accordance with **Section 8.1.23.1**, "Financial Reporting Requirements," 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 **UMCM Chapter 5.4.4.5**, "HUB Progress Assessment Report Instructions," of the, its use of HUB subcontractors to fulfill the subcontracting opportunities identified in the HSP.

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

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

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

#### **Section 7.08 Compliance with Fraud, Waste, and Abuse requirements.**

MCO, MCO's personnel, and all Subcontractors must comply with all fraud, waste, and abuse requirements found in [HHS Circular C-027](#). The MCO must comply with Circular C-027 requirements in addition to other fraud, waste, and abuse provisions in the contract and in state and federal law.

#### **Article 8. Amendments and Modifications**

##### **Section 8.01 Mutual agreement.**

This Contract may be amended at any time by mutual agreement of the Parties. The amendment must be in writing and signed by individuals with authority to bind the Parties.

##### **Section 8.02 Changes in law or contract.**

If federal or state laws, rules, regulations, policies, or guidelines are adopted, promulgated, judicially interpreted or changed, or if contracts are entered or changed, and the effect of which alters the ability of either Party to fulfill its obligations under this

Contract, the Parties will promptly negotiate in good faith appropriate modifications or alterations to the Contract and any schedule(s) or attachment(s) made a part of this Contract. Any modifications or alterations must be in writing and signed by individuals with authority to bind the parties, must equitably adjust the terms of this Contract, and must be limited to those provisions of this Contract affected by the change.

**Section 8.03 Modifications as a remedy.**

This Contract may be modified under the terms of **Article 12** (Remedies and Disputes).

**Section 8.04 Modifications upon renewal or extension of Contract.**

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

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

**Section 8.05 Modification of HHSC Uniform Managed Care Manual.**

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

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

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

**Section 8.06 CMS approval of Contracts.**

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

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

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

**Article 9. Audit and Financial Compliance**

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

MCO agrees to maintain, and require its Subcontractors to maintain, records, books, documents, and information (collectively "records") that are adequate to document that services are provided and payments are made in accordance with the requirements of this Contract, including applicable federal and state requirements (e.g., 45 CFR § 74.53). The records must be retained by MCO and its Subcontractors for a period of five years after the Contract Expiration Date or until the resolution of all litigation, claims, financial management reviews, or audits pertaining to this Contract, whichever is longer.

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

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

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

- (1) Examination;

- (2) Audit;
- (3) Investigation;
- (4) Contract administration; or
- (5) The making of copies, excerpts, or transcripts.

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

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

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

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

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

### **Section 9.03 General Access to Accounting Records**

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

(b) The MCO must:

(1) Cooperate with the state and federal governments in their evaluation, inspection, audit, or review of accounting records and any necessary supporting information.

(2) Permit authorized representatives of the state and federal governments full access, during normal business hours, to the accounting records that the state and federal governments reasonably determine are relevant to the Contract. This access is guaranteed at all times during the performance and retention period of the Contract and will include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the MCO. Except in the case of unannounced inspections or audits, the state or federal government will provide reasonable advance written notice of the inspections or audits, as determined by the state or federal government.

(3) At the MCO's expense, make copies of any accounting records or supporting documentation relevant to the MCO available to HHSC or its agents within 10 Business Days of receiving a written request from HHSC for specified records or information. If the MCO does not produce the documentation as requested, the MCO agrees to reimburse HHSC for all costs, including transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, and reproduction functions at the location(s) of the accounting records or supporting documentation.

(4) Pay any and all additional costs incurred by the state or federal government that are the result of the MCO's failure to provide the requested accounting records or financial information within 10 Business Days of receiving a written request from the state or federal government.

### **Section 9.04 Audits and Inspections of Services and Deliverables.**

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

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- (1) service locations, facilities, or installations;
- (2) records; and
- (3) Software and Equipment.

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

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

- (1) MCO's capacity to bear the risk of potential financial losses;
- (2) the Services and Deliverables provided;
- (3) a determination of the amounts payable under this Contract;
- (4) a determination of the allowability of costs reported under this contract;
- (5) detection of fraud, waste, or abuse;
- (6) an examination of Subcontract terms or transactions;
- (7) an assessment of financial results under this Contract; or
- (8) will be for other purposes HHSC determines it needs to perform its regulatory function or to enforce the provisions of this Contract.

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

(d) If, as a result of an audit or review of payments made to the MCO, HHSC discovers a payment error or overcharge, HHSC will notify the MCO of that error or overcharge. HHSC will be entitled to recover those funds as an offset to future payments to the MCO, or to collect the funds directly from the MCO. MCO must return funds owed to HHSC within 30 days after receiving notice of the error or overcharge, or interest will accrue on the amount due. HHSC will calculate interest at 12% per annum, compounded daily. In the event that an audit reveals that errors in reporting by the MCO have resulted in errors in payments to the MCO or errors in the calculation of the Experience Rebate, the MCO will indemnify HHSC for any losses resulting from these errors, including the cost of audit. If the interest rate stipulated in this Section is found by a court of competent jurisdiction to be outside the legal and enforceable range, then the rate in this Section will be adjusted to the maximum allowable rate the court of competent jurisdiction finds legal and enforceable.

**Section 9.05 SAO Audit**

The MCO understands that acceptance of funds under this Contract acts as acceptance of the

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

**Section 9.06 Response/compliance with audit or inspection findings.**

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

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

- (1) Required by state or federal law, regulation, rule or other audit requirement relating to MCO's business;
- (2) Performed by MCO as part of the Services or Deliverables; or
- (3) Necessary due to MCO's noncompliance with any law, regulation, rule, or audit requirement imposed on MCO.

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

**Section 9.07 Notification of Legal and Other Proceedings and Related Events.**

The MCO must notify HHSC of all proceedings, actions, and events as specified in the **UMCM Chapter 5.8**, "Report of Legal and Other Proceedings and Related Events."

**Article 10. Terms of Payment****Section 10.01 Calculation of monthly Capitation Payment.**

(a) This is a Risk-based contract. The MCO will provide Healthcare Services for Members on a fully insured basis. HHSC will calculate the fixed monthly Capitation Payments by multiplying the number of Members enrolled on the first day of the month by the Capitation Rate. HHSC will not pay a Capitation Payment for new Members during the first month of coverage unless the Member's Effective Date of Coverage occurs on the first day of the month. In consideration of the Monthly Capitation Payment(s), the MCO agrees to provide the Services and Deliverables described in this Contract.

(b) MCO will be required to provide timely financial and statistical information necessary in the Capitation Rate determination process. Encounter Data provided by MCO must conform to all HHSC requirements. Encounter Data containing non-compliant information, including inaccurate client or member identification numbers, inaccurate provider identification numbers, or diagnosis or procedure codes insufficient to adequately describe the diagnosis or medical procedure performed, will not be considered in the MCO's experience for rate-setting purposes.

(c) Information or data, including complete and accurate Encounter Data, as requested by HHSC for rate-setting purposes, must be provided to HHSC: (1) within 30 days of receipt of the letter from HHSC requesting the information or data; and (2) no later than March 31 annually.

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

- (1) an amount for Healthcare Services performed during the month;
- (2) an amount for administering the Program; and
- (3) an amount for the MCO's Risk margin.

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

(e) MCO understands and expressly assumes the risks associated with the performance of the duties and responsibilities under this Contract, including the failure, termination, or suspension of funding to HHSC, delays or denials of required approvals, and cost overruns not reasonably attributable to HHSC.

**Section 10.02 Time and Manner of Payment.**

(a) During the Contract Term and beginning after the Operational Start Date, HHSC will pay the

monthly Capitation Payments by the 10th Business Day of each month.

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

(c) HHSC may adjust the monthly Capitation Payment to the MCO: in the case of an overpayment to the MCO; for Experience Rebate amounts due and unpaid; and if monetary damages (including any associated interest) are assessed in accordance with **Article 12** (Remedies and Disputes).

(d) HHSC's payment of monthly Capitation Payments is subject to availability of federal and state appropriations. If appropriations are not available to pay the full monthly Capitation Payment, HHSC may:

- (1) equitably adjust Capitation Payments and reduce scope of service requirements as appropriate in accordance with **Article 8** (Amendments and Modifications); or
- (2) terminate the Contract in accordance with **Article 12** (Remedies and Disputes).

**Section 10.03 Certification of Capitation Rates.**

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

**Section 10.04 Modification of Capitation Rates.**

The Parties understand and agree that the 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 with notice of a modification to the Capitation Rates 60 days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the MCO does not accept the rate change, either Party may terminate the Contract in accordance with **Article 12** (Remedies and Disputes).

**Section 10.05 Capitation Structure.**

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

HHSC will establish base Capitation Rates for the Rate Periods following Rate Period 1 by analyzing historical Encounter Data and financial data. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

(b) Value-added Services.

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

**Section 10.06 MCO input during rate-setting process.**

(1) MCO must provide certified Encounter Data and financial data as described in the **UMCM**. The required information may include: claims lag information, capitation expenses, and stop loss reinsurance expenses. HHSC may request clarification or additional financial information from the MCO. HHSC will notify the MCO of the deadline for submitting 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 base Capitation Rates. This will include Fee-for-Service data for Rate Periods 1 and 2. HHSC will notify the MCO of the deadline for submitting comments, which will include a reasonable amount of time for response. HHSC will not consider comments received after the deadline in its rate analysis.

(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 appropriate method determined by HHSC. Prior to the first meeting, HHSC will provide the MCO with proposed Capitation Rates. During the first meeting, HHSC will describe the process used to generate the proposed Capitation Rates, discuss major changes in the rate-setting process, and receive input from the MCO. HHSC will notify the MCO of the deadline for submitting comments, which will include a reasonable amount of time to review and comment on the proposed Capitation Rates and rate-setting process. After reviewing any comments and making any necessary changes due to those comments, HHSC will conduct a second meeting to discuss the final Capitation Rates and any changes.

**Section 10.07 Adjustments to Capitation Payments.**

(a) Adjustment.

HHSC may adjust a payment made to the MCO for a Member if:

- (1) a Member's eligibility status or Program type is changed, corrected as a result of error, or is retroactively adjusted;
- (2) the Member is enrolled into the MCO in error;
- (3) the Member moves outside the United States;
- (4) the Member dies before the first day of the month for which the payment was made; or

(5) payment has been denied by CMS in accordance with the requirements in 42 C.F.R. §438.730.

(b) Appeal of adjustment.

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

**Section 10.08 Experience Rebate.**

(a) MCO's duty to pay.

(1) General.

At the end of each FSR Reporting Period, the MCO must pay an Experience Rebate if the MCO's Net Income Before Taxes is greater than the percentage set forth below of the total Revenue for the period. The Experience Rebate is calculated in accordance with the tiered rebate method in **Section 10.08 (b)**. The Net Income Before Taxes and the total Revenues are as measured by the FSR and as reviewed and confirmed by HHSC. Various factors in this Contract may impact the final amount used in the calculation of the percentage, including the Loss Carry Forward, the Admin Cap, or the Reinsurance Cap.

(2) Basis of consolidation.

The percentages are calculated on a Consolidated Basis and include the consolidated Net Income Before Taxes for all of the MCO's and its Affiliates' Texas HHSC Programs and Service Areas, with the exception of the Dual Demonstration.

(b) Graduated Experience Rebate Sharing Method.

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

HHSC and the MCO will share the consolidated Net Income Before Taxes for its HHSC programs as follows, unless HHSC provides the MCO an Experience Rebate Reward in accordance with **Section 6**, "Premium Payment Incentives and Disincentives," and **UMCM Chapter 6.2**, "Financial Incentive Methodology":

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(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 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% and 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% and 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 applicable federal regulations **and UMCM Chapter 6.1**, “Cost Principles for Expenses,” and **Chapter 5.3**, “Financial Reports/Formats,” and other similar instructions for other HHSC programs. The Net Income Before Taxes will be confirmed by HHSC or its agent for the FSR Reporting Period relating to all Revenues and Allowable Expenses incurred under the Contract. HHSC reserves the right to modify the **UMCM Chapter 6.1**, “Cost Principles for Expenses,” and **Chapter 5.3**, “Financial Reports/Formats,” in accordance with **Section 8.05**, “Modification of the Uniform Managed Care Manual.”

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

(i) the payment of an Experience Rebate;

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

(iii) financial incentives; and

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

See **UMCM Chapter 6.1**, “Cost Principles for Expenses.”

(3) Financial incentives are true net bonuses and must not be reduced by the potential increased Experience Rebate payments. Financial disincentives are true net disincentives, and must not be offset in whole or part by potential decreases in Experience Rebate payments.

(4) For FSR reporting purposes, financial incentives incurred must not be reported as an increase in Revenues or as an offset to costs, and any financial incentive award will not increase reported income. Financial disincentives incurred must not be included as reported expenses, and must not reduce reported income. The reporting or recording of any of these incurred items will be done on a memo basis, which is below the income line, and will be listed as separate items.

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

Losses incurred on a Consolidated Basis for a given FSR Reporting Period may be carried forward to the next FSR Reporting Period, and applied as an offset against consolidated pre-tax net income for determination of any Experience Rebate due. These prior losses may be carried forward for the next two contiguous FSR Reporting Periods.

In the case of a loss in a given FSR Reporting Period being carried forward and applied against profits in either or both of the next two FSR Reporting Periods, the loss must first be applied against the first subsequent FSR Reporting Period such that the profit in the first subsequent FSR Reporting Period is reduced to a zero pre-tax income; any additional loss then remaining unapplied may be carried forward to any profit in the next subsequent FSR Reporting Period. In this case, the revised income in the third FSR Reporting Period would be equal to the cumulative income of the three contiguous FSR Reporting Periods. In no case could the loss be carried forward to the fourth FSR Reporting Period or beyond.

Carrying forward of losses may be impacted by the Admin Cap; see **Section 10.08.1(f)**, “Administrative Expense Cap.”

Losses incurred in the last or next-to-last FSR Reporting Period of a prior contiguous contract with HHSC may be carried forward up to two FSR

Reporting Periods, into the first or potentially second FSR Reporting Period of this Contract, if such losses meet all other requirements of both the prior and current contracts.

(2) Basis of consolidation.

In order for a loss to be eligible as a potential loss carry-forward to offset future income, the MCO must have a negative Net Income Before Taxes for an FSR Reporting Period on a Consolidated Basis.

(e) Settlements for payment.

(1) There may be one or more MCO payment(s) of HHSC's share of the Experience Rebate on income generated for a given FSR Reporting Period under the STAR Health Program. The first scheduled payment (the "Primary Settlement") will equal 100% of HHSC's share of the Experience Rebate as derived from the FSR, and will be paid on the same day the 90-day FSR Report is submitted to HHSC.

The "Primary Settlement," as utilized in this Article, refers strictly to what should be paid with the 90-day FSR, and does not refer to the first instance in which an MCO may tender a payment. For example, an MCO may submit a 90-day FSR indicating no Experience Rebate is due, but then submit a 334-day FSR with a higher income and a corresponding Experience Rebate payment. In this case, this initial payment would be subsequent to the Primary Settlement.

(2) The next scheduled payment will be an adjustment to the Primary Settlement, if required, and will be paid on the same day that the 334-day FSR Report is submitted to HHSC if the adjustment is a payment from the MCO to HHSC. **Section 10.08(f)**, (Experience Rebate) describes the interest expenses associated with any payment after the Primary Settlement.

An MCO may make non-scheduled payments at any time to reduce the accumulation of interest under **Section 10.08(f)**, (Experience Rebate). For any nonscheduled payments prior to the 334-day FSR, the MCO is not required to submit 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 10.08(f)** (Experience Rebate).

(4) In the event that any Experience Rebates or corresponding interest payments owed to HHSC are not paid by the required due dates, then HHSC may offset these amounts from any future Capitation Payments, or collect these sums directly from the MCO. HHSC may adjust the Experience Rebate if HHSC determines the MCO has paid amounts for goods or services that are not reasonable, necessary, allocable, or allowable in accordance with **UMCM Chapter 6.1**, "Cost Principles for Expenses," and **Chapter 5.3**, "Financial Reports/Formats," and the Federal Acquisition Regulations (FAR), or other applicable federal or state regulations. HHSC has final authority in auditing and determining the amount of the Experience Rebate.

(f) Interest on Experience Rebate.

(1) Interest on *any* Experience Rebate owed to HHSC will be charged beginning 35 days after the due date of the Primary Settlement, as described in **Section 10.08(e)(1)**, (Experience Rebate). Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at 35 days after the due date for the 90-day FSR Report. For example, any Experience Rebate payment(s) made in conjunction with the 334-day FSR, or as a result of audit findings, will accrue interest back to 35 days after the due-date for submission of the 90-day FSR.

The MCO has the option of preparing an additional FSR based on 120 days of claims 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 under **Section 10.08** that are not timely paid will be subject to accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

(4) All interest assessed under **Section 10.08** (Experience Rebate) will continue to accrue until such point as a payment is received by HHSC, at which point interest on the amount received will stop accruing. If a balance remains at that point that is subject to interest, then the balance will continue to accrue interest. If interim payments are made, then any interest that may be due will only be charged on amounts for the time period during which they remained unpaid. By way of example only, if \$100,000 is subject to interest commencing on a given day, and a payment is received for \$75,000 27 days after the start of interest, then the \$75,000 will be subject to 27 days of interest, and the \$25,000 balance, along with any unpaid interest, will continue to accrue interest until paid. The accrual of interest as defined under **Section 10.08(f)** (Experience Rebate) will not stop during any period of dispute. If a dispute is resolved in the MCO's favor, then interest will only be assessed on the revised unpaid amount.

(5) If the MCO incurs an interest obligation under **Section 10.08** (Experience Rebate) for an Experience Rebate payment, HHSC will assess that interest at 12% per annum, compounded daily. If the interest rate stipulated in this Section is found by a court of competent jurisdiction to be outside the legal and enforceable range, then the rate in this Section will be adjusted to the maximum allowable rate the court of competent jurisdiction finds legal and enforceable.

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

(g) In the event that the MCO achieves a net profit in Rate Period 1 or any subsequent Rate Period, the Parties agree to enter into good faith negotiations to develop reasonable financial incentives for the MCO's Providers for the following Rate Period.

### **Section 10.08.1 Administrative Expense Cap**

#### (a) General requirement.

The calculation methodology of Experience Rebates described in **Section 10.08** (Experience Rebate) will be adjusted by an Administrative Expense Cap (Admin Cap). The Admin Cap is a calculated maximum amount of administrative expense dollars that can be deducted from Revenues for purposes of determining income subject to the Experience Rebate. While Administrative Expenses may be limited by the Admin Cap to determine Experience Rebates, all valid Allowable Expenses will continue to be reported on the Financial Statistical Reports (FSRs). Thus, the Admin Cap does not impact FSR reporting, but may impact any associated Experience Rebate calculation.

The calculation of any Experience Rebate due under this Contract will be subject to limitations on total deductible administrative expenses.

The limitations will be calculated as follows:

#### (b) Calculation methodology.

HHSC will determine the administrative expense component of the applicable Capitation Rate structure for the MCO prior to each applicable Rate Period. At the conclusion of an FSR Reporting Period, HHSC will apply that predetermined administrative expense component against the MCO's actually incurred number of Member Months and aggregate premiums received (monthly Capitation Payments plus any Delivery Supplemental Payments, which excludes any investment income or interest earned), to determine the specific Admin Cap, in aggregate dollars, for a given MCO.

If rates are changed during the FSR Reporting Period, this same methodology of multiplying the predetermined HHSC rates for a given month against the ultimate actual number of member months or revenues that occurred during that month will be utilized, such that each month's actual results will be applied against the rates that were in effect for that month.

#### (c) Data sources.

In determining the amount of Experience Rebate payment to include in the Primary Settlement (or in conjunction with any subsequent payment or settlement), the MCO will need to make the appropriate calculation, in order to assess the impact, if any, of the Admin Cap.

1. The total premiums paid by HHSC (received by the MCO), and corresponding Member Months, will be taken from the relevant

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FSR (or audit report) for the FSR Reporting Period.

2. There are three components of the administrative expense portion of the Capitation Rate structure:

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

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

(iii) the portion incorporated into the pharmacy (prescription expense) rate that pertains to prescription administrative expenses.

These will be taken from the supporting details associated with the official notification of final Capitation Rates, as supplied by HHSC. This notification is sent to the MCOs during the annual rate setting process via e-mail, labeled as “the final rate exhibits for your health plan.” The e-mail has one or more spreadsheet files attached, which are particular to the given MCO. The spreadsheet(s) show the fixed amount and percentage of premium components for the administrative component of the Capitation Rate.

The components of the administrative expense portion of the Capitation Rate can also be found on HHSC’s Medicaid website, under “Rate Analysis for Managed Care Services.” Under each Program, there is a separate Rate-Setting document for each Rate Period that describes the development of the Capitation Rates. Within each document, there is a section entitled “Administrative Fees,” where it refers to “the amount allocated for administrative expenses.”

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

(d) Example of Calculation.

By way of example only, HHSC will calculate the Admin Cap as follows:

1. Multiply the predetermined administrative expense rate structure “fixed amount,” or dollar rate per Member Month (for example, \$8.00), by the actual number of Member Months for the Program during the FSR Reporting Period (for example, 70,000):

$$\bullet \$8.00 \times 70,000 = \$560,000.$$

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).

$$\bullet 5.75\% \times \$6,000,000 = \$345,000.$$

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):

$$\$1.80 \times 70,000 = \$126,000.$$

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:

$$\bullet (\$560,000 + \$345,000 + \$126,000) + \$112,000 = \$1,143,000.$$

In this example, \$1,143,000 would be the MCO’s Admin Cap for a single Program, for the FSR Reporting Period.

(e) Consolidation and offsets.

The Admin Cap will be first calculated individually by Program, and then totaled and applied on a Consolidated Basis. There will be one aggregate amount of dollars determined as the Admin Cap for each MCO, which will cover all of an MCO’s and its Affiliates’ Programs and Service Areas, excluding the Dual Demonstration. (The Dual Demonstration will have its own separate Admin Cap calculated.) This consolidated Admin Cap will be applied to the administrative expenses of the MCO on a Consolidated Basis. The net impact of the Admin Cap will be applied to the Experience Rebate calculation. Calculation details are provided in the applicable FSR Templates and FSR Instructions in the UMCM.

(f) Impact on Loss carry-forward.

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

(g) Unforeseen events.

If, in HHSC’s sole discretion, it determines that unforeseen events have created significant hardships

for one or more MCOs, HHSC may revise or temporarily suspend the Admin Cap as necessary.

**Section 10.09 Payment by Members.**

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

- (1) inform Members of costs for non-covered services prior to rendering the services; and
- (2) obtain a signed Private Pay form from Members prior to rendering the services.

**Section 10.09.1 Reinsurance Cap**

Reinsurance is reported on HHSC's FSR report format as: 1) gross reinsurance premiums paid, and 2) reinsurance recoveries received. The premiums paid are treated as a part of medical expenses, and the recoveries received are treated as an offset to those medical expenses (also known as a contra-cost). The net of the gross premiums paid minus the recoveries received is called the net reinsurance cost. The net reinsurance cost, as measured in aggregate dollars over the FSR Reporting Period, divided by the number of member-months for that same period, is referred to as the net reinsurance cost per-member-per-month (PMPM).

The MCO will be limited to a maximum amount of net reinsurance cost PMPM for purposes of calculating the pre-tax net income that is subject to the Experience Rebate. This limitation does not impact an MCO's ability to purchase or arrange for reinsurance. It only impacts what is factored into the Experience Rebate calculation. The maximum amount of allowed net reinsurance cost PMPM (Reinsurance Cap) varies by MCO Program and is equal to 110% of the net reinsurance cost PMPM contained in the Capitation Rates for the Program during the FSR Reporting Period.

Regardless of the maximum amounts as represented by the Reinsurance Cap, all reinsurance reported on the FSR is subject to audit, and must comply with **UMCM Chapter 6.1**, "Cost Principles for Expenses."

**Section 10.10 Restriction on assignment of fees.**

During the term of the Contract, MCO may not, directly or indirectly, assign to any third party any beneficial or legal interest of the MCO in or to any payments to be made by HHSC under this Contract. This restriction does not apply to fees paid to Subcontractors.

**Section 10.11 Liability for taxes.**

HHSC is not responsible in any way for the payment of any federal, state, or local taxes related to or incurred in connection with the MCO's performance of this Contract. MCO must pay and discharge any taxes, including any penalties and interest. In addition, HHSC is exempt from federal excise taxes and will not pay any personal property taxes or income taxes levied on MCO or any taxes levied on employee wages.

**Section 10.12 Liability for employment-related charges and benefits.**

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

**Section 10.13 No additional consideration.**

(a) MCO is not entitled to nor will receive from HHSC any additional consideration, compensation, salary, wages, charges, fees, costs, or any other type of remuneration for Services and Deliverables provided under the Contract, except by properly authorized and executed Contract amendments.

(b) No other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other state agency, nor will the failure of HHSC or any other party to pay for these incidental or ancillary services entitle the MCO to withhold Services and Deliverables due under the Agreement.

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

**Section 10.14 Federal Disallowance**

If the federal government recoups money from the state for unallowable expenses or costs, the state has the right to recoup payments made to the MCO in turn for these same expenses or costs. HHSC is allowed to recoup payments from the MCO even if the expenses or costs had not been previously disallowed by the state and were incurred by the MCO. Any of the same future expenses or costs would then be unallowable by the state. If the state retroactively recoups money from the MCO due to a federal disallowance, the state will recoup the entire amount paid to the MCO for the federally disallowed expenses or costs, not just the federal portion.

**Section 10.15 Pass-through Payments for Provider Rate Increases**

The capitation rates do not include the costs of federally-mandated provider rate increases, per PPACA as amended by Section 1202 of the Health Care and Education Reconciliation Act. HHSC will make supplemental payments to the MCO for these rate increases, and the MCO will pass through the full amount of the supplemental payments to qualified providers no later than 30 calendar days after receipt of HHSC's supplemental payment report, contingent upon the receipt of HHSC's payment allocation. Additional information regarding these requirements is located in **Section 8.1.4.9.2**, "Supplemental Payments for Qualified Providers."

**Section 10.16 Non-risk Payments for Certain Drugs**

The capitation rates do not include the costs of certain drugs as identified in UMCM Chapter 2.2, "Covered Drugs Under Non-Risk Payment." For providing these drugs to Members, HHSC will make non-risk payments to the MCO based on pharmacy encounter data received by HHSC's Administrative Services Contractor during an encounter reporting period. The first non-risk payment will cover pharmacy encounter data received from the date the drugs are added to the Medicaid formulary through the end of that State Fiscal Quarter. Thereafter, non-risk payments will cover quarterly encounter reporting periods. HHSC will make non-risk payments within a reasonable amount of time after the encounter reporting period, 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. 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.

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

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

Beginning in calendar year 2014, the PPACA requires the MCO to pay the HIP Fee no later than September 30th (as applicable to each relevant year,

the "HIP Fee Year") with respect to premiums paid to the MCO in the preceding calendar year (as applicable to each relevant year, the "HIP Data Year"), and continuing similarly in each successive year. In order to satisfy the requirement for actuarial soundness set forth in 42 C.F.R. § 438.6(c) 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;

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

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

This provision will survive the termination of the Agreement.

***Section 10.18 Supplemental Payments for Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products***

Section 10.18 added by Version 2.3

The capitation rates do not include the costs of Medicaid wrap-around services for outpatient drugs and biological products for STAR Health Members, as described in Attachment B-1, Section 8.1.43. HHSC will make supplemental payments to the MCO for these Medicaid wrap-around services, based on encounter data received by HHSC's Administrative Services Contractor during an encounter reporting period. Supplemental payments will cover six-month encounter reporting periods. HHSC will make supplemental payments within a reasonable amount of time after the encounter reporting period, generally no later than 95 calendar days after HHSC's Administrative Services Contractor has processed the encounter data. Supplemental payments will be limited to the actual amounts paid to pharmacy providers for these Medicaid wrap-around services, as represented in "Net Amount Due" field (Field 281) on the National Council for Prescription Drug Programs (NCPDP) encounter transaction. To be eligible for reimbursement, encounters must contain a Financial Arrangement Code "14" in the "Line of Business" field (Field 270) on the NCPDP encounter transaction.

**Article 11. Disclosure and Confidentiality of Information**

***Section 11.01 Confidentiality***

Section 11.01 modified by Version 2.1

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

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

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

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

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

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

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

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

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

(5) Lawfully released without restriction to anyone.

**Section 11.02 Disclosure of HHSC's Confidential Information.**

(a) MCO will immediately 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. 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 7.06** (HIPAA), regarding the transfer of Member Records.

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

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

**Section 11.04 Requests for public information.**

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

commercial interest. HHSC will deliver a copy of the request for public information to MCO.

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

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

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

**Section 11.05 Privileged Work Product.**

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

(b) HHSC will notify MCO of any privileged work product to which MCO has or may have access. After the MCO is notified or otherwise becomes aware that these documents, data, databases, or communications are privileged work product, only MCO personnel, for whom access is necessary for the purposes of providing the Services, may have access to privileged work product.

(c) If MCO receives notice of any judicial or other proceeding seeking to obtain access to HHSC's privileged work product, MCO will:

- (1) Immediately notify HHSC; and
- (2) Use all reasonable efforts to resist providing access.

(d) If MCO resists disclosure of HHSC's privileged work product in accordance with this Section, HHSC will, to the extent authorized under Civil Practices and Remedies Code or other applicable state law, have the right and duty to:

- (1) represent MCO in the resistance; or
- (2) to retain counsel to represent MCO.

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

**Section 11.06 Unauthorized acts.**

Each Party agrees to:

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

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

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

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

**Section 11.07 Legal action.**

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

**Section 11.08 Information Security**

The MCO and all Subcontractors, consultants, or agents must comply with all applicable laws, rules, and regulations regarding information security, including the following:

(1) [Health and Human Services Enterprise Information Security Standards and Guidelines](#);

(2) Title 1, Sections 202.1 and 202.3 through 202.28, Texas Administrative Code;

(3) The Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

(4) The Health Information Technology for Economic and Clinical Health Act (HITECH Act).

**Section 11.09 MCO's Breach Notice, Reporting and Correction Requirements**

**Section 11.09.1 Notification to HHSC.**

- (A) MCO will cooperate fully with HHSC in investigating, mitigating to the extent practicable and issuing notifications directed by HHSC, for any unauthorized disclosure or suspected disclosure of Confidential Information to the extent and in the manner determined by HHSC.
- (B) MCO's obligation begins at discovery of unauthorized disclosure or suspected disclosure and continues as long as related activity continues, until all effects of the incident are mitigated to HHSC's satisfaction (the "incident response period").
- (C) MCO will require that its subcontractors and providers comply with all of the following breach notice requirements.
- (D) Breach Notice:
  - 1. Initial Notice.
    - a. For federal information, including without limitation, Federal Tax Information, Social Security Administration Data, and Medicaid Member Information, within the first, consecutive clock hour of discovery, and for all other types of Confidential Information not more than 24 hours after discovery, **or in a timeframe otherwise approved by HHSC in writing**, initially report to HHSC's Privacy and Security Officers via email at: [privacy@HHSCC.state.tx.us](mailto:privacy@HHSCC.state.tx.us) and to the HHSC division responsible for this UMCC;
    - b. Report all information reasonably available to MCO about the privacy or security incident; and
    - c. Name, and provide contact information to HHSC for, MCO's single point of contact who will communicate with

Sections  
11.09,  
11.09.1,  
11.09.2, and  
11.09.3  
added by  
Version 2.3

- HHSC both on and off business hours during the incident response period.
2. 48-Hour Formal Notice. No later than 48 consecutive clock hours after discovery, or a time within which discovery reasonably should have been made by MCO, provide formal notification to HHSC, including all reasonably available information about the incident or breach, and MCO's investigation, including without limitation and to the extent available:
    - a. The date the incident or breach occurred;
    - b. The date of MCO's and, if applicable, subcontractor's discovery;
    - c. A brief description of the incident or breach; including how it occurred and who is responsible (or hypotheses, if not yet determined);
    - d. A brief description of MCO's investigation and the status of the investigation;
    - e. A description of the types and amount of Confidential Information involved;
    - f. Identification of and number of all individuals reasonably believed to be affected, including first and last name of the individual and if applicable the, legally authorized representative, last known address, age, telephone number, and email address if it is a preferred contact method, to the extent known or can be reasonably determined by MCO at that time;
    - g. MCO's initial risk assessment of the incident or breach demonstrating whether individual or other notices are required by applicable law or this DUA for HHSC approval, including an analysis of whether there is a low probability of compromise of the Confidential Information or whether any legal exceptions to notification apply;
    - h. MCO's recommendation for HHSC's approval as to the steps individuals and/or MCO on behalf of Individuals, should take to protect the Individuals from potential harm, including without limitation MCO's provision of notifications, credit protection, claims monitoring, and any specific protections for a legally authorized representative to take on behalf of an Individual with special capacity or circumstances;
  - i. The steps MCO has taken to mitigate the harm or potential harm caused (including without limitation the provision of sufficient resources to mitigate);
  - j. The steps MCO has taken, or will take, to prevent or reduce the likelihood of recurrence;
  - k. Identify, describe or estimate of the persons, workforce, subcontractor, or individuals and any law enforcement that may be involved in the incident or breach;
  - l. A reasonable schedule for MCO to provide regular updates to the foregoing in the future for response to the incident or breach, but no less than every three (3) business days or as otherwise directed by HHSC, including information about risk estimations, reporting, notification, if any, mitigation, corrective action, root cause analysis and when such activities are expected to be completed; and
- Any reasonably available, pertinent information, documents or reports related to an incident or breach that HHSC requests following discovery.
- Section 11.09.2 Investigation, Response and Mitigation.**
- (A) MCO will immediately conduct a full and complete investigation, respond to the incident or breach, commit necessary and appropriate staff and resources to expeditiously respond, and report as required to and by HHSC for incident response purposes and for purposes of HHSC's compliance with report and notification requirements, to the satisfaction of HHSC.
  - (B) MCO will complete or participate in a risk assessment as directed by HHSC following an incident or breach, and provide the final assessment, corrective actions and mitigations to HHSC for review and approval.
  - (C) MCO will fully cooperate with HHSC to respond to inquiries and/or proceedings by state and federal authorities, persons and/or incident about the incident or breach.
  - (D) MCO will fully cooperate with HHSC's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such incident or breach, or to recover or protect any Confidential Information,

including complying with reasonable corrective action or measures, as specified by HHSC in a Corrective Action Plan if directed by HHSC under the UCCM.

**Section 11.09.3 Breach Notification to Individuals and Reporting to Authorities.**

- (A) HHSC may direct MCO to provide breach notification to individuals, regulators or third-parties, as specified by HHSC following a breach.
- (B) MCO must obtain HHSC's prior written approval of the time, manner and content of any notification to individuals, regulators or third-parties, or any notice required by other state or federal authorities. Notice letters will be in MCO's name and on MCO's letterhead, unless otherwise directed by HHSC, and will contain contact information, including the name and title of MCO's representative, an email address and a toll-free telephone number, for the Individual to obtain additional information.
- (C) MCO will provide HHSC with copies of distributed and approved communications.
- (D) MCO will have the burden of demonstrating to the satisfaction of HHSC that any notification required by HHSC was timely made. If there are delays outside of MCO's control, MCO will provide written documentation of the reasons for the delay.

If HHSC delegates notice requirements to MCO, HHSC shall, in the time and manner reasonably requested by MCO, cooperate and assist with MCO's information requests in order to make such notifications and reports.

**Article 12. Remedies and 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 stated 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 or requirement. Any responsibilities or requirements not fulfilled may be subject to remedies stated in this 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 this 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 Covered Services.

(2) MCO will, within five 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:

(A) 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

(B) If MCO disagrees with HHSC's findings, its reasons for disagreeing with HHSC's findings.

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

(c) Corrective Action Plan.

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

(2) The Corrective Action Plan must provide:

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

(B) MCO's assessment or diagnosis of the cause; and

(C) 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:

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

(B) Disapprove portions of MCO's proposed Corrective Action Plan; or

(C) 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:

(A) Excuse MCO's prior substandard performance;

(B) Relieve MCO of its duty to comply with performance standards; or

(C) 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:

(A) Assess liquidated damages in accordance with **Attachment B-3**, Managed Care Contract document, "Deliverables/Liquidated Damages Matrix;"

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

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

(D) Decline to renew or extend the Contract;

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

(F) Initiate disenrollment of a Member or Members;

(G) Suspend enrollment of Members;

(H) Withhold payment to or recoup payment from MCO;

(I) Require forfeiture of all or part of the MCO's bond; or

(J) 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:

(A) Violates a material provision of the Contract;

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

(C) Represents a failure of MCO to be reasonably responsive to a reasonable request of HHSC relating to the Services or Deliverable 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 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 or to meet specific performance standards stated 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 or to meet the specific performance standards identified by HHSC in **Attachment B-3**, Managed Care Contract document, "Deliverables/Liquidated Damages Matrix." Liquidated damages will be assessed if HHSC reasonably determines any failure is the fault of the MCO (including the MCO's Subcontractors or consultants), and will not be assessed if HHSC determines the failure is 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 or the specific performance standards due to mitigating circumstances, HHSC reserves the right to waive all

or part of the liquidated damages. All 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:

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

(B) 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 this Contract, HHSC may be irreparably harmed. Under these circumstances, 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 material 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:

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

(B) HHSC has reason to believe that MCO has committed, or assisted in the commission by any party of, Fraud, Abuse,

Waste, malfeasance, misfeasance, or nonfeasance concerning the Contract;

(C) HHSC determines that the MCO knew, or should have known, of Fraud, Abuse, Waste, malfeasance, or nonfeasance by any party concerning the Contract, and the MCO failed to take appropriate action; or

(D) 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. Notice under this Section will:

(A) Be delivered in writing to MCO;

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

(C) 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.**

This Contract will terminate upon the Expiration Date. In addition, prior to completion of the Contract Term, all or a part of this 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 this Contract, in whole or in part, upon the following conditions:

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

HHSC may terminate this Contract at any time if MCO:

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

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

(C) 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 this 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 the violation prevents or substantially impairs performance of MCO's duties under this Contract. HHSC will provide at least 30 days' advance written notice of termination under this subsection.

(3) *Breach of confidentiality.*

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

(4) *Failure to maintain adequate personnel or resources.*

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

(5) *Termination for gifts and gratuities.*

(A) HHSC may terminate this 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.

(B) MCO must include a similar provision in each of its Subcontracts and must 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 MCO's behalf.

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

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

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

(D) 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 or federal law.

(6) *Termination for non-appropriation of funds.*

Notwithstanding any other provision of this Contract, if funds for the continued fulfillment of this 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 this 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 termination under this subsection. HHSC will use reasonable efforts to ensure appropriated funds are available.

(7) *Judgment and execution.*

(A) 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:

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

(2) Procure a stay of execution of the judgment within 30 days from the date of entry; or

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

(B) 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 the 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 subsection.

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

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

(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, abuse, or exploitation of patients 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.

**Section 12.04 Termination by MCO.**

## (a) Failure to pay.

MCO may terminate this Contract if HHSC fails to pay the MCO undisputed charges when due as required under this Contract. Retaining premium, recoupment, sanctions, or penalties that are allowed under this Contract or that result from the MCO's failure to perform or the MCO's default under the terms of this 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(d)** (Termination by MCO). 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 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) Notice of intent to terminate.

In order to terminate the Contract under this Section, MCO must give HHSC at least 90 days' written notice of intent to terminate. 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 is received by HHSC.

**Section 12.05 Termination by mutual agreement.**

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

**Section 12.06 Effective date of termination.**

Except as otherwise provided in this Contract, termination will be effective as of the date specified in the notice of 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 under 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 this 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 this 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** (Amendments and Modifications). MCO must negotiate these proposed modifications in good faith.

**Section 12.10 Turnover assistance.**

Upon receipt of notice of termination of the Contract by HHSC, 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.

**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 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 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 this Contract. The Parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b) Duty to negotiate in good faith.

Any dispute that in the judgment of any Party to this 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 the dispute and the Parties must 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 must 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 this 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 this 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 Tex. Gov't Code Chapter 2260, Subchapter B.

(A) To initiate the process, MCO must submit written notice to HHSC that specifically states that MCO invokes the provisions of Tex. Gov't Code Chapter 2260, Subchapter B. The notice must comply with the requirements of 1 Tex. Admin. Code Chapter 392, Subchapter B.

(B) The Parties expressly agree that the MCO's compliance with Tex. Gov't Code Chapter 2260, Subchapter B, will be a condition precedent to the filing of a contested case proceeding under Tex. Gov't Code Chapter 2260, Subchapter C.

(3) *Contested case proceedings.* The contested case process provided in Tex. Gov't Code Chapter 2260, Subchapter C, 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 Tex. Gov't Code Chapter 2260, Subchapter C, will be a condition precedent to seeking consent to sue from the Texas Legislature under Tex. Civ. Prac. & Rem. Code Chapter 107. Neither the execution of this Contract by HHSC nor any other conduct of any representative of HHSC relating to this Contract will be considered a waiver of HHSC's sovereign immunity to suit.

(4) *HHSC's rules.* The submission, processing, and resolution of MCO's claim is governed by the rules adopted by HHSC under Tex. Gov't Code Chapter 2260 found at 1 Tex. Admin. Code Chapter 392, Subchapter B.

(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 this Contract. Any changes to the Contract as a result of a dispute resolution will be implemented in accordance with **Article 8** (Amendments and Modifications).

**Section 12.14 Liability of MCO.**

(a) MCO bears all risk of loss or damage to HHSC or the State of Texas 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 this Contract.

**Section 12.15 Pre-termination Process**

The following process will apply when HHSC terminates the Agreement for any reason set forth in **Section 12.03(b)**, (Termination for cause), other than Subpart 6, "Termination for Non-appropriation of Funds." HHSC will provide the MCO with reasonable advance written notice of the proposed termination, as it deems appropriate under the circumstances. The notice will include the reason for the proposed termination, the proposed effective date of the termination, and the time and place where the parties will meet regarding the proposed termination. During this meeting, the MCO may present written information explaining why HHSC should not affirm the proposed termination. HHSC's Associate Commissioner for Medicaid and CHIP will consider the written information, if any, and will provide the MCO with a written notice of HHSC's final decision affirming or reversing the termination. An affirming decision will include the effective date of termination.

The pre-termination process described in this Section will not limit or otherwise reduce the parties'

rights and responsibilities under **Section 12.13**, (Dispute Resolution); however, HHSC's final decision to terminate is binding and is not subject to review by the State Office of Administrative Hearings under Tex. Gov't Code Chapter 2260.

**Article 13. Assurances and Certifications**

**Section 13.01 Proposal certifications.**

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

**Section 13.02 Conflicts of interest.**

(a) Representation.

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

(b) General duty regarding conflicts of interest.

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

**Section 13.03 Organizational conflicts of interest.**

(a) Definition.

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

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

Except as otherwise disclosed and approved by HHSC prior to the Effective Date of the Contract, MCO warrants that, as of the Effective Date and to

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

(c) Continuing duty to disclose.

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

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

(d) Remedy.

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

(e) Flow-down obligation.

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

**Section 13.04 HHSC personnel recruitment prohibition.**

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

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

**Section 13.05 Anti-kickback provisions.**

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

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

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

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

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

**Section 13.08 Outstanding debts and judgments.**

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

**Article 14. Representations and Warranties**

**Section 14.01 Authorization.**

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

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

**Section 14.02 Ability to perform.**

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

**Section 14.03 Minimum Net Worth.**

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

**Section 14.04 Insurer solvency.**

(a) The MCO must be and remain in full compliance with all applicable state and federal solvency requirements for basic-service health maintenance organizations, including all reserve requirements, net worth standards, debt-to-equity ratios, or other debt limitations. 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 healthcare 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 under this Contract.

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

**Section 14.06 Warranty of deliverables.**

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

**Section 14.07 Compliance with Contract.**

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

**Section 14.08 Technology Access.**

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

**Section 14.09 Electronic and Information Resources Accessibility Standards.**

(a) Applicability.

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

(b) Definitions.

For purposes of this Section:

"Accessibility Standards" means the Electronic and Information Resources Accessibility Standards and the Web Site Accessibility Standards/Specifications.

"Electronic and Information Resources" means information resources, including information resources technologies, and any equipment or interconnected system of equipment that is used in the creation, conversion, duplication, or delivery of data or information. The term includes telephones and other telecommunications products, information kiosks, transaction machines, Internet websites, multimedia resources, and office equipment, including copy machines and fax machines.

"Electronic and Information Resources Accessibility Standards" means the accessibility standards for electronic and information resources contained in Volume 1 Tex.Admin. Code Chapter 213.

"Web Site Accessibility Standards/Specifications" means standards contained in Volume 1 Tex. Admin. Code Chapter 206.

"Product" means information resources technology that is, or is related to, EIR.

(c) Accessibility Requirements.

Under Tex. Gov't Code Chapter 2054, Subchapter M, and implementing rules of the Texas Department of Information Resources, HHSC must procure Products that comply with the Accessibility Standards when those Products are available in the commercial marketplace or when those Products are developed in response to a procurement solicitation.

Accordingly, MCO must provide electronic and information resources and associated Product documentation and technical support that comply with the Accessibility Standards.

(d) Evaluation, Testing, and Monitoring.

(1) HHSC may review, test, evaluate and monitor MCO's Products and associated documentation and technical support for compliance with the Accessibility Standards. Review, testing, evaluation and monitoring may be conducted before and after the award of a contract. Testing and monitoring may include user acceptance testing.

Neither (1) the review, testing (including acceptance testing), evaluation or monitoring of any Product, nor (2) the absence of review, testing, evaluation or monitoring, will result in a waiver of the State's right to contest the MCO's assertion of compliance with the Accessibility Standards.

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

(e) Representations and Warranties.

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

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

(3) MCO acknowledges and agrees that these representations and warranties are

essential inducements on which HHSC relies in awarding this Contract.

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

(f) Remedies.

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

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

**Article 15. Intellectual Property**

**Section 15.01 Infringement and misappropriation.**

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

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

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

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

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

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

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

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

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

(b) Deliverables.

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

(c) Ownership rights.

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

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

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

(d) License Rights

HHSC will have a royalty-free and non-exclusive license to access the MCO Proprietary Software and associated documentation during the term of the Contract. HHSC will also have ownership and unlimited rights to use, disclose, duplicate, or publish all information and data developed, derived, documented, or furnished by MCO under or resulting from the Contract. The data will include all results, technical information, and materials developed for or obtained by HHSC from MCO in the performance of the Services under this Contract, including all reports, surveys, plans, charts, recordings (video or sound), pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda, and documents whether finished or unfinished, which

result from or are prepared in connection with the Services performed as a result of the Contract.

(e) Proprietary Notices

MCO will reproduce and include HHSC's copyright and other proprietary notices and product identifications provided by MCO on the copies, in whole or in part, or on any form of the Deliverables.

(f) State and Federal Governments

In accordance with 45 C.F.R. § 95.617, all appropriate state and federal agencies will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use, for federal government purposes, all materials, the Custom Software and modifications of it, and associated documentation designed, developed, or installed with federal financial participation under the Contract, including those materials covered by copyright and all software source and object code, instructions, files, and documentation.

## **Article 16. Liability**

### **Section 16.01 Property damage.**

(a) MCO will protect HHSC's real and personal property from damage arising from MCO's, its agent's, employees' and Subcontractors' performance of the Contract, and MCO will be responsible for any loss, destruction, or damage to HHSC's property that results from or is caused by MCO's, its agents', employees' or Subcontractors' negligent or wrongful acts or omissions. Upon the loss of, destruction of, or damage to any property of HHSC, MCO will notify the HHSC Project Manager and, subject to direction from the Project Manager or her or his designee, will take all reasonable steps to protect that property from further damage.

(b) MCO agrees to observe and encourage its employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

(c) MCO will distribute a policy statement to all of its employees and agents that directs the employee or agent to promptly report to HHSC or to MCO any special defect or unsafe condition encountered while on HHSC premises. MCO will promptly report to HHSC any special defect or an unsafe condition it encounters or otherwise learns about.

### **Section 16.02 Risk of Loss.**

During the period Deliverables are in transit and in possession of MCO, its carriers, or HHSC prior to being accepted by HHSC, MCO will bear the risk of loss or damage, unless the loss or damage is caused by the negligence or intentional misconduct of HHSC.

After HHSC accepts a Deliverable, HHSC will bear the risk of loss or damage to the Deliverable, except loss or damage attributable to the negligence or intentional misconduct of MCO's agents, employees, or Subcontractors.

**Section 16.03 Limitation of HHSC's Liability.**

HHSC WILL NOT BE LIABLE FOR ANY INCIDENTAL, INDIRECT, SPECIAL, OR CONSEQUENTIAL DAMAGES UNDER CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHER LEGAL THEORY. THIS WILL APPLY REGARDLESS OF THE CAUSE OF ACTION AND EVEN IF HHSC HAS BEEN ADVISED OF THE POSSIBILITY OF THESE DAMAGES.

HHSC'S LIABILITY TO MCO UNDER THE CONTRACT WILL NOT EXCEED THE TOTAL CHARGES TO BE PAID BY HHSC TO MCO UNDER THE CONTRACT, INCLUDING CHANGE ORDER PRICES AGREED TO BY THE PARTIES OR OTHERWISE ADJUDICATED.

MCO's remedies are governed by the provisions in **Article 12** (Remedies and Disputes).

**Article 17. Insurance and Bonding**

**Section 17.01 Insurance Coverage.**

(a) Statutory and General Coverage

MCO will maintain, at the MCO's expense, the following insurance coverage

(1) Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles for bodily injury and property damage;

(2) Comprehensive General Liability Insurance of at least \$1,000,000.00 per occurrence and \$5,000,000.00 in the aggregate (including Bodily Injury coverage of \$100,000.00 per each occurrence and Property Damage Coverage of \$25,000.00 per occurrence); and

(3) If MCO's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, MCO will obtain Umbrella liability insurance to compensate for the difference in the coverage amounts. If Umbrella Liability Insurance is provided, it must follow the form of the primary coverage.

(b) Professional Liability Coverage.

(1) MCO must maintain, or cause its Network Providers to maintain, Professional Liability Insurance for each Network Provider of \$100,000.00 per occurrence and \$300,000.00 in the aggregate, or the limits required by the hospital at which the Network Provider has admitting privileges.

(2) MCO must maintain an Excess Professional Liability (Errors and Omissions) Insurance Policy for the greater of \$3,000,000.00 or an amount (rounded to the nearest \$100,000.00) that represents the number of Members enrolled in the MCO in the first month of the applicable State Fiscal Year multiplied by \$150.00, not to exceed \$10,000,000.00.

(c) General Requirements for All Insurance Coverage

(1) Except as provided in this subsection, all exceptions to the Contract's insurance requirements must be approved in writing by HHSC. HHSC's written approval is not required in the following situations:

(A) An MCO or a Network Provider is not required to obtain the insurance coverage described in **Section 17.01** if the MCO or Network Provider qualifies as a state governmental unit or municipality under the Texas Tort Claims Act, and is required to comply with, and subject to the provisions of, the Texas Tort Claims Act.

(B) An MCO may waive the Professional Liability Insurance requirement described in Section 17.01(b)(1) for a Network Provider of Community-based Long Term Care Services. An MCO may not waive this requirement if the Network Provider provides other Covered Services in addition to Community-based Long Term Care Services, or if a Texas licensing entity requires the Network Provider to carry Professional Liability coverage. An MCO that waives the Professional Liability Insurance requirement for a Network Provider under this provision is not required to obtain coverage on behalf of the Network Provider.

(C) An MCO may waive the Professional Liability Insurance requirement described in 17.01(b)(1) for Network Providers of durable medical equipment. An MCO that waives the Professional Liability Insurance requirement for a Network Provider pursuant to this provision is not required to obtain such coverage on behalf of the Network Provider.

(2) The MCO or the Network Provider is responsible for any deductibles stated in the insurance policies.

(3) Insurance coverage must be issued by insurance companies authorized to conduct business in the State of Texas.

(4) With the exception of Professional Liability Insurance maintained by Network Providers, all insurance coverage must name HHSC as an

additional insured. In addition, the Professional Liability Insurance maintained by Network Providers and Business Automobile Liability Insurance must name HHSC as a loss payee.

(5) Insurance coverage kept by the MCO must be maintained in full force at all times during the Term of the Contract, and until HHSC's final acceptance of all Services and Deliverables. Failure to maintain insurance coverage will constitute a material breach of this Contract.

(6) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must have extended reporting periods of two years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.

(7) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must provide that prior written notice be given to HHSC at least 30 calendar days before coverage is reduced below minimum HHSC contractual requirements, canceled, or non-renewed. The MCO must submit a new coverage binder to HHSC to ensure no break in coverage.

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

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

(10) If the MCO, or its Network Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, the MCO or its Network Providers will be responsible for the acquisition and cost of such additional protection. This additional protection will not be an Allowable Expense under this Contract.

(11) MCO will require all insurers to waive their rights of subrogation against HHSC for claims arising from or relating to this Contract.

(d) Proof of Insurance Coverage

(1) Except as provided in **Section 17.01(d)(2)**, the MCO must furnish the HHSC Project Manager original Certificates of Insurance evidencing the required insurance coverage on or before the Effective Date of the Contract. If insurance coverage is renewed during the Term of the Contract, the MCO must furnish the HHSC Project Manager renewal certificates of insurance, or such similar evidence, within five Business Days of renewal. The failure of

HHSC to obtain this evidence from the MCO will not be deemed to be a waiver by HHSC and the MCO will remain under continuing obligation to maintain and provide proof of insurance coverage.

(2) The MCO is not required to furnish the HHSC Project Manager proof of Professional Liability Insurance maintained by Network Providers on or before the Effective Date of the Contract, but must provide that information upon HHSC's request during the Term of the Contract.

**Section 17.02 Performance Bond.**

(a) Beginning on the Operational Start Date of the Contract, the MCO must obtain a performance bond with a one-year term. The performance bond must be renewable and renewal must occur no later than the first day of each subsequent State Fiscal Year. The performance bond must continue to be in effect for one year following the expiration of the final renewal period. MCO must obtain and maintain the annual performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, securing MCO's faithful performance of the terms of this Contract. The performance bond must comply with Tex. Ins. Code Chapter 843 and 28 Tex. Admin. Code § 11.1805. At least one performance bond must be issued. The amount of the performance bond(s) should total \$100,000.00 for the MCO Program covered under this Contract. Performance bonds must be issued by a surety licensed by TDI and specify cash payment as the sole remedy. MCO must deliver the initial performance bond to HHSC prior to the Operational Start Date of the Contract and each renewal prior to the first day of the State Fiscal Year.

(b) Prior performance bonds received for a specific SFY will be released upon completion of the audit of the 334-day FSR for the corresponding SFY.

**Section 17.03 TDI Fidelity Bond.**

The MCO will secure and maintain throughout the life of the Contract a fidelity bond in compliance with Tex. Ins. Code Chapter 843 and 28 Tex. Admin. Code § 11.1805. The MCO must promptly provide HHSC with copies of the bond and any amendments or renewals.

## DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	2.0	July 1, 2015	Initial version of Attachment B-1, RFP Sections 1 – 5, “Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria” that includes all modifications negotiated by the Parties.
Revision	2.1	September 1, 2015	Contract amendment did not revise Attachment B-1, Sections 1 – 5, “Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria.”
Revision	2.2	March 1, 2016	All references to “abuse and neglect” are changed to “Abuse, Neglect, and Exploitation.”
Revision	2.3	September 1, 2016	Section 1.8 is modified to remove the FFCHE program.
<p><sup>1</sup> Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions</p> <p><sup>2</sup> 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.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			

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## 1 GENERAL INFORMATION

### 1.1. Scope

The State of Texas, by and through the Health and Human Services Commission (HHSC), announces the release of request for proposal (RFP) # 529-15-0001 for STAR Health managed care services.

Public comments concerning the RFP are subject to public disclosure under the Public Information Act, Texas Government Code Chapter 552.

### 1.2. Point-of-Contact

The sole point-of-contact for inquiries concerning this RFP is the following.

Rick Blincoe, CTPM  
Procurement and Contract Services  
Health and Human Services Commission  
4405 N Lamar  
Austin, TX 78756  
Phone: (512) 206-5468  
[richard.blincoe@hhsc.state.tx.us](mailto:richard.blincoe@hhsc.state.tx.us)

Respondents must direct all communications relating to this RFP to the HHSC point-of-contact named above. All other communications between a Respondent and HHSC and the HHS agencies, their agents, employees, or contractors concerning this RFP are prohibited. In no instance is a Respondent to discuss cost information contained in a proposal with the HHSC point-of-contact or any other staff. Failure to comply with this requirement may result in HHSC's disqualification of the proposal.

Only the HHSC point-of-contact can clarify issues and render any opinion regarding this RFP. No other individual HHSC employee or state employee is empowered to make binding statements regarding this RFP. No statements, clarifications, or opinions regarding this RFP are valid or binding except those issued in writing by the HHSC point-of-contact and posted on HHSC's website at [http://www.hhsc.state.tx.us/about\\_hhsc/BusOpp/BO\\_opportunities.asp](http://www.hhsc.state.tx.us/about_hhsc/BusOpp/BO_opportunities.asp).

### 1.3. Procurement Schedule

The anticipated schedule for this procurement is as follows. HHSC reserves the right to revise this schedule. Any revisions will be posted on the HHSC website at [http://www.hhsc.state.tx.us/about\\_hhsc/BusOpp/BO\\_opportunities.asp](http://www.hhsc.state.tx.us/about_hhsc/BusOpp/BO_opportunities.asp).

Procurement Schedule	
Draft RFP Release Date	February 6, 2014
Draft RFP Respondent Comments Due	February 20, 2014
RFP Release Date	April 16, 2014
Vendor Conference	April 29, 2014 2:00 p.m. CDT
Respondent Questions Due	May 9, 2014
Letters Claiming Mandatory Contract Status Due	May 9, 2014
HHSC Posts Responses to Respondent Questions	May 16, 2014
Proposals Due	June 13, 2014
Deadline for Proposal Withdrawal	June 13, 2014
Respondent Demonstrations/Oral Presentations (HHSC option)	To be Announced
Tentative Award Announcement	To be Announced
Anticipated Contract Effective Date	March 1, 2015
Operational Start Date	September 1, 2015

#### 1.4. Purpose

The purpose of this procurement is to contract with one Managed Care Organization (MCO) to manage a statewide STAR Health Program.

#### 1.5. Mission Statement

HHSC's mission in this procurement is:

1. To ensure continuous delivery of integrated physical and Behavioral Health Services, centralize Service Coordination, and effectively manage healthcare data and information;
2. to ensure the STAR Health population is provided with a consistent source of healthcare through a Medical Home; and
3. to continue to improve health care outcomes for children in foster care through enhanced quality of services.

## 1.6. Mission Objectives

To accomplish HHSC's mission, HHSC will prioritize desired outcomes and benefits for the STAR Health population and will focus its monitoring efforts on the MCOs' ability to provide satisfactory results for these mission objectives.

### 1.6.1. Network Adequacy and Access to Care

HHSC intends that all Members have timely access to quality care through a Provider Network designed to meet the needs of the STAR Health population. The MCO will be accountable for creating and maintaining a Network capable of delivering all Covered Services to Members throughout the State of Texas. The MCO must provide Members with access to qualified Network Providers within the travel distance and waiting time for appointment standards defined in this RFP. Refer to **RFP Section 8.1.3.2**, "Access to Network Providers," for travel distance standards and **RFP Section 8.1.3.1**, "Waiting Times for Appointments," for waiting time standards. HHSC will especially focus on Members' access to dental and Behavioral Health Services.

### 1.6.2. Behavioral Health Services

The MCO must focus on access to, and delivery of, Behavioral Health Services. The MCO must provide Members with timely access to Medically Necessary Behavioral Health Services, such as mental health and substance abuse treatment and counseling, as well as timely and appropriate follow-up care. Contract requirements emphasize the importance of integration of care and formal, regular communication between Providers for Members who need assessment and evaluation for behavioral health concerns, or who are receiving both primary physical health and Behavioral Health Services. The Provider Network must include Providers experienced in treating victims of child Abuse, Neglect, and Exploitation, and Providers who specialize in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and other evidence-based treatments.

### 1.6.3. Service Management and Service Coordination

The MCO must ensure coordinated and integrated health care for Members through a Medical Home. Service Managers will assist Primary Care Providers (PCPs) in managing clinical services for Members with needs that require specialty care. The MCO will be responsive to inquiries and requests from the Department of Family and Protective Services (DFPS) Staff, Members, and Caregivers. The Service Coordinators will provide information to DFPS Staff, Members, and Caregivers, and assist these parties with accessing non-clinical services.

### 1.6.4. Medical Home

HHSC is committed to providing a consistent source of healthcare for the STAR Health population through a Medical Home. The MCO must develop and uphold the Medical Home model through the management and coordination of Healthcare Services.

### 1.6.5. Timeliness of Initial Texas Health Steps Visit

Except as provided below, the Network Providers must provide an initial Texas Health Steps medical checkup within 30 days of enrollment for all Members through the month of their 21st birthday. Network Providers must provide an initial Texas Health Steps dental checkup within 60 days of enrollment for Members who are between six months through 21 (until the end of the month of their 21st birthday). Network Providers must provide Members who are less than six months' old at the time of enrollment their initial Texas Health Steps dental checkup within 30 days of their turning six months' old.

### 1.6.6. Health Passport

The MCO must develop and maintain an electronic Health Passport for Members to ensure that health information provided to DFPS Staff, DFPS residential contractors, Single Source Continuum Contractor (SSCC) staff, the court system, Court Appointed Special Advocate (CASA) staff, Network Providers, Members, and Medical Consenters is timely, portable, and readily accessible.

### 1.6.7. Timeliness of Claims Payments

A key element of an MCO's success is the ability to ensure that Network Providers receive timely and fair payment for services rendered. MCOs must pay Clean Claims and appealed claims on a timely basis, as well as resolve Pended Claims in a timely manner. HHSC will require strict adherence to basic claims processing standards.

## 1.7. STAR Health Overview

Children and young adults in the STAR Health population often have significant healthcare needs. While they may have multiple and complex physical health, mental health, and developmental needs, they also have health needs similar to those of all children, requiring well-child health care, immunizations, and the treatment of acute childhood illnesses. Children and young adults in the STAR Health population may have health problems associated with poverty, such as low birth weight and malnutrition. They are also at risk for conditions associated with parental neglect, physical or sexual abuse, parental substance abuse or mental illness, and the separation and loss associated with out-of-home care.<sup>1</sup>

In 2005, the Texas Legislature addressed the special healthcare needs of the STAR Health population in Senate Bill 6<sup>2</sup>. HHSC designed a comprehensive, cost-effective medical services delivery model to meet the STAR Health population's physical and behavioral health needs as required.<sup>3</sup> On April 1, 2008, HHSC launched the STAR Health program as the first comprehensive health and medical network for children and young adults who are, or were formerly, in the state's foster care system. The

<sup>1</sup> Bruskas, Delilah, RN, MN, "Children in Foster Care: A Vulnerable Population at Risk," *Journal of Children and Psychiatric Nursing*, 21(2), May 2008, [http://www.alumniocare.org/assets/files/jcap\\_134.pdf](http://www.alumniocare.org/assets/files/jcap_134.pdf)

<sup>2</sup> Senate Bill 6, 79th Legislature, Regular Session, 2005.

<sup>3</sup> Section 1.65 of Senate Bill 6, codified in Texas Family Code, Chapter 266, effective September 1, 2005

goal is to give each of these children and young adults Healthcare Services that are coordinated, comprehensive, easy to find, and uninterrupted when the child moves.

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

### 1.7.1. Child Protective Services and Substitute Care in Texas

Through its Child Protective Services (CPS) Program, DFPS provides child welfare services to the state's children and families. CPS is responsible for conducting civil investigations of reported child Abuse, Neglect, and Exploitation; protecting children from Abuse, Neglect, and Exploitation; promoting the safety, integrity, and stability of families; and providing permanent placements for children who cannot safely remain with their own families.<sup>4</sup> State law requires anyone who suspects a child is being abused or neglected to report his or her concerns to the DFPS abuse hotline (1-800-252-5400).

When CPS can reasonably assure child safety, CPS provides in-home services to help stabilize the family and reduce the risk of future abuse or neglect. When it is not safe for children to live with their own families, CPS petitions the court to remove the children from their homes. CPS may temporarily place a child with relatives, a verified substitute family, an emergency shelter, a specialized group home, a residential treatment center, or other licensed residential child-care facilities. CPS is required to provide all medical, dental, and therapeutic services needed by the child.<sup>5</sup>

After CPS removes children from their home and places the children in the state's custody, CPS works with parents, Caregivers, and professionals to ensure that children live in a stable, nurturing environment and do not remain in Substitute Care. Whether the plan is for a child to return home, to be adopted, or to live independently, CPS works to avoid unnecessary delays in permanency. When it is not possible for a child to return home, the court may terminate the parent's rights and legally make the child available for adoption.<sup>6</sup>

In 2011, the Texas Legislature addressed the redesign of the Child Protective Services and foster care systems in Senate Bill 218<sup>7</sup>. DFPS, along with various child welfare stakeholders, developed a redesigned foster care system that would address existing problems and improve permanency outcomes for children and youth. The foundation of this redesigned foster care system rests primarily upon eight quality indicators:

1. First and foremost, children are safe in their placements.
2. Children are placed in their home communities.
3. Children are appropriately served in the least restrictive environment that supports minimal moves for the child.
4. Connections to family and others important to the child are maintained.

<sup>4</sup> Texas Department of Family and Protective Services, "2012 Annual Report," page 16.

<sup>5</sup> Texas Department of Family and Protective Services, "2012 Annual Report," page 19.

<sup>6</sup> Texas Department of Family and Protective Services, "2012 Annual Report," page 20.

<sup>7</sup> Senate Bill 218, 82nd Legislature, Regular Session, 2011.

5. Children are placed with siblings.
6. Services respect the child's culture.
7. To be fully prepared for successful adulthood, children and youth are provided opportunities, experiences, and activities similar to those experienced by their non-foster care peers.
8. Children and youth are provided opportunities to participate in decisions that impact their lives.

DFPS is in the process of transitioning to this redesigned system. (For the most up-to-date information, see

[http://www.dfps.state.tx.us/Adoption and Foster Care/About Foster Care/redesign.asp](http://www.dfps.state.tx.us/Adoption%20and%20Foster%20Care/About%20Foster%20Care/redesign.asp).) DFPS is contracting with Single Source Continuum Contractors (SSCCs) responsible for providing the full continuum of paid foster care placement and services for children and youth in DFPS conservatorship in the designated geographic catchment area.

Section 1.8  
modified by  
Version 2.3

## 1.8. Eligible Population

The following groups (“the Eligible Population” or the “STAR Health population”) will be eligible to enroll in STAR Health: (1) children and young adults in DFPS conservatorship, (2) young adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement, and (3) young adults aged 18 through the month of their 21st birthday who are participating in the Former Foster Care Children (FFCC) program or are participating in the Medicaid for Transitioning Foster Care Youth (MTFCY) Program due to ineligibility for the FFCC program.

## 1.9. Authorization

The Texas Legislature has designated HHSC as the single state agency to administer the Medicaid and managed care models in the State of Texas. HHSC has authority to contract with an MCO to carry out the duties and functions of the STAR Health Program under [Title XIX of the Social Security Act](#); [Texas Health and Safety Code § 12.011](#) and [§ 12.021](#); [Texas Family Code Chapter 266](#); and [Texas Government Code Chapter 533](#). Contracts awarded under this RFP are subject to all necessary federal and state approvals, including Centers for Medicare and Medicaid Services’ (CMS) approval.

## 1.10. Eligible Respondents

Except as provided in this document, eligible Respondents include insurers that are licensed by the Texas Department of Insurance (TDI) as MCOs in accordance with Chapter 843 of the Texas Insurance Code, a certified Approved Non-Profit Health Corporation (ANHC) formed in compliance with Chapter 844 of the Texas Insurance Code, and Exclusive Provider Organizations (EPO) with TDI-approved Exclusive Provider Benefit Plans (EPP).

Throughout this RFP, the term MCO includes HMOs, ANHCs, and EPOs. A Respondent that has submitted its application for licensure as an HMO, for certification as an ANHC, or for approval of an

EPP prior to the Proposal due date is also eligible to respond to this RFP; however, the Respondent must receive TDI approval no later than 60 days after HHSC executes the Contract (see **RFP Section 1.3**, “Procurement Schedule”). Failure to receive the required approval within 60 days after HHSC executes the Contract will result in the cancellation of the award.

**Failure to timely submit proof of TDI licensure, certification, or approval will result in HHSC’s termination of the Contract. The MCO will be at risk for all costs incurred by HHSC or its authorized representatives through the date of termination, as well as all costs HHSC incurs to replace the MCO.**

For more information on the reasons for HHSC’s disqualification of Respondents, see **RFP Section 3.3.2**, “Conflicts of Interest,” and **Section 3.3.3**, “Former Employees of a State Agency.”

### **1.11. Contract Term**

The Contract will begin on the Contract’s Effective Date and will continue through August 31, 2018 (Initial Contract Period). HHSC may, at its option, extend the Contract for an additional period or periods, not to exceed a total of eight operational years. All reserved Contract extensions beyond the Initial Contract Period will be subject to good faith negotiation between the parties.

As discussed in other sections of the RFP, the MCO must begin serving Members on the Operational Start Date, which HHSC anticipates will be September 1, 2015.

### **1.12. Development of Contracts**

For reference only, HHSC has included a template of a STAR Health Managed Care Contract in the **Procurement Library**. The Managed Care Contract identifies an MCO’s awarded MCO Program and identifies all documents that will become part of the agreement, including **RFP Attachment A**, “STAR Health Contract Terms.”

## 2 PROCUREMENT STRATEGY AND APPROACH

HHSC seeks to contract with one MCO to provide statewide coordinated services to the STAR Health population.

HHSC conducts this procurement as a competitive negotiation in accordance with HHSC administrative rules [1 Tex. Admin. Code Ch. 391](#).

[Tex. Gov't Code § 2155.144](#) obligates HHSC to purchase goods and services on the basis of best value. HHSC rules define “best value” as the optimum combination of economy and quality that is the result of fair, efficient, and practical procurement decision-making and that achieves health and human services procurement objectives (see [1 Tex. Admin. Code § 391.31](#)). As stated in [1 Tex. Admin. Code § 391.121](#), HHSC may consider any of the following factors in determining best value:

1. Any installation costs;
2. The delivery terms;
3. The quality and reliability of the vendor’s goods or services;
4. The extent to which the goods or services meet the agency's needs;
5. Indicators of probable vendor performance under the contract such as past vendor performance, the vendor's financial resources and ability to perform, the vendor’s experience and responsibility, and the vendor's ability to provide reliable maintenance agreements;
6. The impact on the ability of the agency to comply with laws and rules relating to historically underutilized businesses or relating to the procurement of goods and services from persons with disabilities;
7. The total long-term cost to the agency of acquiring the vendor’s goods or services;
8. The cost of any employee training associated with the acquisition;
9. The effect of an acquisition on agency productivity;
10. The acquisition price;
11. The extent to which the goods or services meet the needs of the client(s) for whom the goods or services are being purchased; and
12. Any other factor relevant to determining the best value for the agency in the context of a particular acquisition that is sufficiently described in a solicitation instrument.

HHSC will evaluate proposals using the criteria developed from these best value factors as set forth in **RFP Section 5**, “Evaluation Process and Criteria.”

### 2.1 Risk-Based Contract

In making the award of the Contract, HHSC will rely on the MCO’s assurances of the following.

1. The MCO is an established HMO, ANHC, or EPO that arranges for the delivery of Healthcare Services, and will be fully authorized by TDI to conduct business in the Service Area no later than 60 days after the Contract’s Effective Date.

2. The MCO and the MCO's Administrative Services Subcontractors have the skills, qualifications, expertise, financial resources, and experience necessary to provide the Services and Deliverables described in this RFP, the Respondent's Proposal, and the Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities.
3. The MCO has thoroughly reviewed, analyzed, and understood this RFP, has timely raised all questions or objections to this RFP, and has had the opportunity to review and fully understand HHSC's current program and operating environment for the activities that are the subject of the Contract and the needs and requirements of HHSC during the Contract term.
4. The MCO has had the opportunity to review and understands HHSC's stated objectives in entering into the Contract and, based on this review and understanding, the MCO currently has the capability to perform in accordance with the terms of the Contract.
5. The MCO is at risk for expenses that may be necessary or incurred in order to deliver contractually required services and deliverables, even if these expenses are in excess of the Capitation Payments received.

## 2.2 HHSC Model Management Strategy

HHSC has identified performance measures and objectives that it expects the MCO to address during the term of the Contract (see **RFP Section 1.6**, "Mission Objectives," and **RFP Section 8**, "Operations Phase Requirements.")

HHSC will use two "Performance Indicator Dashboards" (one for administrative and financial measures and another for quality measures). The two **Performance Indicator Dashboards** are included in the [Uniform Managed Care Manual \(UMCM\)](#) Chapter **10.1.3**, "STAR Health Performance Indicator Dashboard for Administrative and Financial Measures," and **Chapter 10.1.8**, "STAR Health Performance Indicator Dashboard for Quality Measures." The Performance Indicator Dashboards are not all-inclusive sets of performance measures; HHSC will measure other aspects of MCO performance as well. Rather, the Performance Indicator Dashboards assemble performance indicators that assess many of the most important dimensions of MCO performance, and include measures that, when publicly shared, will also serve to incentivize MCO excellence.

HHSC will seek to accelerate improvement efforts in areas of high priority, including those identified in **RFP Section 1.6**, "Mission Objectives." As described in **RFP Section 8.1.1**, "Performance Evaluation," HHSC's method for accelerating improvement is to establish with the MCO a series of performance improvement projects. The MCO will be committed to making its best efforts to achieve the established projects. HHSC may establish some or all of the performance improvement projects. HHSC and the MCO will negotiate any remaining projects. These projects will be highly specified and measurable. The projects will reflect areas that present significant opportunities for performance improvement. Once finalized and approved by HHSC, the projects will become part of the MCO's plan for its Quality Assurance and Performance Improvement (QAPI) Program, as defined in **RFP Section 8.1.7**, "Quality Assessment and Performance Improvement," and will be incorporated by reference into the Contract.

HHSC recognizes the importance of applying a variety of financial and non-financial incentives and disincentives for demonstrated MCO performance. It is HHSC’s objective to recognize and reward both excellence in MCO performance and improvement in performance, within existing state and federal financial constraints. It is likely that HHSC will modify this approach over time based on several variables, including accumulated experience by HHSC and the MCO, changes in the status of state finances, and changes in MCO performance levels. **RFP Section 6.3**, “Performance Incentives and Disincentives,” describes the incentive and disincentive approach in additional detail.

HHSC anticipates that incentives and disincentives will be linked to some of the measures in the Performance Indicator Dashboards, as found in the **UMCM Chapters 10.1.3** and **10.1.8**. HHSC may use MCO performance relative to the performance improvement projects (PIPs) to identify and reward excellence and improvement by the MCO in subsequent years.

Finally, HHSC plans to improve methods for sharing policy information with the MCO through HHSC-sponsored work groups and other initiatives.

### **2.3 Performance Measures and Associated Remedies**

The MCO must provide all services and deliverables under the Contract at an acceptable quality level and in a manner consistent with acceptable industry standard, custom, and practice. Failure to do so may result in HHSC’s assessment of contractual remedies, including liquidated damages, as set forth in **Attachment B-3**, “Deliverables/Liquidated Damages Matrix.”

### **3 GENERAL INSTRUCTIONS AND REQUIREMENTS**

#### **3.1 Strategic Elements**

##### **3.1.1 Contract Elements**

The term “Contract” means the contract awarded as a result of this RFP and all attachments. At a minimum, the following documents will be incorporated into the contract: this RFP and all attachments; any modifications, addendum, or amendments issued in conjunction with this RFP; HHSC’s STAR Health Contract Terms; and the successful Respondent’s proposal. Respondents are responsible for reviewing all parts of the Contract, including the STAR Health Contract Terms, and noting any exceptions, reservations, and limitations on the Respondent Information and Disclosures form.

##### **3.1.2 HHSC’s Basic Philosophy: Contracting for Results**

HHSC’s fundamental commitment is to contract for results. A successful result is defined as the generation of defined, measurable, and beneficial outcomes that support HHSC’s Missions and Objectives and satisfy the Contract requirements. This RFP describes what is required of the MCO in terms of performance measures and outcomes, and places the responsibility for meeting objectives on the MCO.

#### **3.2 External Factors**

External factors such as budgetary and resource constraints could affect the project. The Contract resulting from this procurement is subject to the availability of state and federal funds. As of the issuance of this RFP, HHSC anticipates that funds are available to fulfill the RFP requirements. However, if funds become unavailable, HHSC reserves the right to withdraw this RFP or terminate the resulting contract without penalty.

#### **3.3 Legal and Regulatory Constraints**

##### **3.3.1 Delegation of Authority**

State and federal laws generally limit HHSC’s ability to delegate certain decisions and functions to a vendor, including: (1) policy-making authority and (2) final decision-making authority on the acceptance or rejection of contracted services.

### 3.3.2 Conflicts of Interest

A conflict of interest is a set of facts or circumstances in which either a Respondent or anyone acting on its behalf in connection with this procurement has past, present, or currently planned personal, professional, or financial interests or obligations that, in HHSC’s determination, would actually or apparently conflict or interfere with the Respondent’s contractual obligations to HHSC. A conflict of interest would include circumstances in which a party’s personal, professional, or financial interests or obligations may directly or indirectly:

1. Make it difficult or impossible to fulfill its contractual obligations to HHSC in a manner that is consistent with the best interests of the State of Texas;
2. Impair, diminish, or interfere with that party’s ability to render impartial or objective assistance or advice to HHSC; or
3. Provide the party with an unfair competitive advantage in future HHSC procurements.

Neither the Respondent nor any other person or entity acting on its behalf, including subcontractors, employees, agents, and representatives, may have a conflict of interest with respect to this procurement. Before submitting a proposal, Respondents should carefully review **RFP Attachment A**, “STAR Health Contract Terms,” for additional information concerning conflicts of interest.

A Respondent must certify that it does not have personal or business interests that present a conflict of interest with respect to this RFP and resulting contract (see the [Required Certifications form](#)). Additionally, if applicable, the Respondent must disclose all potential conflicts of interest. The Respondent must describe the measures it will take to ensure that there will be no actual conflict of interest and that it will maintain fairness, independence, and objectivity (see the [Respondent Information and Disclosures form](#)). HHSC will determine to what extent, if any, a potential conflict of interest can be mitigated and managed during the term of the Contract. **Failure to identify potential conflicts of interest may result in HHSC’s disqualification of a proposal or termination of the Contract.**

### 3.3.3 Former Employees of a State Agency

Respondents must comply with state and federal laws and regulations relating to the hiring of former state employees, such as [Texas Government Code § 572.054](#), [Texas Government Code § 669.003](#), and [45 C.F.R. § 74.43](#). “Revolving door” provisions generally restrict former agency heads from communicating with or appearing before the agency on certain matters for 2 years after leaving the agency, or from contracting with the agency 4 years after leaving the agency. These “revolving door” provisions also restrict some former employees from representing clients on or receiving compensation for services rendered on behalf of any person regarding matters that the employee participated in during state service or matters that were in the employees’ official responsibility.

As a result of these and similar laws and regulations, a Respondent must certify that it has complied with all applicable laws and regulations regarding all former state employees (see the Required Certifications Forms). Furthermore, a Respondent must disclose any relevant past

state employment of the Respondent's or its subcontractors' employees and agents in the Respondent Information and Disclosure form.

### **3.4 HHSC Amendments and Announcements Regarding this RFP**

HHSC will post all official communication regarding this RFP on its website, including the notice of tentative award. HHSC reserves the right to revise the RFP at any time. HHSC will issue any changes, clarifications, amendments, addendum, or written responses to Respondents' questions on HHSC's website. Respondents should check the website frequently for notice of matters affecting the RFP. To access the website, go to the "[HHSC Contract Opportunities](#)" page and enter a search for this procurement. Also, Respondents can find announcements regarding this RFP on the ESD website at: <http://esbd.cpa.state.tx.us/>.

### **3.5 RFP Cancellation/Partial Award/Non-Award**

HHSC reserves the right to cancel this RFP, to make a partial award, or to make no award if it determines that action is in the best interest of the State of Texas.

### **3.6 Right to Reject Proposals or Portions of Proposals**

HHSC may, in its discretion, reject any proposal or portion of the proposal.

### **3.7 Costs Incurred**

Respondents understand that issuance of this RFP in no way constitutes a commitment by HHSC to award a contract or to pay any costs incurred by a Respondent in the preparation of a response to this RFP. HHSC is not liable for any costs incurred by a Respondent prior to issuance of or entering into a formal agreement, contract, or purchase order. Costs of developing proposals, preparing for or participating in oral presentations and site visits, or any other similar expenses incurred by a Respondent are entirely the Respondent's responsibility, and HHSC will not reimburse the Respondent in any manner.

### **3.8 Respondent Protest Procedures**

[1 Tex. Admin. Code Ch. 392, Subchapter C](#) outlines HHSC's Respondent protest procedures.

### 3.9 Vendor Conference

HHSC will hold a vendor conference according to the time and date in **RFP Section 1.3**, “Procurement Schedule,” in HHSC Building 2, Hearing Room 164, located at 909 West 45<sup>th</sup> Street, Austin, Texas, 78751. Vendor conference attendance is strongly recommended, but is not required.

Respondents may e-mail questions for the conference to the HHSC Point-of-Contact (see **RFP Section 1.2**, “Point-of-Contact”) no earlier than five days before the conference. HHSC will also give Respondents the opportunity to submit written questions at the conference. All questions should reference the appropriate RFP page and section number. HHSC will attempt to respond to questions at the vendor conference, but responses are not official until posted in final form on the HHSC website. HHSC reserves the right to amend answers prior to the proposal submission deadline.

### 3.10 Questions and Comments

All questions and comments regarding this RFP should be sent to the HHSC Point-of-Contact (see **RFP Section 1.2**). Questions should reference the appropriate RFP page and section number, and must be submitted by the deadline set forth in **RFP Section 1.3**, “Procurement Schedule.” HHSC will not respond to questions received after the deadline. HHSC’s responses to Respondent questions will be posted to the HHSC website. HHSC reserves the right to amend answers prior to the proposal submission deadline.

Respondents must notify HHSC of any ambiguity, conflict, discrepancy, exclusionary specification, omission, or other error in the RFP by the deadline for submitting questions and comments. If a Respondent fails to notify HHSC of these issues, it will submit a proposal at its own risk, and if awarded a contract: (1) will have waived any claim of error or ambiguity in the RFP or resulting contract, (2) must not contest HHSC’s interpretation of such provision(s), and (3) is not entitled to additional compensation, relief, or time by reason of the asserted ambiguity, error, or its later correction.

### 3.11 Modification or Withdrawal of Proposal

Prior to the proposal submission deadline set forth in **RFP Section 1.3**, “Procurement Schedule,” a Respondent may: (1) withdraw its proposal by submitting a written request to the HHSC Point-of-Contact, or (2) modify its proposal by submitting a written amendment to the HHSC Point-of-Contact. HHSC may request proposal modifications at any time.

HHSC reserves the right to waive minor informalities in a proposal and award a contract that is in the best interest of the State of Texas. A “minor informality” is an omission or error that, in HHSC’s determination, if waived or modified when evaluating proposals, would not give a Respondent an unfair advantage over other Respondents or result in a material change in the proposal or RFP requirements. When HHSC determines that a proposal contains a minor informality, it may, at its discretion, provide the Respondent with the opportunity to correct the minor informality.

### **3.12 News Releases**

Prior to tentative award, a Respondent may not issue a press release or provide any information for public consumption regarding its participation in the procurement. After tentative award, a Respondent must receive prior written approval from HHSC before issuing a press release or providing information for public consumption regarding its participation in the procurement. Requests should be directed to the HHSC Point-of-Contact identified in **RFP Section 1.2**.

**Section 3.12** does not preclude business communications necessary for a Respondent to develop a proposal, or required reporting to shareholders or governmental authorities.

### **3.13 Incomplete Proposals**

HHSC may reject without further consideration a proposal that does not include a complete, comprehensive, or total solution as requested by this RFP.

### **3.14 State Use of Ideas**

HHSC reserves the right to use any and all ideas and information presented in a proposal. A Respondent may not object to HHSC's use of this information.

### **3.15 Property of HHSC**

Except as otherwise provided in this RFP or the resulting Contract, all products produced by a Respondent, including without limitations the proposal, all plans, designs, software, and other contract deliverables, become the sole property of HHSC. See **RFP Attachment A, Article 15**, "Intellectual Property," for additional information concerning intellectual property rights.

### **3.16 Copyright Restriction**

HHSC will not consider any proposal that is copyrighted by the Respondent, in whole or part.

### **3.17 Additional Information**

By submitting a proposal, the Respondent grants HHSC the right to obtain information from any lawful source, whether identified in Respondent's proposal or not, regarding the Respondent's and its

directors', officers', and employees': (1) past business history, practices, and conduct, (2) ability to supply the goods and services, and (3) ability to comply with Contract requirements. By submitting a proposal, a Respondent generally releases from liability and waives all claims against any party providing HHSC information about the Respondent. HHSC may take this information into consideration in evaluating proposals.

### **3.18 Multiple Proposals**

A Respondent may only submit one proposal as a prime contractor. If a Respondent submits more than one proposal, HHSC may reject one or more of the submissions. This requirement does not limit a subcontractor's ability to collaborate with one or more Respondents submitting proposals.

A Respondent may not entice or require a subcontractor to enter into an exclusive subcontract for the purpose of this procurement. Any subcontract entered into by a Respondent with a third party to meet a requirement of this RFP must not include any provision that would prevent or bar that subcontractor from entering into a comparable contractual relationship with another Respondent submitting a proposal under this procurement. This prohibition against exclusive subcontracts does not apply to professional services that solely pertain to development of the proposal, including gathering of competitive intelligence.

### **3.19 No Joint Proposals**

HHSC will not consider joint or collaborative proposals that require it to contract with more than one Respondent.

### **3.20 Use of Subcontractors**

Subcontractors providing services under the Contract must meet the same requirements and level of experience as required of the Respondent. No subcontract under the Contract must relieve the Respondent of the responsibility for ensuring the requested services are provided. Respondents planning to subcontract all or a portion of the work to be performed must identify the proposed subcontractors and describe the subcontracted functions in their proposals.

### **3.21 Texas Public Information Act**

Proposals will be subject to the Texas Public Information Act (the Act), located in [Chapter 552 of the Texas Government Code](#), and may be disclosed to the public upon request. By submitting a proposal, the Respondent acknowledges that all information and ideas presented in the proposal are public information and subject to disclosure under the Act, with the limited exception of Social Security Numbers and certain non-public financial reports or information submitted in response to **RFP Sections**

**4.2.3.4, “Financial Capacity,” and 4.2.3.5, “Financial Report of Parent Organization and Corporate Guarantee.”**

If the Respondent asserts that financial reports or information provided in response to **RFP Sections 4.2.3.3 and 4.2.3.4** contain trade secret or other confidential information as specified under the provisions of the Act, the Respondent must clearly mark that information in boldface type and include the words “confidential” or “trade secret” at the top of each page the Respondent claims is confidential or trade secret. Furthermore, the Respondent must identify by specific page numbers the financial reports or information, and provide an explanation of why the reports or information are excepted from public disclosure under the provisions of the Act, on the Respondent Information and Disclosures form.

HHSC will process any request from a member of the public in accordance with the procedures outlined in the Act. Respondents should consult the Texas Attorney General’s website ([www.oag.state.tx.us](http://www.oag.state.tx.us)) for information concerning the Act’s application to applications and potential exceptions to disclosure.

### **3.22 Inducements**

HHSC submits this RFP setting forth certain information regarding the objectives of the Contract and HHSC’s desire to mitigate risk throughout the life of the Contract by use of expert MCO services.

Therefore, HHSC will consider all representations contained in a Respondent’s proposal, oral or written presentations, correspondence, discussions, and negotiations as representations of the Respondent’s expertise. HHSC accepts these representations as inducements to contract.

### **3.23 Definition of Terms**

Defined terms have the meaning described in **RFP Attachment A**, “STAR Health Contract Terms”), unless the context clearly indicates otherwise. Defined terms are capitalized throughout this RFP.

## 4 Submission Requirements

To be considered for award, the Respondent must address all applicable RFP specifications to HHSC's satisfaction. If requested by HHSC, the Respondent must provide HHSC with information necessary to validate any statements made in its Proposal. This includes granting permission or access for HHSC to verify information with third parties, whether identified by the Respondent or HHSC. If any requested information is not provided within the timeframe allotted, HHSC may reject the Proposal.

Respondents must prepare and submit proposals in accordance with the provisions of this section. Proposals received that do not follow these instructions may be evaluated as non-responsive and may not be considered for award.

If a Respondent believes that parts of a Proposal are exempted from required public disclosure under the Texas Public Information Act, the Respondent must specify those parts and the exception(s) that it believes apply, with specific detailed reasons. See **RFP Section 3.21 "Texas Public Information Act"** for more information.

### 4.1 Part 1 - General Instructions

A Proposal must include the following two components:

1. Business Proposal; and
2. Programmatic Proposal.

Respondents must submit all Proposal information on 8½" x 11", white bond paper, three-hole punched, and placed in sturdy three-ring binders. Text must be no smaller than 11-point font, single-spaced. Figures may not incorporate text smaller than 8-point font. All pages must have one-inch margins and page numbering must be sequential per section. Where practical, pages should be double-sided. Respondents must clearly label each binder with the title of this RFP, the Respondent's legal name, and the title of the document contained in the binder, e.g., Business Proposal or Programmatic Proposal.

Proposals must be organized and numbered in a manner that facilitates reference to this RFP and its requirements. Respondents must respond to each item in the order it appears in the RFP. The Respondent's response must include headings and numbering to match the corresponding section of the RFP. Respondents may place attachments in a separate section, if the attachments are not included in any page limits specified in the RFP.

#### 4.1.1 Economy of Presentation

HHSC does not want unnecessarily elaborate Proposals beyond those sufficient to provide a complete and effective response to this RFP and they may be construed as an indication of the Respondent's lack of ability to provide efficient work products.

The Respondent must adhere to page limits where specified. Page limits are listed in parentheses at the end of the title of the section to which the page limit applies. A three-page limit, for example, means that the response should not be in excess of three one-sided pages that meet the size, font, and margin requirements specified in the General Instructions in **RFP Section 4.1**.

In other cases, additional pages may be provided based on certain aspects of the Respondent's Proposal or organization, such as the number of organizational charts submitted reflecting arrangements with Material Subcontractors, or the number of Key Contract Personnel included in the Proposal.

If the Respondent chooses to repeat the RFP question in its Proposal, the question text will be included in the page limit.

In responding to questions in **RFP Section 4.2**, "Business Proposal," and **Section 4.3**, "Programmatic Proposal," for which the Respondent includes information about a Material Subcontractor or Corrective Action Plan, up to one page may be used to describe each Material Subcontractor arrangement, and up to one page may be used to describe each Corrective Action Plan. These pages are outside of the page limit instructions for the specific submission requirement.

HHSC reserves the right not to review information provided in excess of the page limits. Respondents need not feel compelled to submit unnecessary text in order to reach the page limits.

Attachments required by the RFP, such as certain policies and procedures, are not counted in calculating the Respondent's page limits. Respondents must not submit information or attachments not explicitly requested in the RFP. Elaborate artwork, expensive paper and bindings, and expensive visual or other presentation aids are neither necessary nor desired.

#### **4.1.2 Number of Copies and Packaging**

Respondents must submit one hardbound original and eight hardbound copies of the Proposal. The original must be clearly labeled "Original" on the outside of the binder. In addition to the hardbound original and copies, Respondents must submit 22 electronic copies of each Proposal component on portable media, such as flash drives or compact discs. The Respondent must clearly label the exterior of the shipping package with proposal number **529-15-0001**. At the Respondent's option, it may produce only electronic copies of certain attachments and appendices. This exception applies to attachments and appendices that exceed 10 pages, such as Geo-Access tables, Significant Traditional Provider (STP) files, Texas Department of Insurance (TDI) filings, and other financial documents. The exception does not apply to the attachments referenced in **RFP Section 4.2**, "Part 2 - Business Proposal," **Section 4.2.5**, "Section 5 - HUB Subcontracting Plan," or **Section 4.2.6**, "Section 6 - Certifications and Other Required Forms," which must be included in both the hardbound and electronic copies of the Proposal. If the Respondent produces only an electronic copy of an attachment or appendix, the hardbound Proposals should refer the reader to the electronic Proposal for the required information.

For the electronic copies, the Proposal, attachments, financial documents, signed forms, pamphlets, and all other documents included in the proposal hardcopy must be submitted on CDs or flash drives compatible with Microsoft Office 2010 files. Portable Document Files (PDF) should be prepared in a format that is text searchable. **HHSC will not accept Proposals by facsimile or e-mail.**

#### **4.1.3 Due Date, Time, and Location**

Submit all copies of the Proposal to HHSC's Procurement and Contracting Services (PCS) no later than **2:00 p.m.** Central Time (CT) according to the timeline in **RFP Section 1.3**, "Procurement Schedule." All submissions will be date and time stamped when received by PCS. The clock in the PCS office is the official timepiece for determining compliance with the deadlines in this procurement. HHSC reserves the right to reject late submissions. It is the Respondent's responsibility to appropriately mark and deliver the Proposal to HHSC's sole point-of-contact by the specified date and time. The sole point-of-contact for inquiries concerning this RFP is:

Rick Blincoe, CTPM  
Procurement and Contracting Services  
Health and Human Services Commission  
4405 North Lamar Blvd  
Austin, Texas 78756-3422  
Phone: (512) 206-5468  
Fax: (512) 206-5552  
Richard.Blincoe@hhsc.state.tx.us

#### **4.2 Part 2 - Business Proposal**

The Business Proposal must include the following:

- **Section 1 – Executive Summary**
- **Section 2 – Respondent Identification and Information**
- **Section 3 – Corporate Background and Experience**
- **Section 4 – Material Subcontractor Information**
- **Section 5 – HUB Subcontracting Plan**
- **Section 6 – Certifications and Other Required Forms**

##### **4.2.1 Section 1 – Executive Summary**

(2 pages)

In this section, condense and highlight the content of the Business Proposal to provide HHSC with a broad understanding of the respondent's approach to meeting the RFP's business requirements. The

summary must demonstrate an understanding of HHSC’s goals and objectives for this procurement. The summary of experience should address projects similar in scope and complexities to the project described in the RFP, and describe the Respondent’s experience serving the STAR Health population or similar populations.

#### 4.2.2 Section 2 – Respondent Identification and Information

(no page limit)

Submit the following information:

1. Respondent identification and basic information.

- a. The Respondent’s legal name, trade name, d.b.a, acronym, and any other name under which the Respondent does business.
- b. The physical address, mailing address, and telephone number of the Respondent’s headquarters office.

2. TDI Authority. A copy of the MCO’s licensure, certification, or approval to operate as an MCO, ANHC, or EPO. If the Respondent has not received TDI approval, then submit a copy of the application filed with TDI. In accordance with **RFP Section 7.3.10**, “TDI Licensure, Certification, or Approval,” the Respondent must receive TDI approval no later than 60 days after HHSC executes the Contract.

3. Authorized Counties. For an HMO, ANHC, or EPO, use the “TDI Certificate of Authority” chart provided in the **RFP Procurement Library** to indicate whether the Respondent is currently certified by TDI as an HMO, ANHC, or EPO in all counties in the state. For each county listed in Column C, the Respondent must document that it applied to TDI for approval prior to the submission of a Proposal for this RFP. The Respondent must indicate the date that it applied for TDI approval and the status of its application to get TDI approval in the relevant counties in this section of its submission to HHSC.

4. Texas Comptroller Certificate. A current Certificate of Good Standing issued by the Texas Comptroller of Public Accounts, or an explanation for why this form is not applicable to the Respondent.

5. Respondent Legal Status and Ownership.

- a. The type of ownership of the Respondent by its ultimate parent:
  - i. wholly-owned subsidiary of a publicly-traded corporation;
  - ii. wholly-owned subsidiary of a private (closely-held) stock corporation;
  - iii. subsidiary or component of a non-profit foundation;
  - iv. subsidiary or component of a governmental entity such as a County Hospital District;
  - v. independently-owned member of an alliance or cooperative network;
  - vi. joint venture (describe ultimate owners);
  - vii. stand-alone privately-owned corporation (no parents or subsidiaries); or
  - viii. other (describe).
- b. The legal status of the Respondent and its parent (any/all that may apply):

- i. Respondent is a corporation, partnership, sole proprietor, or other (describe);
    - ii. Respondent is for-profit, or non-profit;
    - iii. the Respondent's ultimate parent is for-profit, or non-profit; or
    - iv. the Respondent's ultimate parent is privately-owned, listed on a stock exchange, a component of government, or other (describe).
  - c. The legal name of the Respondent's ultimate parent (e.g., the name of a publicly-traded corporation, or a County Hospital District).
  - d. The name and address of any other sponsoring corporation, or others (excluding the Respondent's parent) who provide financial support to the Respondent, and the type of support (e.g., guarantees, letters of credit). Indicate if there are maximum limits of the additional financial support.
6. Hospital District/Non-Profit Corporation. **RFP Section 5**, "Evaluation Process and Criteria," requires Respondents who believe they qualify for mandatory STAR Health contracts under Texas Government Code § 533.004 to submit a detailed, written notice to HHSC no later than May 9, 2014. Please indicate whether the Respondent provided this notice to HHSC in the manner described in **RFP Section 5**.
7. The name and address of any health professional that has at least a 5% financial interest in the Respondent, and the type of financial interest.
8. The full names and titles of the Respondent's officers and directors.
9. The state in which the Respondent is incorporated and the state in which the Respondent is licensed to do business as an MCO. The Respondent must also indicate the state where it is commercially domiciled, if outside Texas.
10. The Respondent's federal taxpayer identification number.
11. If any change of ownership of the Respondent's company or its parent is anticipated during the 12 months following the Proposal due date, the Respondent must describe the circumstances of the change and indicate when the change is likely to occur.
12. Whether the Respondent or its parent (including other managed care subsidiaries of the parent) had a managed care contract terminated or not renewed for any reason within the past 5 years. In this instance, the Respondent must describe the issues and the parties involved, and provide the address and telephone number of the principal terminating party. The Respondent must also describe any corrective action taken to prevent any future occurrence of the problems that may have led to the termination or non-renewal.
13. Whether the Respondent has ever sought, or is currently seeking, accreditation status from an organization as allowed by the Texas Department of Insurance (such as the National Committee for Quality Assurance (NCQA)), and if it has or is, indicate:
- a. its current accreditation status;
  - b. if accredited, its accreditation term effective dates; and
  - c. if not accredited, a statement describing whether and when accreditation status was ever denied the Contractor.
14. The website address (URL) for the homepage of any website operated, owned, or controlled by the Respondent, including any that the Respondent may have contracted to be run by another

entity. If the Respondent has a parent, then also provide the same for the parent, and any parent of the parent. If none exists, provide a clear and definitive statement to that effect.

#### **4.2.3 Section 3 - Corporate Background and Experience**

(no page limit)

1. Provide the following information on all publicly-funded managed care contracts (if the Respondent does not have publicly-funded managed care contracts, it may include information on privately-funded managed care contracts). Include information for all current contracts, as well as work performed in the past 3 years:
  - a. client name and address;
  - b. name, telephone, and e-mail address of the person HHSC could contact as a reference that can speak to the Respondent's performance;
  - c. contract size: average monthly covered lives and annual revenues;
  - d. whether payments under the contract were capitated or non-capitated;
  - e. contract start date and duration;
  - f. whether work was performed as a prime contractor or Subcontractor; and
  - g. a general and brief description of the scope of services provided by the Respondent; including the covered population and services (e.g., Medicaid, state-funded program).
2. With respect to the Respondent and its parent (and including other managed care subsidiaries of the parent), briefly describe any regulatory actions, sanctions, or fines imposed by any federal or Texas regulatory entity, or a regulatory entity in another state, within the last three years. Include a description of any letters of deficiencies, corrective actions, findings of non-compliance, or sanctions. Please indicate which of these actions or fines, if any, were related to the Medicaid program. HHSC may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the Respondent.
3. If the Respondent had a contract terminated or not renewed for nonperformance or poor performance within the past five years, the Respondent must describe the issues, the parties involved, and provide the address and telephone number of the principal terminating party. The Respondent must also describe any corrective action taken to prevent any future occurrence of the problem leading to the termination.

Respondents should not include letters of support or endorsement from any individual, organization, agency, interest group, or other identified entity in this section or other parts of the Proposal.

When evaluating proposals, HHSC may consider a current or past contractor's performance under an agreement with an HHS agency in Texas, including any corrective actions or damages imposed by HHSC or another HHS agency.

##### **4.2.3.1 Organizational Chart**

(1 page narrative for each organizational chart, excluding organizational chart itself)

Respondents should submit the following:

1. An organizational chart (**Chart A**), showing the corporate structure and lines of responsibility and authority in the administration of the Respondent's business as a health plan.
2. An organizational chart (**Chart B**) showing the Texas organizational structure, including staffing and functions performed within the state. Specifically show the organizational structure if the Respondent proposes to maintain offices in more than one city in Texas. If **Chart A** represents the entire organizational structure, label the submission as **Charts A and B**.
3. An organizational chart (**Chart C**) that illustrates how administration of services to Members is integrated into the overall administrative structure of the Respondent's business as an MCO. Specifically show the organizational structure if the Respondent proposes to maintain offices in more than one city in Texas.
4. An organizational chart (**Chart D**) showing the Management Information System (MIS) staff organizational structure, including staffing and functions performed in Texas and, if applicable, outside of Texas. Specifically show the organizational structure if the Respondent proposes to maintain offices in more than one city in Texas.
5. An organizational chart (**Chart E**) showing the Respondent's committee structure and committee lines of accountability. Indicate which committee(s) will participate in establishing treatment guidelines and criteria for delivery of Covered Services to Members.
6. If the Respondent is proposing to use a Material Subcontractor, the Respondent must include an organizational chart demonstrating how the Material Subcontractors will be managed within the Respondent's Texas organizational structure, including the primary individuals at the Respondent's organization and at each Material Subcontractor organization responsible for overseeing the key functional areas under each Material Subcontract. This information may be included in **Chart B**, or in a separate organizational chart (**Chart F**).
7. A brief narrative explaining the organizational charts submitted, and highlighting the key functional responsibilities and reporting requirements of each organizational unit relating to the Respondent's proposed management of the STAR Health Program. With regard to any proposed Material Subcontractors managing BH Services, dental services, vision services, or pharmacy services, indicate whether (and if so, how and where) the Respondent and any proposed Material Subcontractor will co-locate their offices.
8. The MCO, HHSC, and DFPS will meet twice monthly for the first three months following any transition regarding the management of the STAR Health Program, and monthly thereafter. Describe how the MCO will integrate these meetings into its overall Program planning and coordination efforts with HHSC and DFPS, and how it will address Program modifications that arise as a result of these meetings.

#### 4.2.3.2 Résumés

(1 page per Key Personnel, excluding résumés)

Identify and describe the respondent's and its Subcontractor's proposed labor skill set, years of experience, and provide résumés of all proposed key personnel. Résumés must demonstrate experience germane to the position proposed. Résumés should include work on projects cited under the respondent's corporate experience, and the specific functions performed on these projects. Each résumé should include at least three references from recent projects, if the projects were performed for unaffiliated parties. References may not be the Respondent's or Subcontractor's employees.

For each of the Key MCO Personnel listed below, submit (a) a job description and qualifications; (b) a resume of each individual expected to hold the position, if the person has already been identified by the

Respondent; and (c) indicate the portion of each person’s time the Respondent anticipates will be dedicated to STAR Health:

1. Executive Director
2. Medical Director
3. Member Services Manager
4. Behavioral Health (BH) Services Manager
5. Dental Services Manager
6. Vision Services Manager
7. Pharmacy Benefits Services Manager
8. MIS Manager
9. Health Passport Manager
10. Claims Processing Manager
11. Provider Network Development and Management Manager
12. Benefit Administration and Utilization Review Manager
13. Service Management Manager
14. Service Coordination Manager
15. Quality Improvement Manager
16. STAR Health Liaison Manager
17. Financial Functions Manager
18. Reporting Manager

**4.2.3.3 Service Managers and Service Coordinators.** Please refer to **RFP Section 8.1.13.2**, “Access to Care and Service Management,” for a description of Service Manager responsibilities and **RFP Section 8.1.14**, “Service Coordination,” for a description of Service Coordinator responsibilities. In addition to the Service management manager and Service Coordination Manager, please submit the following for each individual Service manager and Service Coordinator:

1. A job description and qualifications; and
2. the résumé of each individual expected to hold the position, if the Respondent has identified them.

#### **4.2.3.4 Financial Capacity**

(no page limit)

Submit the following financial documents to demonstrate the Respondent’s financial solvency, and its capacity to comply with **RFP Section 6**, “Premium Payment, Incentives, and Disincentives,” and **RFP Section 8**, “Operations Phase Requirements,” and **RFP Attachment A**, “STAR Health Contract Terms”:

1. Audited Financial Statements covering the two most recent years of the Respondent’s financial results. These statements must include the independent auditor’s report (audit opinion letter to the Board or shareholders), the notes to the financial statements, any written description of legal issues or contingencies, and any management discussion or analysis.

Make sure that the name and address of the firm that audits the Respondent is shown. State the date of the most-recent audit, and whether the Respondent is audited annually or otherwise. State definitively if there has, or has not, been any of the following:

- a. a “going concern” statement was issued by any auditor in the last three years and if so, include the relevant audit report and opinion letter;
  - b. a qualified opinion was issued by any auditor in the last three years and if so, include the relevant audit report and opinion letter;
  - c. a change of audit firms in the last three years; and
  - d. any significant delay (two months or more) in completing the current audit.
2. The most recent quarterly and annual financial statements filed with the TDI, and if the Respondent is domiciled in another state, the financial statements filed with the state insurance department in its state of domicile. The annual financial statement must include all schedules, attachments, supplements, management discussion, analysis, and actuarial opinions.
3. The most recent financial examination report issued by TDI and by any state insurance department in states where the Respondent operates a Medicaid or comparable managed care product. If any submitted financial examination report is 2 or more years old, or if Respondent has never had a financial examination report issued, submit the anticipated approximate date of the next issuance of a TDI or state department of insurance financial examination report.
4. The most recent Form B Registration Statement disclosure filed by Respondent with TDI, and any similar form filed with any state insurance department in other states where the Respondent operates a Medicaid or comparable managed care product. If Respondent is exempt from the TDI Form B filing requirement, demonstrate this and explain the nature of the exemption.
5. Other related documents, as applicable:
  - a. SEC Form 10-K and 10-Q. If Respondent is a publicly-traded (stock-exchange-listed) corporation, then submit the most recent United States Securities and Exchange Commission (SEC) Form 10-K Annual Report, and the most-recent 10-Q Quarterly report.
  - b. IRS Form 990. If the Respondent is a non-profit entity, then submit the most recent annual Internal Revenue Service (IRS) Form 990 filing, complete with all attachments or schedules. If Respondent is a non-profit entity that is exempt from the IRS 990 filing requirement, demonstrate this and explain the nature of the exemption.
  - c. Non-Profit Entities. If the Respondent is a non-profit entity that is a component or subsidiary of a County Hospital District, or otherwise an entity of a government, then submit the most recent annual financial statements as prepared under the relevant rules or statutes governing annual financial reporting and disclosure for Respondent, including all attachments, schedules, and supplements.
  - d. Bond or debt rating analysis. If Respondent has been, in the last three years, the subject of any bond rating analysis, ratings affirmation, write-up, or related report, such as by AM Best, Fitch Ratings, Moody’s, Standard & Poor, submit the most-recent detailed report from each rating entity that has produced a report.
  - e. Annual Report. If Respondent produces any written “annual report” or similar item that is in addition to the above-referenced documents, submit the most recent version. This might be a yearly report or letter to shareholders, the community, regulators, lenders, customers, employees, the Respondent’s owner, or other constituents.
  - f. Press Releases. If the Respondent has issued any press releases in the 12 months prior to the submission due date, and the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or

losses, penalties/fines/sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, provide a copy of each press release. HHSC does not wish to receive other types of press releases that are primarily promotional in nature.

With respect to items 5(a) through 5(e), Respondent must also submit a schedule that shows for each of the five categories: whether there is any applicable filing or report; the name(s) of the entity that does the filing or report; and the regular or estimated filing/distribution date(s).

At a minimum, the financial statements and reports submitted must include:

1. balance sheet;
2. statement of income and expense;
3. statement of cash flows;
4. statement of changes in financial position (capital & surplus; equity);
5. independent auditor's letter of opinion;
6. description of organization and operation, including ownership, markets served, type of entity, number of locations and employees, and, dollar amount and type of any Respondent business outside of that with HHSC; and
7. disclosure of any material contingencies, and any current, recent past, or known potential material litigation, regulatory proceedings, legal matters, or similar issues.

The Respondent must include key non-financial metrics and descriptions, such as facilities, number of covered lives, area of geographic coverage, years in business, material changes in business situation, key risks, and prospective issues.

#### **4.2.3.5 Financial Report of Parent Organization and Corporate Guarantee**

(no page limit)

If another corporation or entity either substantially or wholly owns the Respondent, submit the most recent detailed financial reports (as required in **Section 4.2.3.4**) for the parent organization. If there are one or more intermediate owners between the Respondent and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

The Respondent must also include a statement that the parent organization will unconditionally guarantee performance by the Respondent of each and every obligation, warranty, covenant, term, and condition of the Contract. This guarantee is not required for Respondents owned by political subdivisions of the State (e.g., hospital districts).

If HHSC determines that an entity does not have sufficient financial resources to guarantee the Respondent's performance, HHSC may require the Respondent to obtain another acceptable financial instrument or resource, or to obtain an acceptable guarantee from another entity with sufficient financial resources to guarantee performance.

#### **4.2.3.6 Bonding**

(no page limit)

The Respondent must submit a statement that, if selected as a Contractor, the Respondent agrees to:

1. secure and maintain throughout the life of the Contract, fidelity bonds required by the TDI in compliance with [Tex. Ins. Code § 843.402](#); and
2. secure and maintain throughout the life of the Contract, a performance bond in accordance with **RFP Attachment A**, "STAR Health Contract Terms," and [28 Tex. Admin. Code § 11.1805](#).

#### 4.2.4 Section 4 – Material Subcontractor Information

(no page limit)

See **RFP Attachment A**, "STAR Health Contract Terms," for contractual definitions of Material Subcontractor and Affiliate. Organize this information by Material Subcontractor, and list them in descending order of estimated annual payments. For *each* Material Subcontractor, the MCO must provide:

1. The Material Subcontractor's legal name, trade name, acronym, d.b.a., and any other name under which the Material Subcontractor does business.
2. The Respondent's estimated annual payments to the Material Subcontractor, by MCO program.
3. The physical address, mailing address, and telephone number of the Material Subcontractor's headquarters office, and the name of its Chief Executive Officer.
4. Whether the Material Subcontractor is an Affiliate of the Respondent or an unrelated third party.
5. If the Material Subcontractor is an Affiliate, then provide:
  - a. the name of the Material Subcontractor's parent organization, and the Material Subcontractor's relationship to the Respondent;
  - b. the proportion, if any, of the Material Subcontractor's total revenues that are received from non-Affiliates. If the Material Subcontractor has significant revenues from non-Affiliates, then also indicate the portion, if any, of those external (non-Affiliate) revenues that are for services similar to those that the Respondent would procure under the proposed Subcontract;
  - c. a description of the proposed method of pricing under the Subcontract;
  - d. indicate if the Respondent presently procures, or has ever procured, similar services from a non-Affiliate;
  - e. the number of employees (staff and management) who are dedicated full-time to the Affiliate's business;
  - f. whether the Affiliate's office facilities are completely separate from the Respondent and the Respondent's parent. If not, identify the approximate number of square feet of office space that are dedicated solely to the Affiliate's business;
  - g. attach an organization chart for the Affiliate, showing head count, Key Personnel names, titles, and locations; and

- h. indicate if the staff and management of the Affiliate are directly employed by the Affiliate itself, or are they legally employed by a different legal entity (such as a parent corporation). The employee's W-2 form identifies the name of the corporation and is indicative of the actual employer.
6. A description of each Material Subcontractor's corporate background and experience, including its estimated annual revenues from unaffiliated parties, number of employees, location(s), and identification of three major clients.
7. A signed letter of commitment from each Material Subcontractor that states the Material Subcontractor's willingness to enter into a Subcontractor agreement with the Respondent, and a statement of work for subcontracted activities. Respondents must provide Letters of Commitment on the Material Subcontractor's official company letterhead, signed by an official with the authority to bind the company for the subcontracted work. The Letter of Commitment must state, if applicable, the company's certified HUB status.
8. The business entity structure of the Material Subcontractor and the Affiliate. [For example, wholly-owned subsidiary of a publicly-traded corporation; wholly-owned subsidiary of a private (closely-held) stock corporation; subsidiary or component of a non-profit foundation; subsidiary or component of a governmental entity such as a County Hospital District; independently-owned member of an alliance or cooperative network; joint venture (describe owners)] Indicate the name of the ultimate owner (e.g., the name of a publicly-traded corporation or a County Hospital District).
9. Indicate status (all that may apply): sole proprietor, partnership, corporation, for-profit, non-profit, privately owned, or listed on a stock exchange. If a Subsidiary or Affiliate, name of the direct and ultimate parent organization.
10. The name and address of any sponsoring corporation or others who provide financial support to the Material Subcontractor and the type of support, e.g., guarantees, letters of credit. Indicate if there are maximum limits of the additional financial support.
11. The name and address of any health professional that has at least a 5% financial interest in the Material Subcontractor and the type of financial interest.
12. The state in which the Material Subcontractor is incorporated, commercially domiciled, and the states in which the organization is licensed to do business.
13. The Material Subcontractor's federal taxpayer identification number.
14. Whether the Material Subcontractor had a managed care contract terminated or not renewed for any reason within the past five years. If so, the Respondent must describe the issues, the parties involved, and provide the address and telephone number of the principal terminating party. The Respondent must also describe any corrective action taken to prevent any future occurrence of the problem that may have led to the termination.
15. Whether the Material Subcontractor has ever sought, or is currently seeking, accreditation status from an organization as allowed by the Texas Department of Insurance (such as NCQA), and if it has or is, indicate:
  - a. its current accreditation or certification status;
  - b. if accredited or certified, its accreditation or certification term effective dates; and

- c. if not accredited, a statement describing whether and when accreditation status was ever denied the Material Subcontractor.
16. The URL for the homepage of any website operated, owned, or controlled by the Material Subcontractor, including any websites run by another entity on the Material Subcontractor's behalf. If the Material Subcontractor has a parent, then also provide the same for the parent organization, and any parent of the parent organization. If none exist, provide a clear and definitive statement to this effect.

#### **4.2.5 Section 5 – Historically Underutilized Business (HUB) Participation**

(no page limit)

In accordance with Texas Government Code § 2162.252, a proposal that does not contain a [HUB Subcontracting Plan](#) (HSP) is non-responsive and will be rejected without further evaluation. In addition, if HHSC determines that the HSP was not developed in good faith, it will reject the proposal for failing to comply with material RFP specifications.

##### **4.2.5.1 Introduction**

HHSC is committed to promoting full and equal business opportunities for businesses in state contracting in accordance with the goals specified in the State of Texas Disparity Study. HHSC encourages the use of HUB) through race, ethnic and gender-neutral means. HHSC has adopted administrative rules relating to HUBs, and a [Policy on the Utilization of HUBs](#), which is located on HHSC's website.

Pursuant to [Texas Government Code § 2161.181](#) and [§ 2161.182](#), and HHSC's HUB policy and rules, HHSC is required to make a good faith effort to increase HUB participation in its contracts. HHSC may accomplish the goal of increased HUB participation by contracting directly with HUBs or indirectly through subcontracting opportunities.

##### **4.2.5.2 HHSC's Administrative Rules**

HHSC has adopted the Comptroller of Public Accounts' (CPA) HUB rules as its own. HHSC's rules are located in [15 Tex. Admin. Code Ch. 392, Subchapter J](#) of the Texas Administrative Code, and the CPA rules are located in [34 Tex. Admin. Code Ch. 20, Subchapter B](#). If there are any discrepancies between HHSC's administrative rules and this RFP, the rules will take priority.

##### **4.2.5.3 HUB Participation Goal**

The CPA has established statewide annual HUB utilization goals for different categories of contracts in [34 Tex. Admin. Code § 20.13](#) of the HUB Rules. In order to meet or exceed the statewide annual HUB utilization goals, HHSC encourages outreach to certified HUBs. Contractors must make a good faith effort to include certified HUBs in the procurement process.

This contract is classified as an “**All Other Services**” contract under the CPA rule, and therefore, has a statewide annual HUB utilization goal of **24.6%** per fiscal year. This goal applies to MCO Administrative Services, as defined below.

#### 4.2.5.4 Required HUB Subcontracting Plan

In accordance with Government Code, Chapter 2161, Subchapter F, each state agency that considers entering into a contract with an expected value of \$100,000 or more over the life of the contract (including any renewals) shall, before the agency solicits bids, proposals, offers, or other applicable expressions of interest, determine whether subcontracting opportunities are probable under the contract.

In accordance with [34 Tex. Admin. Code § 20.14\(a\)\(1\)\(C\)](#) of the HUB Rule, state agencies may determine that subcontracting is probable for only a subset of the work expected to be performed or the funds to be expended under the contract. If an agency determines that subcontracting is probable on only a portion of a contract, it must document its reasons in writing for the procurement file.

HHSC has determined that subcontracting opportunities are probable for this RFP for MCO Administrative Services. MCO Administrative Services are those services or functions other than the direct delivery of medical Covered Services necessary to manage the delivery of and payment for these services. MCO Administrative Services include Network, utilization, clinical or quality management, service authorization, claims processing, MIS operation, and reporting. The Respondent must submit an HSP (see the **RFP Procurement Library**) with its proposal for these MCO Administrative Services. The HSP is required whether a Respondent intends to subcontract or not.

HSP requirements will not apply to subcontracts with Network Providers (providers who contract directly with the MCO to deliver medical Covered Services to STAR Health Members). A Respondent therefore should not include Network Providers' participation in its HSP submissions.

In the HSP, a Respondent must indicate whether it is a Texas-certified HUB. Being a certified HUB does not exempt a respondent from completing the HSP requirement.

HHSC will review the documentation submitted by the respondent to determine if a good faith effort has been made in accordance with solicitation and HSP requirements. During the good faith effort evaluation, HHSC may, at its discretion, allow revisions necessary to clarify and enhance information submitted in the original HSP.

If HHSC determines that the respondent's HSP was not developed in good faith, the HSP will be considered non-responsive and will be rejected as a material failure to comply with advertised specifications. The reasons for rejection will be recorded in the procurement file.

#### 4.2.5.5 CPA Centralized Master Bidders List (CMBL)

Respondents may search for HUB subcontractors in the CPA's Centralized Master Bidders List (CMBL) HUB Directory, which is located on the CPA's website at <http://www2.cpa.state.tx.us/cmb/cmbhub.html>. For this procurement, HHSC has identified the following class and item codes for potential subcontracting opportunities.

NIGP Class/Item Code:

1. 948-07: Administration Services, Health;
2. 958-56: Healthcare Management Services (Including Managed Care Services); and

3. 915-49: High Volume, Telephone Call Answering Services (See 915-05 for Low Volume Services)

Respondents are not required to use, nor limited to using, the class and item codes identified above, and may identify other areas for subcontracting.

HHSC does not endorse, recommend, or attest to the capabilities of any company or individual listed on the CPA's CMBL. The list of certified HUBs is subject to change, so Respondents are encouraged to refer to the CMBL often to find the most current listing of HUBs.

**4.2.5.6 HUB Subcontracting Procedures – If a Respondent Intends to Subcontract**

An HSP must demonstrate that the Respondent made a good faith effort to comply with HHSC's HUB policies and procedures. The following subparts outline the items that HHSC will review in determining whether an HSP meets the good faith effort standard. A Respondent that intends to subcontract must complete the HSP to document its good faith efforts.

**4.2.5.6.1 Identify Subcontracting Areas and Divide Them into Reasonable Lots**

A Respondent should first identify each area of the contract MCO Administrative Service work it intends to subcontract. Then, to maximize HUB participation, it should divide the contract MCO Administrative Service work into reasonable lots or portions, to the extent consistent with prudent industry practices.

**4.2.5.6.2 Notify Potential HUB Subcontractors**

The HSP must demonstrate that the respondent made a good faith effort to subcontract with HUBs. The Respondent's good faith efforts will be shown through utilization of all methods in conformance with the development and submission of the HSP and by complying with the following steps:

1. Divide the contract work into reasonable lots or portions to the extent consistent with prudent industry practices. The Respondent must determine which portions of work, including goods and services, will be subcontracted.
2. Use the appropriate method(s) to demonstrate good faith effort. The Respondent can use method(s) 1, 2, 3, or 4:

**Method 1: Respondent Intends to Subcontract with only HUBs:**

The Respondent must identify in the HSP the HUBs that will be utilized and submit written documentation that confirms 100% of all available subcontracting opportunities will be performed by one or more HUBs; **or**,

**Method 2: Respondent Intends to Subcontract with HUB Protégé(s):**

The Respondent must identify in the HSP the HUB protégé(s) that will be utilized and should:

1. Include a fully executed copy of the Mentor Protégé Agreement, which must be registered with the CPA prior to submission to HHSC; and

2. Identify areas of the HSP that will be performed by the protégé.

HHSC will accept a Mentor Protégé Agreement that has been entered into by a respondent (mentor) and a certified HUB (protégé) in accordance with Texas Government Code § 2161.065. When a Respondent proposes to subcontract with a protégé(s), it does not need to provide notice to three HUB vendors for that subcontracted area.

Participation in the Mentor Protégé Program, along with the submission of a protégé as a subcontractor in an HSP, constitutes a good faith effort for the particular area subcontracted to the protégé; or,

**Method 3: Respondent Intends to Subcontract with HUBs and Non-HUBs (Meet or Exceed the Goal):**

The Respondent must identify in the HSP and submit written documentation that one or more HUB subcontractors will be utilized; and that the aggregate expected percentage of subcontracts with HUBs will meet or exceed the goal specified in this solicitation. When utilizing this method, only HUB subcontractors with existing contracts with the Respondent for five years or less may be used to comply with the good faith effort requirements.

When the aggregate expected percentage of subcontracts with HUBs meets or exceeds the goal specified in this solicitation, respondents may also use non-HUB subcontractors; or,

**Method 4: Respondent Intends to Subcontract with HUBs and Non-HUBs (Does Not Meet or Exceed the Goal):**

The Respondent must identify in the HSP and submit documentation regarding both of the following requirements:

1. written notification to minority or women trade organizations or development centers to assist in identifying potential HUBs of the subcontracting opportunities the respondent intends to subcontract.

Respondents must give minority or women trade organizations or development centers at least seven working days prior to submission of the Respondent's response for dissemination of the subcontracting opportunities to their members. A list of minority and women trade organizations is located on HHSC's website under the [Minority and Women Organization link.](#)

2. written notification to at least three HUB businesses of the subcontracting opportunities that the respondent intends to subcontract. The written notice must be sent to potential HUB subcontractors prior to submitting proposals and must include:

- a. a description of the scope of work to be subcontracted;
- b. information regarding the location to review project plans or specifications;
- c. information about bonding and insurance requirements;
- d. required qualifications and other contract requirements; and
- e. a description of how the subcontractor can contact the respondent.

Respondents must give potential HUB subcontractors a reasonable amount of time to respond to the notice, at least seven working days prior to submission of the respondent's response unless circumstances require a different time period, which is determined by the agency and documented in the contract file.

Respondents must also use the CMBL, the HUB Directory, and Internet resources when searching for HUB subcontractors. Respondents may rely on the services of contractor groups; local, state, and federal business assistance offices; and other organizations that provide assistance in identifying qualified applicants for the HUB program.

#### **4.2.5.6.3 Written Justification of the Selection Process**

HHSC will make a determination if a good faith effort was made by the respondent in the development of the required HSP. One or more of the methods identified in the previous sections may be applicable to the respondent's good faith efforts in developing and submission of the HSP. HHSC may require the respondent to submit additional documentation explaining how the respondent made a good faith effort in accordance with the solicitation.

A Respondent must provide written justification of its selection process if it chooses a non-HUB subcontractor. The justification should demonstrate that the respondent negotiated in good faith with qualified HUB bidders, and did not reject qualified HUBs who were the best value responsive bidders.

#### **4.2.5.7 HUB Subcontracting Procedures – If a Respondent Does Not Intend to Subcontract**

If the Respondent plans to complete all contract MCO Administrative Service requirements with its own equipment, supplies, materials, or employees, it is still required to complete an HSP.

The Respondent must complete the "Self Performance Justification" portion of the HSP, and attest that it does not intend to subcontract for any administrative goods or services, including the class and item codes identified in **RFP Section 4.2.5.5**, "CPA Centralized Master Bidders List." In addition, the Respondent must identify the sections of the proposal that describe how it will complete the Scope of Work using its own resources or provide a statement explaining how it will complete the Scope of Work using its own resources. The Respondent must agree to comply with the following if requested by HHSC:

1. Provide evidence of sufficient respondent staffing to meet the RFP requirements;
2. provide monthly payroll records showing the respondent staff fully dedicated to the contract;
3. allow HHSC to conduct an on-site review of company headquarters or work site where services are to be performed; and
4. provide documentation proving employment of qualified personnel holding the necessary licenses and certificates required to perform the Scope of Work.

#### **4.2.5.8 Post-award HSP Requirements**

The HSP will be reviewed and evaluated prior to contract award and, if accepted, the finalized HSP will become part of the contract with the successful respondent(s).

After contract award, HHSC will coordinate a post-award meeting with the successful Respondents to discuss HSP reporting requirements. The MCO must maintain business records documenting compliance with the HSP, and must submit monthly reports to HHSC by completing the HUB “[Prime Contractor Progress Assessment Report](#).” This monthly report is required as a condition for payment and tells the agency the identity and the amount paid to all subcontractors.

As a condition of award the Contractor is required to send notification to all selected subcontractors as identified in the accepted/approved HSP. In addition, a copy of the notification must be provided to the agency’s Contract Manager or HUB program Office within 10 days of the contract award.

During the term of the contract, if the parties in the contract amend the contract to include a change to the scope of work or add additional funding, HHSC will evaluate to determine the probability of additional subcontracting opportunities. When applicable, the Contractor must submit an HSP change request for HHSC review. The requirements for an HSP change request will be covered in the post-award meeting.

**UMCM-Chapter 5.4.4**, “HUB Reports,” outlines the procedures for changing the HSP, as well as the HSP compliance and reporting requirements. When making a change to an HSP, the Contractor will obtain prior written approval from HHSC before making any changes to the HSP. Proposed changes must comply with the HUB program good faith effort requirements relating to the development and submission of the HSP.

If the MCO decides to subcontract any part of the contract after the award, it must follow the good faith effort procedures outlined in **RFP Section 4.2.5.6**, “HUB Subcontracting Procedures,” (e.g., divide work into reasonable lots, notify at least three vendors per subcontracted area, provide written justification of the selection process, or participate in the Mentor Protégé Program).

For this reason, HHSC encourages Respondents to identify, as part of their HSP, multiple subcontractors who are able to perform the work in each area the Respondent plans to subcontract. Selecting additional subcontractors may help the selected MCO make changes to its original HSP, when needed, and will allow HHSC to approve any necessary changes expeditiously.

Failure to meet the HSP and post-award requirements will constitute a breach of contract, and will be subject to remedial actions. HHSC may also report noncompliance to the CPA in accordance with the provisions of the Vendor Performance and Debarment Program (see [34 Tex. Admin. Code § 20.108](#) and [34 Tex. Admin. Code § 20.105](#)).

#### **4.2.6 Section 6 – Certifications and Other Required Forms**

Respondents must submit the following required forms with their proposals:

1. Child Support Certification;
2. Debarment, Suspension, Ineligibility, and Voluntary Exclusion of Covered Contracts;
3. Federal Lobbying Certification;
4. Nondisclosure Statement;

5. Required Certifications; and
6. Respondent Information and Disclosures.

The required forms are located on HHSC’s website, under the “Business Opportunities” link. HHSC encourages Respondents to carefully review all of these forms and submit questions regarding their completion prior to the deadline for submitting questions (see **RFP Section 1.3**, “Procurement Schedule”).

Respondents should note that the “[Respondent Information and Disclosures](#)” form asks Respondents to provide information on certain litigation matters. In addition to the information required on this form, Respondents must provide all of the information described in **UMCM Chapter 5.8**, “[Report of Legal and Other Proceedings and Related Events](#).” Respondents may include this supplemental information on the “Respondent Information and Disclosures” form, or under a separate submission.

### **4.3 Part 3 – Programmatic Proposal**

Respondents must provide a detailed description of the proposed programmatic solution, which must support all business activities and requirements described in the RFP. The Programmatic Proposal must reflect a clear understanding of the nature of the work undertaken.

Respondents should carefully read the submission requirement instructions for specific questions in this section. For each applicable programmatic submission requirement, the Respondent must indicate, in addition to the information requested in each subsection, the following information if applicable to the Respondent and its Proposal:

**Material Subcontractor:** If the Respondent plans to provide the service or perform the function through a Material Subcontractor, the Respondent must detail the services or function to be subcontracted, and how the Respondent and the Material Subcontractor will coordinate the service or function. Describe the specific management tools and strategies the Respondent will use to provide oversight of the Material Subcontractor’s performance. Respondents should describe any prior working relationships with the Material Subcontractor.

**Action Plan:** This requirement applies to any Respondent who is not currently (1) providing services or performing functions relating to a specific RFP submission, or (2) meeting the Operations Phase Requirements in **RFP Section 8** relating to a specific submission requirement for the STAR Health Program. In the Action Plan, the Respondent must, for each submission requirement describe:

1. the services, functions, or requirements the Respondent is not currently performing;
2. its current comparable experience and abilities, if any; and
3. how the Respondent must meet the STAR Health Contract responsibilities, including assigned staffing and resources for completing the services, functions, or requirements and a timeline for completing each.

In responding to questions for which the Respondent includes information about a Material Subcontractor or Action Plans, up to one page may be used to describe each Material Subcontractor

arrangement and up to one page may be used to describe each Action Plan. These pages are outside of the page limit instructions for the specific submission requirement.

HHSC understands that some Respondents may not have current experience providing managed care services to STAR Health Program members in Texas. In responding to questions relating to experience, Respondents should clearly indicate if their experience is in Texas, and if their experience is with STAR Health or other comparable populations.

The Programmatic Proposal must include a detailed description of the following Program components, at a minimum:

- **Section 1 – Proposed Capacity**
- **Section 2 – Experience Providing Covered Services**
- **Section 3 – Value-added and Case-by-Case Added Services**
- **Section 4 – Access to Care**
- **Section 5 – Provider Network Provisions**
- **Section 6 – Member Services**
- **Section 7 – Quality Assessment and Performance Improvement (QAPI)**
- **Section 8 – Utilization Management (UM)**
- **Section 9 – Early Childhood Intervention (ECI)**
- **Section 10 – Health Passport**
- **Section 11 – Service Management and Service Coordination**
- **Section 12 – Health Home**
- **Section 13 – Disease Management (DM)**
- **Section 14 – Behavioral Health (BH) Services**
- **Section 15 – Pharmacy Services**
- **Section 16 – Management Information Systems (MIS) Requirements**
- **Section 17 – Fraud, Waste, and Abuse**
- **Section 18 – Transition Plan**

#### **4.3.1 Section 1 – Proposed Capacity**

(3 pages, excluding tables)

The Respondent must:

1. complete the MCO program Proposed Capacity table found in the **RFP Procurement Library**, which must include an estimate of the number of HHSC MCO Members the Respondent has the capacity to serve on the Operational Start Date;
2. describe the calculations and assumptions used to arrive at these capacity projections. In developing these projections, the Respondent should consider the capacity of its Network, including its PCP Network, its BH Services Network, its specialty care Network, and its Pharmacy Network. Respondents should specify:
  - a. the anticipated STAR Health Program enrollment;
  - b. the expected utilization of services, taking into consideration the characteristics and healthcare needs of specific populations represented in the STAR Health Program;
  - c. the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the Covered Services;
  - d. the numbers of Network Providers and providers with signed contracts, LOAs, or LOIs who are not accepting new patients, by MCO program;
  - e. the geographic location of providers and HHSC MCO members, considering travel time, the means of transportation ordinarily used by HHSC MCO members, and whether the location provides physical access for members with disabilities; and
  - f. generally describe anticipated capacity changes, if any, over the Initial Contract Period; and
  - g. generally describe methods that the MCO will use to ensure access to all Covered Services upon potential population growth due to changes in law.

#### **4.3.2 Section 2 – Experience Providing Covered Services**

(3 pages)

Covered Services are described in **RFP Section 8.1.2**, “Covered Services,” and **Section 11**, “Covered Services.”

The Respondent must briefly describe the Respondent’s experience providing services equivalent or comparable to STAR Health Covered Services described in **RFP Section 11**:

1. Indicate which STAR Health Covered Service(s) (in whole or in part) the Respondent does not have experience providing on a capitated basis or does not have experience providing to a comparable population.
2. Briefly describe the Respondent’s proposal for providing Covered Services, including any plans for expansions of its Provider Network prior to a Readiness Review. If the Respondent proposes to use a Material Subcontractor to provide BH Services, the Respondent must describe its relationship with the Material Subcontractor, as required by **RFP Section 4.3**, “Part 3--Programmatic Proposal.”
3. Describe the Respondent’s experience in providing Service Management or Service Coordination to the STAR Health population or a comparable population. Respondent should specifically describe the processes and procedures used to coordinate non-capitated services and community

resources. If the Respondent does not have experience coordinating these services, indicate how the Respondent intends to meet this requirement.

### **4.3.3 Section 3 – Value-added and Case-by-Case Added Services**

#### **4.3.3.1 Value-Added Services**

(1 page per Value-added Service)

Respondents may propose to offer Value-added Services as described in **RFP Section 8.1.2.1**, “Value-added Services.” If offered, the Respondent will not receive additional compensation for Value-added Services, and may not report the costs of Value-added Services as allowable medical or administrative costs.

For each MCO program and Value-added Service proposed, the Respondent must:

1. define and describe the Value-added Service;
2. identify the category or group of Members eligible to receive the proposed Value-added Services if it is a type of service that is not appropriate for all Members;
3. note any limitations or restrictions that apply to the Value-added Services;
4. if the Value-added Service is not a Healthcare Service or benefit, specify which staff will determine whether a Member is eligible to receive the Value-added Service;
5. identify the types of Providers or other person(s) responsible for providing the Value-added Service, including any limitations on Provider or other person’s capacity if applicable;
6. describe how the Respondent will identify the Value-added Service in administrative data (Encounter Data), or will otherwise document the delivery of the Value-added Service;
7. propose how and when Providers and Members will be notified about the availability of any Value-added Service;
8. describe how a Member may obtain or access the Value-added Service; and
9. include a statement that the Respondent will provide any Value-added Service(s) that are approved by HHSC for at least 12 months after the Operational Start Date of the Contract.

#### **4.3.3.2 Case-by-Case Added Services**

(1 page per Service)

Respondents must briefly describe any Case-by-Case Added Services, which the Respondent proposes could, based upon Medical Necessity criteria, be cost-effective and have the potential for the improved health status of Members in the STAR Health population or a comparable population. Describe an example in which a service might be proposed to the Member, or the Member’s Medical Consenter, in lieu of the typical scope of services.

### **4.3.4 Section 4 – Access to Care**

Access to Care standards are described in **RFP Section 8.1.3**, “Access to Care.”

#### 4.3.4.1 Travel Distances

(no page limit, should only submit applicable tables)

Submit tables created using **UMCM Chapter 5.14.4**, “STAR Health Geo-Mapping Report,” **UMCM Chapter 5.14.5**, “STAR Health and Medicaid Dental Geo-Mapping Report,” and maps created using Geo-Access, or a comparable software program, to demonstrate the geographic adequacy of the Respondent’s proposed Provider Network compared to the projected population statewide. For purposes of Geo Mapping, the distribution method will be to place all members at the center of the zip code.

Providers in the demonstrated Provider Network must have an executed contract with the Respondent, a letter of intent (LOI), or a letter of agreement (LOA) indicating the provider intends to contract with the Respondent if HHSC awards the Respondent an MCO Contract. Respondents do not need to submit the signed contracts, LOIs, or LOAs with the Proposal, but HHSC may request to review these documents during its evaluation of the Proposal. Providers who have not signed a Network Provider contract or LOI/LOAs may **not** be included in the Respondent’s Network for purposes of responding to this RFP submission requirement.

Respondents should submit one set of the above tables and maps.

#### 4.3.4.2 Assessing Access to Care

(5 pages)

1. Identify the processes by which the Respondent must measure and regularly verify:
  - a. Network compliance, including pharmacy, regarding travel distance access in **RFP Section 8.1.3.2**, “Access to Network Providers;”
  - b. Provider compliance regarding appointment access standards in **RFP Section 8.1.3.1**, “Waiting Times for Appointments,” and
  - c. PCP compliance with after-hours coverage standards in **RFP Section 8.1.4.2**, “Primary Care Providers and the Medical Home.”
2. Describe the steps the Respondent has taken in the past when it identified a deficiency in its compliance with plan or state travel distance access standards. The description should include how the Respondent will address deficiencies in the Network related to:
  - a. the lack of an age-appropriate PCP with an Open Panel within the required travel distance;
  - b. the lack of inpatient BH Services within the required travel distance;
  - c. the lack of outpatient BH Services from Providers, including child psychiatrists, within the required travel distance;
  - d. the lack of a specialist within the travel distance of a Member's residence;
  - e. for female Members that may have experienced sexual abuse and female Members of childbearing age, the lack of an OB/GYN within the travel distance of the Member's residence; and
  - f. the lack of a Network pharmacy within the travel distance of the Member's residence.
3. Describe the steps the Respondent has taken in the past when it identified a deficiency in its compliance with a Provider that:
  - a. was not meeting plan or state appointment access standards, and

- b. a PCP that was not in compliance with the plan or state after-hours coverage requirements.

If the Respondent has not taken the steps listed in 2 and 3 above with regularity, describe how it proposes to take those steps in the future.

- 4. Describe the processes the Respondent will implement to accommodate additional Members and to ensure the access standards are met if actual enrollment exceeds projected enrollment.
- 5. Describe how the Respondent will provide training to ensure the Providers understand and respond to the STAR Health population’s special healthcare needs.
- 6. Describe how the Respondent plans to provide BH Emergency Services, including emergency screening services, Emergency Services and short-term crisis stabilization services, and how the Respondent will address a Provider not meeting the Respondent’s or state’s appointment standards.

#### **4.3.5 Section 5 – Provider Network Provisions**

Provider Network requirements are primarily described in **RFP Section 8.1.4**, “Provider Network.” In addition, the STP requirements applicable to Medicaid MCOs are described in **RFP Section 8.1.29**, “Medicaid Significant Traditional Providers (STPs).” Respondents should review these RFP requirements when developing their responses to questions in this section.

The Respondent must provide a narrative overview in its proposal of the Respondent’s Network. This narrative must include a description of the deficiencies in the Respondent’s proposed Provider Network and a description of how the Respondent’s Network addresses the BH needs and other special needs of the STAR Health population.

The Respondent must provide a Provider Network Development Plan in its proposal that details how the Respondent will address any Provider Network deficiencies before the Operational Start Date. The Respondent should describe the items below as part of the Provider Network Development Plan:

- 1. Timeframes for addressing deficiencies;
- 2. types of providers that the Respondent will recruit, including STPs;
- 3. how the Respondent will recruit the providers, including STPs;
- 4. who will be responsible for recruiting the providers; and
- 5. how the Respondent will determine that the Provider Network is complete.

After the Contract Effective Date, the MCO must provide updates to the Provider Network Development Plan on a fixed schedule as determined by HHSC.

##### **4.3.5.1 Provider Network**

(1 page, excluding Provider listing and tables)

Network Providers must have an executed contract with the Respondent, a (LOI, or a LOA indicating the Provider intends to contract with the Respondent should HHSC award the Respondent a contract for the applicable MCO program. Network Providers must be licensed in the State of Texas to provide the contracted Covered Services. As described in **RFP Section 8.1.4**, “Provider Network,” Network Providers must be credentialed by selected Respondents prior to serving Members. Sample LOI/LOA agreements and sample Network Providers tables can be found in the **RFP Procurement Library**.

1. The Respondent must submit a complete list of proposed Network Providers for each of the following Acute Care provider types that would be responsible for providing Covered Services. The list must indicate for each provider type, the name, address, and NPI (and TPIN, if applicable) of the Providers with signed contracts, LOIs, or LOAs. The Respondent must include in an Excel file at least the two nearest Providers meeting each of the following provider type descriptions. The Respondent must also include in the Excel file all Providers in the designated provider type within the Service Area. The listing must include separate lists of each provider type of Acute Care Services in the order listed below:
  - a. Acute Care Hospitals, inpatient, and outpatient services;
  - b. Hospitals providing Level 1 trauma care;
  - c. Hospitals providing Level 2 trauma care;
  - d. Hospitals designated as transplant centers;
  - e. Hospitals designated as Children’s Hospitals by the CMS;
  - f. other Hospitals with specialized pediatric services;
  - g. Psychiatric Hospitals providing mental health services, inpatient and outpatient;
  - h. other facilities or clinics providing outpatient BH services;
  - i. Hospitals providing substance abuse services, inpatient and outpatient; and
  - j. other facilities or clinics providing outpatient substance abuse services.
2. Identify the types of Providers the Respondent allows as PCPs for adults, PCPs for children, and outpatient BH Service Providers. The Respondent should identify its contractual requirements for these provider types and any exceptions. For example, Respondent should note under what circumstances, if any, an internist is allowed to be a PCP for children, a family practitioner is allowed to be an OB/GYN, or a certified nurse midwife practicing under a physician that qualifies as a PCP is allowed to be a PCP.

#### **4.3.5.2 Significant Traditional Providers (STPs)**

(No page limit for STP tables, 1 page for narrative)

The STP requirements applicable to Medicaid MCOs are described in **RFP Section 8.1.29**. HHSC-designated Medicaid STPs can be found in the **RFP Procurement Library**. For each STP provider type, the Respondent must complete the “STP Network Percentage Table” charts provided in the **RFP Procurement Library**. The total number of STPs can be found in the **RFP Procurement Library** by type of STP.

Respondent may provide a one-page narrative to explain STP status.

### 4.3.5.3 Provider Network Capacity

(3 pages)

HHSC has targeted improved Network capacity and improved Member access to Covered Services as a priority for the Initial Contract Period.

1. Indicate which, if any, Covered Services are not available from a qualified Provider in the Respondent’s proposed Network in the Service Area and how the Respondent proposes to provide the Covered Services to Members in the Service Area; and
2. Briefly describe how deficiencies will be addressed when the Provider Network is unable to provide a Member with appropriate access to Covered Services due to lack of a qualified, Network Providers within the travel distance of the Member’s residence specified in **RFP Section 8.1.3.2**, “Access to Network Providers.” The description should include how the Respondent will address deficiencies in the Network related to:
  - a. the lack of an age-appropriate PCP with an Open-Panel within the required travel distance of the Member’s residence;
  - b. the lack of inpatient and outpatient BH Services, including child psychiatrists, within the required travel distance;
  - c. the lack of a cardiologist within the travel distance of the Member’s residence;
  - d. the lack of an OB/GYN within the travel distance of the Member’s residence; and
  - e. the lack of a Network pharmacy within the travel distance of the Member’s residence.

### 4.3.5.4 Credentialing and Re-credentialing

(5 pages)

Provider credentialing and re-credentialing requirements are described in **RFP Section 8.1.4.4**, “Provider Credentialing and Re-credentialing.” For all of the following submission requirements, instead of attaching copies of the Respondent’s credentialing/re-credentialing policies and procedures, the Respondent should provide a brief summary of its policies and procedures.

1. Describe the Respondent’s minimum credentialing and licensure requirements and procedures for each type of Provider listed in **RFP Section 8.1.4**, “Provider Network,” and demonstrate how the Respondent ensures, or proposes to ensure, that the minimum credentialing requirements are met by any Provider rendering Covered Services. The description must demonstrate compliance with **RFP Section 8.1.4.4**, “Provider Credentialing and Re-credentialing.” If the Respondent uses a Material Subcontractor for any portion of its Provider Network and delegates responsibility for that Network to the Material Subcontractor, the Respondent must describe how it will ensure that the Material Subcontractor’s Providers meet minimum credentialing requirements.
2. Describe the re-credentialing process, including any credentialing activities that occur between formal re-credentialing cycles for Providers.
3. Describe how the DFPS background check process is integrated into the Respondent’s credentialing process.
4. Describe how the Respondent will capture and assess the following information:

- a. Member Pre-Appeals, Complaints and Appeals
  - b. Results from quality reviews and Provider quality profiling
  - c. UR information
  - d. Information from licensing and accreditation agencies.
5. A Respondent currently operating in Texas must separately report the following information. A Respondent not currently operating in Texas must separately report the same information for a managed care program it operates in another state similar to the STAR Health Program:
- a. the percentage of providers in its Texas network re-credentialed in the past three years, for the following provider types: Primary Care Provider specialty care physician, and masters-level outpatient BH providers; and
  - b. the number and percentage of providers in its Texas network who were subjected to the regularly scheduled re-credentialing process over the past 24 months that were denied continued network status.
  - c. the number and percentage of providers in its Texas network who were subjected to a DFPS background check and were denied network status due to the associated findings.

#### **4.3.5.5 Provider Training**

(5 pages)

Provider training requirements are described in **RFP Section 8.1.4.6**, “Provider Relations Including Manual, Materials and Training.”

1. Provide a brief description of the proposed Provider training programs. The description should include:
  - a. the types of programs to be offered, including the modality of training;
  - b. what topics will be covered (such as billing, complaints and appeals, service coordination);
  - c. how the Respondent will specifically train Providers on issues such as the special needs of the STAR Health population and accessing local community resources relevant to the STAR Health population;
  - d. which Providers will be invited to attend;
  - e. how the Respondent proposes to maximize Provider participation, including how the Respondent proposes to use Internet and televideo capabilities to provide training;
  - f. how Provider training programs will be evaluated;
  - g. the frequency of Provider training;
  - h. how the Respondent will facilitate training programs for Providers to receive continuing education credits; and
  - i. how the Respondent will specifically train Providers to be attuned to the need for increased sensitivity and respect for confidentiality in dealing with the STAR Health population.
2. Briefly describe two examples of recent Provider training programs conducted by the Respondent that may be relevant to the STAR Health Program. These examples must include:
  - a. a description of the training program;
  - b. a summary of distributed materials (the actual materials are not to be submitted);
  - c. number and type of attendees; and
  - d. results of any evaluations from the training.

A Respondent currently participating in any of HHSC’s Medicaid MCO programs must submit the above Provider training examples for each MCO program.

A Respondent not currently participating in one or more of HHSC’s Medicaid MCO programs must submit the above provider training examples for a similar managed care program. If the Respondent referenced a non-HHSC managed care program in another submission requirement, the Respondent must submit its provider education information in this submission requirement.

#### **4.3.5.6 Provider Hotline**

(3 pages; excluding hotline telephone reports)

Describe the proposed Provider Hotline function and how the Respondent would meet the requirements of **RFP Section 8.1.4.8**, “Provider Hotline.” The description must include:

1. normal hours of operation of the hotline;
2. staffing for the hotline;
3. training for the hotline staff on Covered Services and STAR Health Program requirements;
4. the routing of calls among hotline staff to ensure timely and appropriate response to provider inquiries;
5. responsibilities of hotline staff, if any, in addition to responding to Provider Hotline calls (e.g., responding to non-Network provider calls or Member Hotline calls);
6. after-hours procedures and available services;
7. Provider Hotline telephone reports for the most recent four quarters with data that show:
  - a. monthly trends for call volume,
  - b. the monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and
  - c. the monthly trends for the abandonment rate.
8. whether the Provider Hotline has the capability to administer automated surveys to callers at the end of calls.

A Respondent currently participating in any of HHSC’s Medicaid MCO programs must submit the information in **RFP Section 4.3.5.6(7)** for each Provider Hotline operated, and identify any proposed changes to Provider Hotline functions that would occur under the STAR Health Program.

A Respondent not currently participating in any of HHSC’s Medicaid MCO programs must submit the information in **RFP Section 4.3.5.6(7)** for a similar managed care program that it operates. If a Respondent referenced a non-HHSC managed care program in another submission requirement, the Respondent must submit its Provider Hotline telephone report for the same managed care program.

#### **4.3.5.7 Provider Incentives**

(2 pages)

Provide a high-level description of the processes the Respondent will put in place to meet the requirements as described in **RFP Section 8.1.4.11**, “Provider Incentives.”

The Respondent must submit a proposal for a pilot “gain sharing” program. The program should focus on collaborating with Network physicians and Hospitals in order to allow them to share a portion of the Respondent’s savings resulting from reducing inappropriate utilization of services, including inappropriate admissions and readmissions. The proposal should include mechanisms for the Respondent to provide incentive payments to Hospitals and physicians for quality care. The proposal should include quality metrics required for incentives, recruitment strategies of providers, and a proposed structure for payment.

#### **4.3.5.8 Medical Advisory Committees (MACs)**

(2 pages)

For the STAR Health Program, the Respondent must:

1. Describe the role of the MAC in establishing and monitoring clinical policies and procedures, and in developing and updating clinical practice guidelines.
2. Describe how the Respondent will encourage and provide an opportunity for its Providers to have access to peer-to-peer consultation and to consult with the MCO’s physical health staff and BH staff.
3. The Respondent must describe the process for implementing and maintaining the MAC, including the selection of participants and how the Respondent will ensure participation.

#### **4.3.6 Section 6 – Member Services**

##### **4.3.6.1 Member Services Staffing**

(7 pages; excluding organizational charts)

The MCO must maintain a Member Services Department to assist Members, Caregivers, Medical Consenters, Single Source Continuum Contractor (SSCC) staff, and DFPS Staff in obtaining Covered Services for Members as described in RFP **Section 8.1.5, “Member Services.”**

1. Provide an organizational chart of the Member Services Department, showing the placement of Member Services within the Respondent’s organization and showing the key staff within the Member Services Department.
2. Explain the functions of the Member Services staff, including brief job descriptions and qualifications.
3. Describe the training the Respondent will provide to Members, Caregivers, SSCC staff, and DFPS staff on topics such as navigating the healthcare system and accessing local community resources.
4. Describe the curriculum for training the MCO will provide to the MCO’s Member Services representatives. The description should include training schedules and how the trainings will prepare Member Services representatives to assist Members, Caregivers, Medical Consenters, SSCC staff, and DFPS Staff with:
  - a. access to Covered Services, including the medical consent process, access to Texas Health Steps (THSteps) medical checkups and BH Services;
  - b. understanding STAR Health requirements;
  - c. coordinating clinical assessments, access to court-ordered services, and special evaluations to facilitate Member facility admissions (such as psychosocial or psychological evaluations,

- psychometric testing, and neuropsychological evaluations) as necessary to meet the Member's needs and facility licensing and admission requirements;
- d. sharing of information between the MCO and other parties such as DFPS and Caregivers responsible for ensuring the Member's safety;
  - e. understanding and being prepared to address Members' cultural needs;
  - f. providing assistance to Members with limited English proficiency, including developing Member Materials and providing language assistance to Members speaking languages of Major Population Groups making up 10 percent or more of the population; and
  - g. educating Members, DFPS staff, SSCC staff, and Caregivers about Non-capitated Services and providing referrals for these services.
5. Identify the turnover rate for Member Services staff in the past two years. A Respondent operating any HHSC Medicaid MCO program must provide the staff turnover rate of these programs. A Respondent not currently operating an HHSC Medicaid MCO program must provide its Member Services staff turnover rate for a comparable managed care program and identify the managed care program.
  6. Identify the number of Member Services staff Respondent intends to dedicate to the Service Coordination function and describe their professional backgrounds.
  7. Identify the percentage of Member Services staff who will be physically located in the Service Area.

#### **4.3.6.2 Member Hotline**

(3 pages; excluding hotline telephone reports)

The Member Hotline requirements are described in **RFP Section 8.1.5.6**, "Nurse and Member Hotline Requirements."

Describe the proposed Member Hotline function, including:

1. normal hours of operation;
2. number of Member Hotline staff dedicated to the STAR Health Program, expressed in the number of full time employees (FTEs) per 1000 Members who are available 8:00 a.m. to 5:00 p.m., local time in all areas of the state, Monday through Friday, excluding state-approved holidays;
3. routing of calls among Member Hotline staff to ensure timely and accurate response to Member inquiries;
4. responsibilities of Member Hotline staff, if any, in addition to responding to STAR Health Member Hotline calls, (e.g., responding to non-STAR Health Member calls or Provider Hotline or BH Hotline calls );
5. after-hours procedures and available services, including those provided to non-English speaking Members and Members who are deaf or hard-of-hearing;
6. the number and percentage of FTE Member Hotline staff who are bilingual in English and Spanish;
7. the number and percentage of FTE Member Hotline staff who are multi-lingual for any additional language, by language spoken;
8. the number and percentage of FTE Member Hotline staff dedicated to the Service Coordination function;
9. Member Hotline telephone reports for the most recent four quarters with data that show:
  - a. the monthly trends for call volume;

- b. monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and
  - c. monthly trends for the abandonment rate; and
10. whether the Member Hotline has the capability to administer automated telephonic surveys to callers at the end of calls.

A Respondent currently participating in any of HHSC’s Medicaid MCO programs must submit the information in items 1 through 10 above for each Member Hotline operated, and identify any proposed changes to hotline functions for the STAR Health Program.

If the Respondent is not currently participating in any of HHSC’s Medicaid MCO programs, it should describe its experience and proposed approach in establishing and maintaining an accessible call center for members that is comparable to the Member Hotline described in **RFP Section 8.1.5.6**, “Nurse and Member Hotline Requirements.” The description must include the information listed in items 1 to 10 above.

Finally, if a Respondent is proposing to use a single point of access, i.e., toll-free number, for multiple hotlines (e.g., Member Services, BH, Nurse Hotline, and Provider Hotline), the Respondent shall note in its proposal the differences, if any, in its staffing for each of these Hotlines, and shall describe how calls to the Hotline(s) are triaged.

#### **4.3.6.3 Member Service Scenarios**

(8 pages)

Describe the procedures a Member Services representative will follow to deal with the following situations:

1. A Member, Caregiver, Medical Consenter, or DFPS caseworker has received a bill for payment of Covered Services from a Network Provider or Out-of-Network provider;
2. a Member, Caregiver or Medical Consenter is unable to reach her PCP after normal business hours;
3. a Member, Caregiver or Medical Consenter is having difficulty scheduling an appointment for preventive care with her PCP;
4. a Member, Caregiver, Medical Consenter, or DFPS caseworker requests assistance as the Member became ill while traveling outside of the state;
5. a Member, Caregiver or Medical Consenter has a request for a specific medication that the pharmacy is unable to provide;
6. a Member or Caregiver does not speak English;
7. a Caregiver or Medical Consenter calls after hours asking for assistance in managing the Member’s BH crisis;
8. a Caregiver or Medical Consenter calls to complain that the Member’s Substitute Care status was discussed in a loud voice in the waiting room of the PCP’s office;
9. a Provider who has been ordered by the Court to provide an assessment of the Member calls with questions regarding the assessment;
10. a DFPS caseworker calls asking for the results of a Member’s medical assessment;
11. a Member’s PCP calls to report a suspicion that he/she is treating an adolescent with a substance abuse problem;

12. a Caregiver, Medical Consenter, or DFPS caseworker believes the Member is not receiving needed home and community-based services;
13. a Caregiver or a Member with a hearing impairment or another communicative disorder calls the Member Hotline and needs assistance; and
14. a Caregiver, Medical Consenter, or DFPS caseworker calls requesting that a Member be enrolled in Service Management; and
15. a Caregiver or a Medical Consenter calls to request Personal Care Services for a Member with complex needs.

#### 4.3.6.4 Nurse Hotline

(3 pages; excluding hotline telephone reports)

The Nurse Hotline requirements are described in **RFP Section 8.1.5.6**, “Nurse and Member Hotline Requirements.”

Describe the proposed Nurse Hotline function and how its purpose differs from the Member Hotline, including:

1. normal hours of operation;
2. number of nurses dedicated to the STAR Health Program Nurse Hotline, expressed in the number of FTEs per 1000 Members who are available 8:00 a.m. to 5:00 p.m., local time in all areas of the state, Monday through Friday, excluding state-approved holidays;
3. routing of calls to Nurse Hotline nurses, to ensure timely and accurate response to Member inquiries;
4. responsibilities of Nurse Hotline staff, if any, in addition to responding to STAR Health Nurse Hotline calls, (e.g., responding to non-STAR Health Member calls or Provider Hotline or BH Hotline calls );
5. after-hours procedures and available services, including those provided to non-English speaking Members and Members who are deaf or hard-of-hearing;
6. the number and percentage of FTE Nurse Hotline staff who are bilingual in English and Spanish;
7. the number and percentage of FTE Nurse Hotline staff who are multi-lingual for any additional language, by language spoken;
8. Nurse Hotline telephone reports for the most recent four quarters with data that show:
  - a. the monthly trends for call volume;
  - b. monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and
  - c. monthly trends for the abandonment rate; and
9. whether the Nurse Hotline has the capability to administer automated telephonic surveys to callers at the end of calls.

A Respondent currently participating in any of HHSC’s MCO programs must submit the information in items 1 through 9 above for each Nurse Hotline operated, and identify any proposed changes to hotline functions for the STAR Health Program.

If the Respondent is not currently participating in any of HHSC’s MCO programs, it should describe its experience and proposed approach in establishing and maintaining an accessible call center for members that is comparable to the Nurse Hotline described in **RFP Section 8.1.5.6**, “Nurse and

Member Hotline Requirements.” The description must include the information listed in items 1 to 9 above.

Finally, if a Respondent is proposing to use a single point of access, i.e., toll-free number, for multiple hotlines, e.g., Member Services, BH, Nurse Hotline, and Provider Hotline, the Respondent must note in its proposal the differences, if any, in its staffing for each of these Hotlines, and must describe how calls to the Hotline(s) are triaged.

#### **4.3.6.5 Nurse Hotline Scenarios**

(5 pages)

Describe the procedures a Nurse Hotline representative will follow to deal with the following situations:

1. a Member, Caregiver, or Medical Consenter calls requesting advice regarding a missed medication dose;
2. a Member, Caregiver, or Medical Consenter is unable to reach her PCP after normal business hours;
3. a Member, Caregiver, Medical Consenter, or DFPS caseworker is having difficulty filling a needed prescription after hours;
4. a Member, Caregiver, or Medical Consenter calls requesting an evaluation of whether or not to go to an Emergency Room for immediate care;
5. a Caregiver or Medical Consenter calls after hours asking for assistance in managing the Member’s BH crisis;
6. a Member, Caregiver, or Medical Consenter calls requesting a referral to a BH provider experienced in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT);
7. a DFPS caseworker calls asking for the results of a Member’s medical assessment;
8. a Caregiver or Medical Consenter calls to report a suspicion that the Member has returned to the home under the influence of drugs or alcohol;
9. a Caregiver or Medical Consenter calls to request a new wheelchair for a Member that was placed in their home today with badly damaged equipment from the biological home; and
10. a Caregiver, Medical Consenter, or DFPS caseworker calls requesting enrollment of the Member into a DM program.

#### **4.3.6.6 STAR Health Liaisons**

(5 pages)

The STAR Health Liaison requirements are described in **RFP Attachment A, Section 4.05**, “STAR Health Liaisons,” and **Section 8.1.11**, “Coordination with the Department of Family and Protective Services.”

For the STAR Health Program, the Respondent must:

1. Explain the functions of the STAR Health Liaisons, including brief job descriptions and qualifications.
2. State the assumptions the Respondent used in determining the number of STAR Health Liaisons that are needed.

3. Identify the number of STAR Health Liaisons who will be physically located in the Service Area they represent.
4. Describe the training curriculum the Respondent will provide to its STAR Health Liaison staff. The description should include training schedules and how the training will prepare Liaisons to:
  - a. understand STAR Health requirements;
  - b. coordinate with DFPS staff to resolve escalated issues related to STAR Health or the individual healthcare of a Member;
  - c. understand and address Members' cultural needs; and
  - d. identify and assist DFPS staff with training needs related to STAR Health or the Member's healthcare.

#### **4.3.6.7 Member Education**

(8 pages)

Member education requirements are described in **RFP Section 8.1.5.7**, "Member Education."

1. Provide a brief description of the proposed Member education materials that will be used to educate Medical Consenters, Members, DFPS staff, Caregivers, guardians ad litem, judges, and attorneys ad litem. The description should include:
  - a. the types of materials to be offered, including the modality of training;
  - b. what topics will be covered (such as the role of the PCP, referrals for services using Network Providers, Value-Added Services, complaints and appeals, Service Coordination and Service Management, and Health Passport);
  - c. how the Respondent will specifically educate Members, Caregivers, and Medical Consenters on issues such as the value of screening, preventative care, and other Medical Home services;
  - d. how the Respondent proposes to increase Member and Medical Conserter attendance, including any proposed use of Internet and televideo capabilities to provide training; and
  - e. the frequency of Provider training.
2. Briefly describe two examples of recent Member education initiatives conducted by the Respondent that may be relevant to the STAR Health Program. These examples must include:
  - a. a description of the education initiative;
  - b. a summary of distributed materials (do not submit the actual materials);
  - c. number and type of attendees; and
  - d. results of any evaluations from the training.

A Respondent currently participating in any of HHSC's MCO programs must submit the above Member education examples for each MCO Program.

A Respondent not currently participating in one or more of HHSC's Medicaid MCO programs must submit the above Member education examples for a similar managed care program. If the Respondent

referenced a non-HHSC managed care program in another submission requirement, the Respondent must submit its Member education information in this submission requirement.

#### **4.3.6.8 Cultural Competency**

(3 pages)

Provide a high-level description of the processes the Respondent will put in place to meet the requirements of the cultural competency requirements as described in **RFP Section 8.1.5.8**, “Cultural Competency Plan.”

1. Describe how the Respondent will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.
2. Describe how the Respondent will develop intervention strategies and work with Network Providers to avoid disparities in the delivery of medical services to diverse populations.

#### **4.3.6.9 Continuity of Care**

(3 pages)

Continuity of Care transition requirements for certain new Members with Out-of-Network providers are in **RFP Section 8.1.27**, “Continuity of Care and Out-of-Network (OON) Providers.”

1. Describe how the Respondent will ensure continuity of prior authorized services whenever a Member transfers from the Fee-for-Service program to the STAR Health Program or from a Medicaid or CHIP MCO to the STAR Health Program. Also, describe how the Respondent will share information with the Fee-for-Service program or another Medicaid or CHIP MCO when the Member transfers out of the STAR Health Program. The Respondent’s description should include how the MCO will authorize the Member’s OON providers to finish the treatment plan authorized by the Fee-for-Service program or another Medicaid or CHIP MCO.
2. Describe the proposed Continuity of Care Transition Plan for serving new Members whose current PCP, OB/GYN, specialty care providers, including BH providers, are not participants in the Respondent’s Provider Network.
3. Describe the MCO’s Provider recruitment process and timeframes (especially for recruiting STP providers) for outreaching to and enrolling OON providers serving new Members.

#### **4.3.6.9 Objection to Providing Certain Services**

(1 page)

In accordance with 42 C.F.R. § 438.102, the Respondent may file an objection to provide, reimburse for, or provide coverage of, counseling or referral service for a Covered Service based on moral or religious grounds, as described in **RFP Section 8.1.28.7**, “Objection to Provide Certain Services.” HHSC reserves the right to make downward adjustments to Capitation Rates for any Respondent that objects to providing certain services based on moral or religious grounds.

Respondent should indicate objections, if any, to providing a Covered Service based on moral or religious grounds. Identify the specific services to which it objects and describe the basis for its objection on moral or religious grounds.

#### **4.3.6.10 Member Complaint, Pre-Appeal and Appeal Processes**

(5 pages, excluding flowchart)

Medicaid Member Complaint, Pre-Appeal, and Appeal Processes are described in **RFP Section 8.1.33**, “Member Complaint and Appeal System.” A Respondent’s submission should reflect how it intends to meet the applicable Member Complaint, Pre-Appeal, and Appeal requirements. A Respondent should not submit detailed Complaint and Appeal policies and procedures as an attachment.

The Respondent must:

1. describe the process the Respondent will put in place for the review of Member Complaints and Appeals, including which staff would be involved;
2. provide a flowchart that depicts the process the Respondent will employ, from the receipt of a request through each phase of the review to notification of disposition, including providing notice of access to HHSC Fair Hearings;
3. document the MCO’s average time for resolution over the past 12 months for Member Complaints and Appeals (excluding expedited appeals), from date of receipt to date of notification of disposition;
4. describe the number and job descriptions of member advocates, how Members are informed of the availability of member advocates, and how Members access Advocates;
5. describe the Pre-Appeals process the Respondent will develop, implement, and maintain to facilitate resolution of Caregiver, Medical Consenter, SSCC staff, DFPS Staff or Member requests for the Respondent to reconsider the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service. Describe how the MCO will work to reach timely compromise and resolution, and reduce the number of formal Appeals; and
6. describe the training, tools, and processes the Respondent will use to ensure that Member Advocates who do not reside in the same geographical area as the Member they are assisting is located are knowledgeable about key Network Providers in the geographic area where the Member resides; and describe how Respondent will help Members access Covered Services in a convenient manner, close to home when feasible and link Members to non-Covered Services.

#### **4.3.6.11 Marketing Activities and Prohibited Practices**

(no page limit)

If the Respondent has been sanctioned or placed under corrective action for prohibited Marketing practices related to managed care products by CMS, Texas, or by another state:

1. describe the basis for each sanction or corrective action, and;
2. explain how the Respondent would ensure that it would not engage in any Marketing practices prohibited by CMS or HHSC, including practices prohibited by **UMCM Chapter 4.3**, “Uniform Managed Care Marketing Policy and Procedures.”

A Respondent should report whether it has been sanctioned or been placed under corrective action by the federal government, Texas, or any other state in the past three years as part of its Business Specifications submission.

#### **4.3.7 Section 7 – Quality Assessment and Performance Improvement**

The Quality Assessment and Performance Improvement (QAPI) requirements of the RFP are described in **RFP Section 8.1.7**, “Quality Assessment and Performance Improvement (QAPI).”

##### **4.3.7.1 Clinical Initiatives**

(3 pages, excluding QAPI plan)

1. Describe data-driven clinical initiatives that the Respondent initiated within the past 24 months that have yielded improvement in clinical care for a managed care population comparable to the STAR Health population.
2. Document two statistically significant improvements generated by the Respondent’s clinical initiatives.
3. Describe two new or ongoing clinical initiatives that the Respondent proposes to pursue in the first year of the Contract. Document why each topic warrants Quality Improvement investment, and describe the Respondent’s measurable goals for the initiative.
4. For Respondents that already participate in an HHSC MCO program, provide a copy of the most recent QAPI Plan. For Respondents that do not participate in an HHSC MCO program, provide a copy of a 2013 quality assessment plan that the Respondent developed for a Medicaid population, or if a Respondent did not operate a Medicaid managed care plan in 2013, the most recent quality assessment plan for a program operated by the Respondent and serving a population comparable to the STAR Health population.

##### **4.3.7.2 Healthcare Effectiveness Data and Information Set (HEDIS) and Other Quality Data**

(3 pages)

HHSC’s External Quality Review Organization (EQRO) will perform HEDIS and Consumer Assessment of Health Plans Survey (CAHPS) calculations required by HHSC for MCO management. The following questions are designed to solicit information on a Respondent’s proposed approach to generating its own clinical indicator information to identify and address opportunities for improvement, as well as the Respondent’s approach to acting on clinical indicator data reported by HHSC’s EQRO.

The Respondent must:

1. identify the MCO-level HEDIS and any other statistical clinical indicator measures the Respondent will generate to identify MCO opportunities for clinical quality improvement;
2. document examples of statistical clinical indicator measures previously generated by the Respondent within the last two years for the STAR Health population or a managed care population comparable to the STAR Health population;
3. describe efforts that the Respondent has made to assess member satisfaction within the last two years for the STAR Health population or a managed care population comparable to the STAR Health population; and

4. describe management interventions implemented within the last two years based on member satisfaction measurement findings for the STAR Health population or a managed care population comparable to the STAR Health population, and whether these interventions resulted in measurable improvements in later member satisfaction findings.

#### **4.3.7.3 Clinical Practice Guidelines**

(5 pages)

There is significant evidence that medical professionals are often slow to adopt evidence-based clinical practice guidelines.

1. Describe four clinical guidelines (two related to non-preventive acute or chronic medical conditions and two related to BH conditions) that are relevant to the STAR Health population and that the Respondent believes are currently not being adhered to at a satisfactory level.
2. Describe what steps the Respondent will take to increase compliance with the clinical guidelines noted in its response to number 1.
3. Provide a general description of the Respondent's process for developing and updating clinical guidelines, and for disseminating them to participating Providers.
4. Discuss how the Respondent will monitor Provider compliance with the requirement to conduct a thorough health history, assessment, mental status exam, and physical exam before prescribing psychotropic medication, as stated in *Psychotropic Medication Utilization Parameters for Foster Children* found at: [http://www.dfps.state.tx.us/documents/Child\\_Protection/pdf/TxFosterCareParameters-September2013.pdf](http://www.dfps.state.tx.us/documents/Child_Protection/pdf/TxFosterCareParameters-September2013.pdf)
5. Describe how the Respondent will use Evidence-based Practices (EBPs) or promising practices that dictate different approaches to BH treatment based on the classification of the Member's disorder.

#### **4.3.7.4 Provider Profiling**

(3 pages, excluding sample profile reports)

1. Describe the Respondent's practice of profiling the quality of care delivered by Network PCPs, and any other Acute Care Providers (e.g., high volume specialists, Hospitals) including the methodology for determining which and how many Providers will be profiled.
2. Submit sample quality profile reports used by the Respondent, or proposed for future use (identify which). Describe any new quality measures that will be included in these reports that are relevant to the STAR Health population.
3. Describe the rationale for selecting the performance measures presented in the sample profile reports.
4. Describe the proposed frequency with which the Respondent will distribute the reports to Network Providers, and identify which Providers will receive the profile reports.
5. Describe the explicit steps the Respondent will take with each profiled Provider following the production of each profile report, including a description of how the Respondent will motivate and facilitate improvement in the performance of each profiled Provider.

#### 4.3.7.5 Network Management

(7 pages)

Describe how the Respondent will actively work with Network Providers to ensure accountability and improvement in the quality of care provided by the Providers. The description should include:

1. how the Respondent will train its Providers specific to the management and treatment of the STAR Health population;
2. the process and timeline the Respondent proposes for periodically assessing Provider progress on its implementation of strategies to attain improvement goals;
3. how the Respondent will reward Providers who demonstrate continued excellence or significant performance improvement over time, through non-financial or financial means, including pay-for-performance;
4. how the Respondent will share “best practice” methods or programs with Providers of similar programs in its Network, specifically, best practices related to the treatment of the STAR Health population;
5. how the Respondent will take action with Providers who demonstrate continued unacceptable performance and performance that does not improve over time;
6. the extent to which the Respondent currently operates a Network management program consistent with HHSC requirements in **RFP Section 8.1.7.9**, “Network Management,” and measurable results it has achieved from those Network management efforts; and
7. how the Respondent will document internally the certifications or special skills possessed by BH Providers, such as TF-CBT, Child Parent Psychotherapy, or other EBPs or promising practices, and increase the numbers of such Providers in the Network.

#### 4.3.8 Section 8 – Utilization Management (UM)

(4 pages)

UM requirements are described generally in **RFP Section 8.1.8**, “Utilization Management (UM),” and specifically for BH Services in **RFP Section 8.1.17**, “Behavioral Health (BH) Services and Network.” A Respondent’s response to this submission requirement should address UM for all Covered Services, including BH Services unless otherwise indicated.

1. Describe the UM guidelines the Respondent plans to employ, including whether and how the guidelines comply with the standards in **RFP Sections 8.1.8** and **8.1.17**.
2. If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.
3. Describe how the UM guidelines will generally be applied to authorize or retrospectively review services for the spectrum of Covered Services, including BH Services.

#### 4.3.9 Section 9 – Early Childhood Intervention (ECI)

(3 pages)

ECI Services are described in **RFP Section 8.1.9**, “Early Childhood Intervention (ECI).”

1. Describe the Respondent’s experience with, and general approach to, providing ECI services, including how the Respondent will identify these individuals.
2. Describe procedures and protocols for using the Individual Family Service Plan (IFSP) information to develop a Member Care Plan and authorize services.
3. Describe procedures and protocols for developing and including the interdisciplinary team in the assessment and care planning process.
4. Describe the process by which the Respondent will provide the IFSP and other necessary information to the PCP.

#### 4.3.10 Section 10 – Health Passport

(9 pages)

Data requirements for the Health Passport are described in **RFP Section 8.1.12**, “Health Passport.” The Respondent can propose additional system functionality or data elements that enhance the productivity of the Health Passport. The Respondent must describe:

1. the Respondent’s experience working with healthcare data and any prior affiliations with local, state, or federal government agencies;
2. the Respondent’s experience with electronic medical records systems;
3. the platform on which the system will reside and describe the software(s) that will be used to maintain and operate the Health Passport;
4. in detail, how the proposed software or system will integrate with the Respondent’s claims database and pharmacy database to ensure that the required Health Passport data for each Member is updated in an accurate and timely manner;
5. the method by which the Respondent will ensure that all applicable state and federal laws protecting patient confidentiality are followed, to include HIPAA, 45 C.F.R. §§ 164.302.318; 164.500.534, HITECH Act, Chapter 390 of the Texas Administrative Code, and current Enterprise Information Security Standards and Guidelines (EISSG).
6. the frequency of the data refresh and the impact that the refresh strategy will have on system availability;
7. how the Respondent will accomplish termination of access to the Health Passport for users who leave the Provider Network or cease employment with DFPS;
8. the method by which the Respondent will train users to utilize the Health Passport and specify the types of training materials the Respondent will provide;
9. how the Respondent will identify security breaches in the Health Passport system, the processes the Respondent will employ to address any breaches, and the process by which the Respondent will notify HHSC in the event of a security breach; and

10. statistical measures related to the Health Passport that the Respondent proposes to report to HHSC to evaluate access, utilization, and compliance with the Health Passport and assist HHCS in identifying issues for improvement.

#### **4.3.11 Section 11 – Service Management and Service Coordination**

(15 pages, excluding assessment/triage tools)

Service Management and Service Coordination requirements are described in **RFP Sections 8.1.13.2**, “Access to Care and Service Management,” and **8.1.14**, “Service Coordination.” Services for Members with Special Healthcare Needs (MSHCN) are described in **RFP Section 8.1.13**.

For the STAR Health Program, the Respondent must:

1. Describe the qualifications for MCO Service Managers and Service Coordinators, including experience, expertise, and responsibilities. Include descriptions of Service Management and Service Coordination activities, including staff expertise working with the PCP or PCP Team, SSCC staff, DFPS Staff, the Medical Consenter, and the Member (or similar parties in a comparable program) as appropriate.
2. Describe the Respondent’s experience with providing Service Management and Service Coordination services for the STAR Health population, or comparable population, including those with a Disability such as a developmental or Intellectual Disability, and chronic or complex medical and BH conditions, including mental health/chemical dependency co-occurring conditions.
3. Describe the process for initially and periodically assessing Members’ needs for services.
4. Describe how the Respondent will arrange to include clinical information and options for Medically Necessary Covered Services in the Member’s Healthcare Service Plan (HCSP), and share this information with the PCP or PCP Team, SSCC staff, DFPS Staff, the Medical Consenter, and the Member, as appropriate.
5. Describe how the Service Manager will evaluate and report Members’ clinical progress and adherence to the HCSP and include this information in the Health Passport after discussing with the PCP or PCP Team.
6. Describe how the Respondent will use Encounter Data and other means to identify MSHCN who have not been identified by the Medical Consenter or through the screening process.
7. Submit the proposed assessment/triage tools the Respondent will use to identify MSHCN for the purposes of enrolling them in Service Management, Service Coordination, or DM programs.
8. Describe how the MCO Service Coordinator and Service Manager will assist the Member to have direct access to a specialist as appropriate for the Member’s condition and access to non-primary care physician specialists as PCPs, as required in **RFP Section 8.1.13**, “Services for Members with Special Healthcare Needs (MSHCN).”
9. Provide a description of the appropriate staffing ratio of Service Managers and Service Coordinators to Members and the Respondent’s target ratio of Service Managers and Service Coordinators to Members.
10. Describe in detail the training provided to Service Managers and Service Coordinators, both initially and ongoing, to ensure they are knowledgeable about the STAR Health population, and

their responsibilities. Include information regarding who trains and his or her credentials, topics covered, frequency of training, and how a determination is made regarding the effectiveness of the training.

11. Describe the MCO's plan for tracking Service Management and Service Coordination provided to its Members, including numbers and types of contact, timeliness of contacts, and the qualifications of individuals making the contact.
12. Describe how the Respondent's Service Management and Service Coordination teams will engage young adults in Target Population categories 2, 3, and 4 in accessing needed healthcare Services and maintaining their health and well-being.

#### **4.3.12 Section 12 – Health Home**

(3 pages)

Health Home requirements are described in **RFP Section 8.1.15**, "Health Home Services."

1. Describe the Respondent's experience in implementing health home services programs for populations comparable to the STAR Health Program.
2. Identify any measurable results in terms of clinical outcomes and program savings that have resulted from the Respondent's health home services initiatives, and briefly describe the analyses used to identify these outcomes and savings.
3. Identify the process by which the Respondent proposes to provide Members with health home services. Describe how the Respondent will identify Members in need of health home services program, the proposed outreach approach, and the health home services program components for Members of different risk levels.
4. Describe the process by which the Respondent will ensure continuity of care with the Member's previous health home services program(s), if any.

#### **4.3.13 Section 13 – Disease Management (DM)**

(5 pages)

Disease Management is described in **RFP Section 8.1.16**, "Disease Management (DM)."

1. Describe the Respondent's current DM programs and the Respondent's experience in implementing DM programs for the STAR Health population or populations comparable to the STAR Health population, including both physical and BH programs.
2. Identify any measurable results in terms of clinical outcomes and program savings that have resulted from the Respondent's DM initiatives, and briefly describe the analyses used to identify the outcomes and savings.
3. Describe the DM programs the Respondent proposes for the STAR Health population and the rationale for proposing these programs.

4. Identify the process by which the Respondent proposes to provide Members with DM. Describe how the Respondent will identify Members in need of the DM program, the proposed outreach approach, and the DM program components.
5. Describe how the Respondent proposes to gain Member and Caregiver or Medical Consenter involvement in the DM program's strategies.
6. Describe the process by which the Respondent will ensure continuity of care with the Member's previous DM program(s), if any.
7. Identify how information on DM programs will be made available to Members and Providers.

#### **4.3.14 Section 14 – Behavioral Health (BH) Services**

The BH Services and Network requirements are described in **RFP Section 8.1.17**, "Behavioral Health (BH) Services and Network."

##### **4.3.14.1 Behavioral Health (BH) Services Hotline**

(3 pages; excluding telephone reports)

The BH Services Hotline requirements are described in **RFP Section 8.1.17.3**, "Behavioral Health (BH) Hotline and Emergency Services." Describe the proposed BH Services Hotline function, including:

1. verification that it is, or will be, staffed 24 hours per day, 365 days per year;
2. staffing of BH Services Hotline staff, including clinical credentials;
3. routing of calls among BH Services Hotline staff to ensure timely and accurate response to inquiries from DFPS Staff, Medical Consenters, Caregivers, and Members, as appropriate.
4. the curriculum for training to be provided to BH Services Hotline representatives, including when the training will be conducted and how the training will address:
  - a. Covered Services;
  - b. STAR Health Program requirements;
  - c. Cultural Competency; and
  - d. providing assistance to Members and Medical Consenters with limited English proficiency.
5. responsibilities of BH Services Hotline staff, if any, in addition to responding to STAR Health Member Hotline calls, (e.g., responding to non-STAR Health member calls or STAR Health Provider Hotline or Member Hotline calls );
6. the number and percentage of FTE BH Services Hotline staff who are bilingual in English and Spanish;
7. the number and percentage of FTE BH Services Hotline staff who are multi-lingual for any additional language, by language spoken;
8. BH Services telephone reports for the most recent four quarters with data that show the monthly trends for call volume, monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and monthly trends for the abandonment rate; and
9. whether the BH Services Hotline has the capability to administer automated surveys to callers at the end of calls.

A Respondent currently participating in any of HHSC’s MCO programs must submit the information above for each BH Services Hotline that it operates, and should provide the monthly call volume by MCO program. The Respondent should also indicate any changes it proposes to its BH Services Hotline.

If the Respondent is not currently participating any of HHSC’s MCO programs, the Respondent must describe its experience and proposed approach in establishing and maintaining an accessible call center for Members that is comparable to the BH Services Hotline described in **RFP Section 8.1.17.3**. The description must include the information listed in items 1 to 9 above.

#### **4.3.14.2 Behavioral Health (BH) Hotline Scenarios**

Describe the procedures a BH Hotline representative will follow to deal with the following situations:

1. a Member, Caregiver, or Medical Consenter is having difficulty scheduling an appointment for medication management with his psychiatrist;
2. a Member, Caregiver, or Medical Consenter has a request for a specific medication that the pharmacy is unable to provide;
3. a Member or Caregiver does not speak English;
4. a Caregiver or Medical Consenter calls after hours asking for assistance in managing the Member’s BH crisis;
5. a Caregiver, Medical Consenter, or DFPS caseworker calls to inquire about the Member entering an inpatient facility;
6. a Provider who has been ordered by the Court to provide an assessment of the Member calls with questions regarding the assessment;
7. a DFPS caseworker calls asking for a Member’s initial assessment and monthly summaries not present in the Health Passport;
8. a Member’s PCP calls to inquire about enrollment for the Member in a substance abuse program;
9. a Caregiver, Medical Consenter, or DFPS caseworker calls requesting that a Member receive Mental Health Rehabilitation services; and
10. a Caregiver, Medical Consenter, or DFPS caseworker calls regarding a Member discharged from a facility (e.g., correctional, inpatient psychiatric, or emergency) without appropriate medications.

#### **4.3.14.3 Health Provider Network Expertise**

(no page limit)

1. Identify BH Service Providers with expertise in providing linguistically appropriate and culturally competent services to children and adolescents with the following treatment needs:
  - a. BH including substance abuse, mental health, and dual diagnosis of mental health and substance abuse;
  - b. Lesbian, Gay, Bi-Sexual, Transgender (LGBT) related issues
  - c. eating disorders;
  - d. physical and sexual abuse;
  - e. sex offender treatment;
  - f. significant trauma;
  - g. intellectual or developmental disabilities; and

- h. fetal alcohol syndrome or related disorders.
- 2. Indicate the criteria the Respondent will use to determine that the BH Providers have the requisite expertise.

**4.3.14.4 Coordination of Behavioral Health (BH) Care**

(2 pages)

Coordination requirements between the BH Service Provider and the PCP are described in **RFP Section 8.1.17.4**, “Coordination between the BH Provider and the PCP.”

- 1. Describe the Respondent’s approach to coordinating BH Service delivery with Acute Care Services delivered by a Member’s PCP, and vice versa.
- 2. Describe or propose innovative programs and identify Network Providers contracted to serve special populations through integrated medical/BH Service delivery models. Describe the program model services, treatment approach, special considerations, and expected outcomes for the special populations.
- 3. Describe the process by which the Respondent will ensure the delivery of outpatient BH Services within seven days of inpatient discharge for BH Services.

**4.3.14.5 Behavioral Health (BH) Quality Management**

(2 pages)

- 1. Identify the areas Respondent believes to be the greatest opportunities for clinical quality improvement in BH in the STAR Health Program and provide supporting information.
- 2. Discuss the approaches the Respondent will pursue to realize an opportunity.
- 3. Describe how the Respondent proposes to integrate BH into its quality assessment program, as described in **RFP Section 8.1.7.5**, “Behavioral Health (BH) Services Integration into QAPI Program.”

**4.3.14.6 Utilization Management (UM) for Behavioral Health (BH) Services**

(2 pages)

- 1. Identify the source of the Respondent’s BH Services UM guidelines and include a copy of internally developed BH Services UM guidelines, if any.
- 2. Describe how the UM guidelines, whether internally or externally developed, will generally be applied to authorize or retrospectively review inpatient, residential, and outpatient BH Services.
- 3. Discuss any special issues in applying the BH Services UM guidelines for:
  - a. substance abuse services;
  - b. Inpatient BH Services provided to children.

**4.3.14.7 Behavioral Health (BH) Emergency Services**

(2 pages)

Describe the Respondent’s experience with, and plans for, providing BH Emergency Services, including, emergency screening services, Emergency Services, and short-term crisis stabilization to the STAR Health population or to a comparable population.

#### **4.3.14.8 Telemedicine**

The Respondent must describe the Respondent’s telemedicine capabilities, how the Respondent will recruit providers with telemedicine capabilities, and how the Respondent will structure its Provider Network to use telemedicine to connect providers throughout Texas. The Respondent must describe how it will meet the telemedicine requirements in **RFP Sections 8.1.3.4**, “Telemedicine Access,” and **8.1.17.1**, “Behavioral Health (BH) Provider Network.”

#### **4.3.15 Section 15 – Pharmacy Services**

(8 pages)

The Pharmacy Services requirements are described in **RFP Section 8.1.20**, “Pharmacy Services.” For all of the following submission requirements, instead of attaching copies of the Respondent’s policies and procedures, the Respondent should describe its policies and procedures, including:

1. the processes it will use to manage the pharmacy benefit when HHSC requires the MCO to implement the Medicaid formulary and preferred drug lists (PDLs);
2. the policies and procedures for how mail-order pharmacies will be available to Members;
3. the rationale for requiring prior authorizations, identify the types of drugs that normally require prior authorization, and describe the policies and procedures for the prior authorization process;
4. how rebates will be negotiated (if HHSC determines that the MCO will perform this service), identified, and reported;
5. the policies and procedures for drug utilization reviews, including ensuring prospective reviews take place at the dispensing pharmacy’s point of sale (POS); and
6. the policies and procedures for targeted interventions for Network Providers over-utilizing certain drugs.

#### **4.3.16 Section 16 – Management Information System (MIS) Requirements**

(10 pages –excluding system diagrams, compliance plan, and process flowcharts.)

The Respondent must:

1. Describe the MIS the Respondent will implement, including how the MIS will comply with HIPAA as amended or modified. The response must address the requirements of **RFP Section 8.1.24**, “Management Information Systems (MIS) Requirements.” At a minimum, the description should address:
  - a. hardware and system architecture specifications;
  - b. data and process flows for all key business processes in **RFP Section 8.1.24.3**, “System-wide Functions;” and

- c. attest to the availability of the data elements required to produce required management reports.
2. If claims processing and payment functions are outsourced, provide the above information for the Material Subcontractor.
3. Describe how the Respondent would ensure accuracy, timeliness, and completeness of Encounter Data submissions.
4. Describe the Respondent's ability and experience in performing coordination of benefits, as well as the Respondent's ability and experience related to Third Party Recovery (TPR).
5. Describe the Respondent's ability and experience in allowing providers to submit claims electronically and its ability and experience in processing electronic claims payments to providers:
  - a. If currently receiving claims electronically, generally describe the type and volume of provider claims received electronically in the previous year versus paper claims for each claim type.
  - b. If currently making claims payments to providers electronically, generally describe the type and volume of provider claims processed electronically.
6. Describe the Respondent's experience and capability to comply with the Internet website requirements of **RFP Section 8.1.5.5**, "Internet Website," and briefly describe any additional website capabilities that the Respondent proposes to offer to Providers, DFPS Staff, Medical Consenters, Caregivers, and Member, as appropriate.
7. Provide acknowledgment and verification that the Respondent's proposed systems are 5010 compliant by submitting a copy of the 5010 compliance plan.
8. Describe the Respondent's capability to pay providers via direct deposit and its experience in doing so, including the percentage, number, and types of providers paid via direct deposit in the most recent 12-month period for which the Respondent has those statistics. If the Respondent operates in Texas, the Respondent must provide this information related to its experience in Texas. If the Respondent does not currently operate in Texas, the Respondent must provide this information for a state in which the Respondent currently operates a managed care program similar to the STAR Health Program.

#### **4.3.17 Section 17 – Fraud, Waste, and Abuse**

(3 pages)

The Fraud, Waste, and Abuse requirements are described in **RFP Section 8.1.25**, "Fraud, Waste, and Abuse." The Respondent must describe how they will implement a Fraud, Waste, and Abuse Plan that will comply with state and federal law and this RFP, including the requirements of Texas Government Code § 531.113. The Respondent must:

1. Include detail about what parts of the organization and which key staff will have responsibilities in implementing and carrying out the Fraud, Waste, and Abuse Program.
2. Identify the officer or director of the Respondent organization who will have overall responsibility and authority for carrying out the Fraud, Waste, and Abuse Program provisions.

#### 4.3.18 Section 18 – Transition Plan

(4 pages)

The Transition Plan Requirements are described in **RFP Section 7**, “Transition Phase Requirements.”

1. Briefly describe the Respondent’s experience establishing and maintaining electronic interfaces with other contractors responsible for portions of Medicaid operations. A Respondent with experience participating in one or more HHSC MCO programs must clearly note its experience in establishing and maintaining these interfaces in Texas. A Respondent without experience establishing and maintaining electronic interfaces with other contractors responsible for Medicaid operations must note its experience in establishing and maintaining similar electronic interfaces with contractors for similar operations.
2. Respondent must answer either (a) or (b) as it applies to Respondent.
  - a. A Respondent that is proposing to participate in STAR Health for the first time must briefly describe its Transition Plan, including major activities related to the System Readiness Review and the Operational Readiness Review, including Network development, internal system testing, and proposed schedule to comply with the anticipated Operational Start Date and other requirements described in **RFP Section 7**. The Respondent must clearly indicate in which Texas counties it currently does not operate as an MCO and any differences in its transition approach by county.
  - b. A Respondent that is currently a contractor for the STAR Health Program must briefly describe its Transition Plan, including major activities related to the System Readiness Review and the Operational Readiness Review, such as Network Development, internal system testing, and schedule to comply with the anticipated Operational Start Date and other requirements described in **RFP Section 7**.

**5 EVALUATION PROCESS AND CRITERIA**

**5.1 Evaluation of Proposals**

HHSC will use a formal evaluation process to select the successful Respondent. HHSC will consider capabilities or advantages that are clearly described in the proposal, which may be confirmed by oral presentations, site visits, demonstrations, and references contacted by HHSC. HHSC reserves the right to contact individuals, entities, or organizations that have had dealings with the Respondent or proposed staff, whether or not identified in the proposal.

HHSC will more favorably evaluate proposals that offer no or few exceptions, reservations, or limitations to the terms of the RFP, including **RFP Attachment A**, “STAR Health Contract Terms.”

**5.2 Evaluation Criteria**

HHSC will evaluate each proposal using the following criteria, in descending order of priority, developed from the best value factors listed in **RFP Section 2**, “Procurement Strategy and Approach.”

<b>Evaluation Criteria</b>	
1	<p>The extent to which the goods and services meets HHSC’s needs and the needs of the Members for whom the goods and services are being purchased, including:</p> <ol style="list-style-type: none"> <li>1. The extent to which the proposal addresses HHSC’s priority objectives for the initial Contract Period, as defined in <b>RFP Section 1.6</b>, “Mission Objectives;”</li> <li>2. The extent to which the Respondent accepts without reservation or exception the RFP’s terms, including <b>Attachment A</b>, “STAR Health Contract Terms;”</li> <li>3. The extent to which the proposal exhibits expertise in providing services to populations comparable to STAR Health Members and ability to comply with the requirements of this RFP—particularly the requirements outlined in <b>RFP Section 8</b>, “Operations Phase Requirements;”</li> <li>4. The quality and reliability of the goods and services, including the ability to retain and maintain providers in Respondent’s Network and to respond timely and adequately to Member Complaints; and</li> <li>5. The degree to which the proposal demonstrates program innovation, adaptability, and exceptional customer service.</li> </ol>
2	<p>Indicators of probable vendor performance, including</p> <ol style="list-style-type: none"> <li>1. Respondent’s past performance in Texas or comparable experience in other states;</li> <li>2. Current financial solvency and the ability to remain financially solvent during the Initial Contract Period;</li> </ol>

	<ol style="list-style-type: none"> <li>3. Capacity for Respondent’s organizational structure to support operations;</li> <li>4. Ability to obtain and maintain TDI approval to operate and a status of Good Standing with the Comptroller; and</li> <li>5. The qualifications and experience of Respondent’s key personnel to achieve program goals.</li> </ol>
3	<p>Effect of the acquisition on agency productivity, including:</p> <ol style="list-style-type: none"> <li>1. The level of effort and resources required by HHSC to monitor the Respondent’s performance under the Contract; and</li> <li>2. The level of effort required by HHSC to maintain a good working relationship with Respondent.</li> </ol>
4	<p>Delivery Terms, including:</p> <ol style="list-style-type: none"> <li>1. The Respondent’s ability to complete transition phase requirements in <b>RFP Section 7</b>, “Transition Phase Requirements,” and to fully implement services by the Operational Start Date;</li> <li>2. The Respondent’s ability to maintain full service operations throughout the Initial Contract Period; and</li> <li>3. The Respondent’s ability to comply with turnover requirements in <b>RFP Section 9</b>, “Turnover Requirements,” upon termination of the Contract.</li> </ol>

If all other considerations are equal, HHSC will give preference to:

1. Proposals that include substantial participation by Network providers who are Significant Traditional Providers (STPs). HHSC defines “substantial participation” as proposals that include at least 50 percent of the STPs in a Service Area. The Respondent must either have a Network Provider agreement in place with the STP, or a Letter of Intent/Letter of Agreement to participate in the Network. A listing of STPs for the new Service Areas can be found in the Procurement Library.
2. Proposals that ensure continuity of coverage for Medicaid Members for at least three months beyond the period of Medicaid eligibility. For purposes of this provision, HHSC defines “continuity of coverage” as providing the full set of Covered Services.

Respondents who are licensed as health maintenance organizations under Texas Insurance Code Chapter 843 and believe they meet the requirements for mandatory contracting under [Texas Government Code § 533.004](#) must provide written notice to HHSC’s Point-of-Contact no later than May 9, 2014. The notice must provide a clear description of why the Respondent believes it is entitled to a mandatory contract under the Texas Government Code and the basis for that belief. The notice must include an in-depth analysis of how the Respondent meets the exact requirements of [Texas Government Code § 533.004](#).

### **5.3 Initial Compliance Screening**

HHSC will perform an initial screening of all proposals received. Unsigned proposals and proposals that do not include all required forms and sections are subject to rejection without further evaluation. In accordance with **RFP Section 3.11**, "Modification or Withdrawal of Proposal," HHSC reserves the right to waive minor informalities in a proposal and award contracts that are in the best interest of the State of Texas.

### **5.4 Competitive Field Determinations**

HHSC may determine that certain proposals are within the field of competition for admission to discussions. The field of competition consists of the proposals that receive the highest or most satisfactory ratings. HHSC may, in the interest of administrative efficiency, place reasonable limits on the number of proposals admitted to the field of competition.

### **5.5 Oral Presentations and Site Visits**

HHSC may, at its sole discretion, request oral presentations, site visits, or demonstrations from one or more Respondents admitted to the field of competition. HHSC will notify selected Respondents of the time and location for these activities, and may supply agendas or topics for discussion. HHSC reserves the right to ask additional questions during oral presentations, site visits, or demonstrations to clarify the scope and content of the written proposal.

The Respondent's oral presentation, site visit, or demonstration must substantially represent material included in the written proposal and should not introduce new concepts or offers unless specifically requested by HHSC.

### **5.6 Best and Final Offers**

Respondents will not submit cost proposals for this RFP. HHSC will establish the Capitation Rates for each Program and Service Area in accordance with the methodology described in **RFP Attachment A, Article 10**, "Terms of Payment."

HHSC may, but is not required to, permit Respondents to prepare one or more revised offers. For this reason, Respondents are encouraged to treat their original proposals, and any revised offers requested by HHSC, as best and final offers of services.

### **5.7 Discussions with Respondents**

HHSC may, but is not required to, conduct discussions with all, some, or none of the Respondents admitted to the field of competition for the purpose of obtaining the best value for the State of Texas. It may conduct discussions for the purpose of:

1. obtaining clarification of proposal ambiguities;
2. requesting modifications to a proposal; or

3. obtaining a best and final offer.

HHSC may make an award prior to the completion of discussions with all Respondents admitted to the field of competition if HHSC determines that the award represents best value to the State of Texas.

## DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	2.0	July 1, 2015	Initial version of Attachment B-1, RFP Section 6, "Incentives & Disincentives" that includes all modifications negotiated by the Parties.
Revision	2.1	September 1, 2015	Section 6.5 is modified to include additional methodologies.
Revision	2.2	March 1, 2016	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	2.3	September 1, 2016	All references to Frew v. Traylor are changed to Frew v. Smith.
<p><sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions</p> <p><sup>2</sup> 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.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			

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## 6 PREMIUM PAYMENT, INCENTIVES, AND DISINCENTIVES

This section describes Capitation Rate payments and performance incentives and disincentives related to HHSC's value-based purchasing approach.

### 6.1 Capitation Rate Payments

Refer to **Attachment A, Article 10**, "Terms of Payment," and **UMCM Chapter 6** "Financial" for information concerning Capitation Rate development, financial payment structure and provisions, and capitation payments, including the time and manner of payment and adjustments to capitation payments.

### 6.2 Performance Incentives and Disincentives

Performance incentives and disincentives are subject to change by HHSC over the course of the Contract Period.

HHSC will refine the methodologies required to implement these strategies after collaboration with the MCO through a new incentives workgroup that HHSC will establish.

MCO is prohibited from passing down financial disincentives or sanctions imposed on the MCO to healthcare providers, except on an individual basis and related to the individual provider's inadequate performance.

Information about the data collection period to be used and performance indicators selected or developed will be found in **UMCM Chapter 10.1.8**, "STAR Health Performance Indicator Dashboard for Quality Measures."

#### 6.2.1 Performance Profiling

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

### 6.3 Frew Incentives and Disincentives

Section 6.3  
modified by  
Version 2.3

This Contract includes a system of incentives and disincentives required by the *Frew v. Smith* "Corrective Action Order: Managed Care" that apply to the MCO. The incentives and disincentives and corresponding methodology are set forth in the **UMCM Chapter 12**, "Frew."

## **6.4 Remedies and Liquidated Damages**

All areas of responsibility and all requirements of the MCO in the Contract will be subject to performance evaluation by HHSC. Any and all responsibilities or requirements not fulfilled may have remedies, and HHSC may assess damages, including liquidated damages. Refer to **Attachment A**, "STAR Health Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix," for performance standards that carry liquidated damage values.

## **6.5 Additional Incentives and Disincentives**

Section 6.5  
modified by  
Version 2.1

HHSC will evaluate all performance-based incentive and disincentive methodologies in consultation with the MCO. HHSC may then modify the methodologies as needed, or develop additional methodologies as funds become available, or as mandated by court decree, statute, or rule in an effort to motivate, recognize, and reward the MCO for performance.

## DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	2.0	July 1, 2015	Initial version of Attachment B-1, RFP Section 7, "Transition Phase Requirements" that includes all modifications negotiated by the Parties.
Revision	2.1	September 1, 2015	Contract amendment did not revise Attachment B-1, Section 7, "Transition Phase Requirements."
Revision	2.2	March 1, 2016	Contract amendment did not revise Attachment B-1, Section 7, "Transition Phase Requirements."
Revision	2.3	September 1, 2016	Contract amendment did not revise Attachment B-1, Section 7, "Transition Phase Requirements."
<p><sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions</p> <p><sup>2</sup> 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.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			

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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, which includes those activities that must take place between the time of Contract award and the Operational Start Date.

The Transition Phase will include a Readiness Review of each MCO, which must be completed successfully prior to an MCO's Operational Start Date. HHSC may, at its discretion, terminate the Contract, postpone the Operational Start Date, or assess other contractual remedies if the MCO fails to timely correct all Transition Phase deficiencies within a reasonable cure period, as determined by HHSC.

If for any reason, an MCO does not fully meet the Readiness Review prior to the Operational Start Date, and HHSC has not approved a delay in the Operational Start Date or approved a delay in the MCO's compliance with the applicable Readiness Review requirement, then HHSC will impose remedies including actual or liquidated damages. Refer to **Attachment A**, "STAR Health Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix," for additional information.

### **7.2 Transition Phase Schedule and Tasks**

The Transition Phase will begin after both Parties sign the Contract. The MCO must complete the Transition Phase no later than the Operational Start Date.

The MCO has overall responsibility for the timely and successful completion of each of the Transition Phase tasks. The MCO is responsible for clearly specifying and requesting information needed from HHSC, other HHSC contractors, and Providers in a manner that does not delay the schedule or work to be performed.

#### **7.2.1 Contract Start-Up and Planning**

HHSC and the MCO will work together during the initial Contract start-up phase to:

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

The MCO is responsible for developing a written work plan, referred to as the Transition/Implementation Plan, which will be used to monitor progress throughout the Transition Phase. The MCO must update the Transition/Implementation Plan provided with its proposal no later than 30 days after the Contract's Effective Date, then provide monthly implementation progress reports through the sixth month of MCO Program operations. HHSC may require more frequent reporting as it determines necessary.

## 7.2.2 Administration and Key MCO Personnel

No later than the Effective Date of the Contract, the MCO must designate and identify Key MCO Personnel that meet the requirements in **Attachment A** “STAR Health Contract Terms.” The MCO will supply HHSC with résumés of each Key MCO Personnel as well as organizational information that has changed relative to the MCO’s Proposal, such as updated job descriptions and updated organizational charts, if applicable. For Service Coordinators and Service Managers, the MCO must also provide information on the anticipated maximum caseload per Service Coordinator and Service Manager (i.e., number of Members per Service Coordinator and number of Members per Service Manager). For the STAR Health Liaisons, provide information on the anticipated number of needed staff to fulfill contract requirements. If the MCO is using a Material Subcontractor, the MCO must also provide the organizational chart for the Material Subcontractor.

### 7.2.2.1 Material Subcontractors

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

1. the requirements for performance of all delegated functions with which the entity must comply;
2. the MCO’s responsibilities for the financial oversight of a Material Subcontractor who has an at-risk contract with the MCO for the provision of covered services;
3. required and periodic reporting and interfaces with Material Subcontractors required to perform an administrative function on behalf of the MCO;
4. a review of the entity’s solvency status, financial operation, and amounts paid for Covered Services (if applicable); and
5. a review of the entity’s contract compliance, logged complaints, and functional performance measurements.

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

## 7.2.3 Organizational and Financial Readiness Review

In order to complete an organizational and financial Readiness Review and assess the most current corporate environment, the MCO must update the organizational and financial

information submitted in its proposal for any awarded Contract. See **Section 4.2**, “Business Proposal,” for a list of Financial Statements, Corporate Background and Status, Corporate Experience, and Material Subcontractor Information the MCO must update for the Readiness Review.

#### **7.2.4 System Testing and Transfer of Data**

The MCO must have hardware, software, network, and communications systems with the capability and capacity to handle and operate all MIS systems and subsystems identified in **Section 8.1.24**, “Management Information System (MIS) Requirements.” For example, the MCO’s MIS system must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act) as indicated in **Section 8.1.24.4**.

During this Readiness Review task, the MCO will accept into its system any and all necessary data files and information available from HHSC or its contractors. The MCO will install and test all hardware, software, and telecommunications required to support the Contract. The MCO will define and test modifications to the MCO’s system(s) required to support the business functions of the Contract.

The MCO will produce data extracts and receive all electronic data transfers and transmissions. The MCO must be able to demonstrate the ability to produce the 837- encounter file by the Operational Start Date.

If any errors or deficiencies are evident, the MCO will develop resolution procedures to address problems identified. The MCO will provide HHSC, or a designated vendor, with test data files for systems and interface testing for all external interfaces. The HHSC Administrative Services Contractor will provide enrollment test files to new MCOs that do not have previous HHSC enrollment files. The MCO will demonstrate its system capabilities and adherence to Contract specifications during readiness review.

#### **7.2.5 System Readiness Review**

The MCO must assure that systems services are not disrupted or interrupted during the Operations Phase of the Contract. The MCO must coordinate with HHSC and other contractors to ensure business and systems continuity for the processing of all healthcare claims and data as required under the Contract.

The MCO must submit descriptions of interface and data and process flow for each key business process described in **Section 8.1.24.3**, “System-wide Functions,” to HHSC.

The MCO must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The MCO must develop, and submit for HHSC review and approval, the following information no later than 120 days prior to the Operational Start Date and within 15 Business Days of HHSC’s written request at any time during the Contract:

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

\*The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.

### **7.2.6 Demonstration and Assessment of System Readiness**

The MCO must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA and the HITECH Act. The MCO must also provide HHSC with a summary of all recent external audit reports, including findings and corrective actions, relating to the MCO's proposed systems, including any SSAE16 audits conducted in the past three years. The MCO must promptly make additional information on the detail of these system audits available to HHSC upon request.

In addition, HHSC will provide to the MCO a test plan that will outline the activities that the MCO needs to perform prior to the Operational Start Date of the Contract. The MCO must be prepared to assure and demonstrate system readiness. The MCO must execute system readiness test cycles to include all external data interfaces, including those with the MCO's Pharmacy Benefits Manager (PBM) and other Material Subcontractors.

HHSC, or its agents, may independently test whether the MCO's MIS has the capacity to administer the STAR Health MCO business. This Readiness Review of a MCO's MIS may include a desk review or an onsite review. HHSC may request from the MCO additional documentation to support the provision of STAR Health Services. Based in part on the MCO's assurances of systems readiness, information contained in the Proposal, additional documentation submitted by the MCO, and any review conducted by HHSC or its agents, HHSC will assess the MCO's understanding of its responsibilities and the MCO's capability to assume the MIS functions required under the Contract.

The MCO must provide a Corrective Action Plan in response to any Readiness Review deficiency no later than 10 calendar days after notification of any deficiency by HHSC. If the MCO documents to HHSC's satisfaction that the deficiency has been corrected within 10 calendar days of the deficiency notification by HHSC, no Corrective Action Plan is required.

### **7.2.7 Operations Readiness**

The MCO must clearly define and document the policies and procedures it will follow to support day-to-day business activities related to the provision of STAR Health Services, including coordination with contractors. The MCO will be responsible for developing and documenting its approach to quality assurance.

HHSC or its designee will conduct a Readiness Review not later than the 15th day before the date on which HHSC plans to begin the enrollment process and again not later than the 15th day prior to the Operational Start Date. MCO is responsible for all reasonable travel costs incurred by HHSC or its authorized agent for onsite Readiness Reviews. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. This provision does not limit HHSC's ability to collect any other costs as damages in accordance with **Attachment A, Section 12.02(e)**, "Damages."

During Readiness Review, the MCO must, at a minimum:

1. Develop new, or revise existing, operations procedures and associated documentation to support the MCO's proposed approach to conducting operations activities in compliance with the contracted Scope of Work.
2. Submit a list of all contracted and credentialed Providers to HHSC in an HHSC-approved format, including a description of additional contracting and credentialing activities scheduled to be completed before the Operational Start Date.
3. Prepare and implement a Member Services staff training curriculum and a Provider training curriculum, and provide documentation demonstrating compliance with training requirements (e.g., enrollment or attendance rosters dated and signed by each attendee or other written evidence of training.)
4. Prepare a Coordination Plan documenting how the MCO will coordinate its business activities with those activities performed by HHSC contractors and the MCO's PBM and other Material Subcontractors, if any. The Coordination Plan will include identification of coordinated activities and protocols for the Transition Phase.
5. Develop and submit a plan to HHSC for providing Behavioral Health (BH) Services, including oversight and management of any subcontracted BH Services. The plan must also address strategies, structures, and incentives for coordinating behavioral and physical Healthcare Services at the organizational and practitioner level.
6. Develop and submit a plan to HHSC for conducting ongoing retrospective reviews of any psychotropic medication regimen that is not compliant with the DFPS Psychotropic Medication Utilization Parameters or standards of care. The plan must address strategies for correcting any non-compliant regimen. The plan must also address strategies and incentives for providers that are routinely non-compliant.
7. Develop and submit a communication plan to HHSC for ongoing coordination with HHSC, DFPS, and HHSC or DFPS contractors that includes strategies for sharing information and resolving issues.
8. Develop and submit the draft Member handbook, draft Provider directory, and draft Member identification card to HHSC for review and approval. At a minimum, the materials must meet the requirements specified in **Section 8.1.5**, "Member Services," and include the Critical Elements defined in the **UMCM Chapters 3.13**, "STAR Health Provider Directory," **3.15**, "STAR Health Member Handbook," and **3.16**, "STAR Health Member ID."
9. Develop and submit the draft Provider manual and draft Provider contract templates to HHSC for review and approval. At a minimum, the materials must meet the requirements specified in **Section 8.1.4**, "Provider Network," and include the Critical Elements defined in the **UMCM Chapters 3.14**, "STAR Health Provider Manual," and **8.1**, "Provider Contract Checklist."
10. Develop and submit all other Provider Materials relating to Medicaid to HHSC prior to use or mailing. If HHSC has not responded to MCO's request for review within 15 Business Days, the MCO may use the submitted materials. HHSC reserves the right to require discontinuation or correction of any Provider Materials that are not in compliance with state and federal laws or the Contract's requirements.
11. Develop and submit the MCO's proposed Member complaint and appeals processes to HHSC.
12. Demonstrate toll-free telephone systems and reporting capabilities for the Nurse Hotline, the Member Services Hotline, the Behavioral Health Hotline, and the Provider Services Hotline.

13. Submit a written Fraud, Waste, and Abuse Compliance Plan to HHSC for approval no later than 30 days after the Contract Effective Date. See **Section 8.1.25**, “Fraud, Waste, and Abuse,” for the requirements of the plan, including new requirements for special investigation units. As part of the Fraud, Waste, and Abuse Compliance Plan, the MCO must:
  - a. Designate executive and essential personnel to attend mandatory training in Fraud, Waste, and Abuse detection, prevention, and reporting. Executive and essential fraud, waste, and abuse personnel means MCO staff members who supervise staff in the following areas: data collection, Provider enrollment or disenrollment, Encounter Data, claims processing, Utilization Review, appeals or grievances, quality assurance and marketing, and who are directly involved in the decision-making and administration of the Fraud, Waste, and Abuse detection program within the MCO. The training will be conducted by the Office of Inspector General, HHSC, and will be provided free of charge. The MCO must schedule and complete training no later than 90 days after the Effective Date.
  - b. Designate an officer or director within the organization responsible for carrying out the provisions of the Fraud, Waste, and Abuse Compliance Plan.
  - c. Ensure that, if the MCO subcontracts this function to another entity, the Subcontractor also meets all the requirements in this section and the Fraud, Waste, and Abuse **Section 8.1.25**.
  - d. Complete hiring and training of Service Management and Service Coordination staff no later than 45 days prior to the STAR Health Operational Start Date.
14. Submit a written plan to HHSC for providing pharmacy services, including proposed policies and procedures for:
  - a. routinely updating formulary data following receipt of HHSC’s daily files (no less frequently than weekly and off-cycle upon HHSC’s request);
  - b. prior authorization (PA) of drugs, including how HHSC’s preferred drug lists (PDLs) will be incorporated into PA systems and processes. The MCO must adopt HHSC’s PA processes, criteria, and edits unless HHSC grants a written exception, and HHSC’s approval is required for all Clinical Edit policies;
  - c. implementing drug utilization review (DUR);
  - d. overriding standard DUR criteria and clinical edits when Medically Necessary based on the individual Member’s circumstances (e.g., overriding quantity limitations, drug-drug interactions, refilling too soon);
  - e. call center operations, including how the MCO will ensure that staff for all appropriate hotlines are trained to respond to PA inquiries and other inquiries regarding pharmacy services; and
  - f. monitoring the Pharmacy Benefit Manager (PBM) Subcontractor.

The plan must also include a written description of the assurances and procedures that must be put in place under the proposed PBM Subcontract, such as an independent audit, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information.

Additionally, the MCO must include a written attestation by the PBM Subcontractor in the plan stating, in the three years preceding the Contract’s Effective Date, the PBM Subcontractor has not been:

1. convicted of an offense involving a material misrepresentation or any act of fraud or of another violation of state or federal criminal law;
2. adjudicated to have committed a breach of contract; or
3. assessed a penalty or fine of \$500,000 or more in a state or federal administrative proceeding. If the PBM Subcontractor cannot affirmatively attest to any of these items, then it must provide a comprehensive description of the matter and all related corrective actions.

During the Readiness Review, HHSC may request from the MCO certain operating procedures and updates to documentation to support the provision of STAR Health Services. HHSC will assess the MCO's understanding of its responsibilities and the MCO's capability to assume the functions required under the Contract, based in part on the MCO's assurances of operational readiness, information contained in the Proposal, and in Transition Phase documentation submitted by the MCO.

The MCO is required to provide a Corrective Action Plan or Risk Mitigation Plan promptly as requested by HHSC in response to Operational Readiness Review deficiencies identified by the MCO or by HHSC or its agent. The MCO must promptly alert HHSC of deficiencies and must correct a deficiency or provide a Corrective Action Plan or Risk Mitigation Plan no later than 10 calendar days after HHSC's notification of deficiencies. If the Contractor documents to HHSC's satisfaction that the deficiency has been corrected within 10 calendar days of any deficiency notification by HHSC, no Corrective Action Plan is required.

### **7.2.8 Assurance of System and Operational Readiness**

In addition to successfully providing the Deliverables described in **Section 7.2**, "Transition Phase Schedule and Tasks," the MCO must assure HHSC that all processes, MIS systems, and staffed functions are ready and able to assume responsibilities successfully for operations prior to the Operational Start Date. In particular, the MCO must assure that Key MCO Personnel, Member Services staff, Provider Services staff, and MIS staff are hired and trained, MIS systems and interfaces are in place and functioning properly, communication procedures are in place, Provider manuals have been distributed, and that Provider training sessions have occurred according to the schedule approved by HHSC.

### **7.2.9 Health Passport Readiness**

The MCO must demonstrate that its web-based Health Passport system has the capability and capacity to meet all requirements set forth in **Section 8.1.12**, "Health Passport."

During Readiness Review, the MCO must, at a minimum:

1. Demonstrate that the Health Passport has the capability to include all external data interfaces and produce all required reports.
2. Provide documentation on Health Passport application security and provide evidence of or demonstrate that the Health Passport application is:
  - a. compliant with security and privacy rules adopted by the U.S. Department of Health and Human Services (HHS) under HIPAA, HITECH Act, and 45 C.F.R. §§ 164.302–.318; 164.500–.534; all applicable state and federal laws, including Tex. Admin. Code Chapter 390, and current Enterprise Information Security Standards and Guidelines (EISSG), which can be found in the **Procurement Library**.

- b. able to restrict information according to role-based restrictions as identified by HHSC;
- c. capable of providing an additional security layer for cases deemed sensitive by DFPS to allow access only by DFPS-designated personnel;
- d. capable of providing audit trail functionality to include security audits (logging of Health Passport access attempts) and data audits (logging when, and by whom, records are created, viewed, updated, extracted, or deleted); and is
- e. able to terminate a user's access to the Health Passport system within 24 hours of notification of the user's change in status.

#### **7.2.10 TDI Licensure, Certification, or Approval**

The MCO must receive TDI licensure, certification, or approval (as applicable) for each county in the state no later than 60 days after the Contract's Effective Date.

#### **7.2.11 Post-Transition**

The MCO will work with HHSC, Providers, and Members to promptly identify and resolve problems identified after the Operational Start Date and to communicate to HHSC, Providers, and Members, as applicable, the steps the MCO is taking to resolve the problems.

The MCO must:

1. meet with HHSC staff and discuss post-Transition Phase issues and problems;
2. work proactively and collaboratively to resolve issues or problems identified by the Provider community, DFPS Staff, and other stakeholders; and
3. document the problems and their causes encountered during start-up and implementation in writing, and provide information regarding steps to correct the problem, including resources that will be used, the timeline for correcting the problem, and the steps that the MCO will take to prevent the issue or problem from recurring. The MCO will also document when the problem is resolved. The MCO will report this information to HHSC every 14 days, or as often as determined necessary by HHSC, during the first six months of operations, at which time HHSC will reassess the required frequency of providing this report.

If an MCO makes assurances to HHSC of its readiness to meet Contract requirements, including MIS and operational requirements, but fails to satisfy requirements set forth in this Section, or as otherwise required pursuant to the Contract, HHSC may, at its discretion do any of the following in accordance with the severity of the non-compliance and the potential impact on Members and Providers:

1. impose contractual remedies, including liquidated damages; or
2. pursue other equitable, injunctive, or regulatory relief.

Refer to **Sections 8.1.1.1**, "Additional Readiness Reviews and Monitoring Efforts," and **8.1.24**, "Management Information System (MIS) Requirements," for additional information regarding MCO Readiness Reviews during the Operations Phase.

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	2.0	July 1, 2015	Initial version of Attachment B-1, RFP Section 8, "Operations Phase Requirements" that includes all modifications negotiated by the Parties.
Revision	2.1	September 1, 2015	<p>Section 8.1.1 is modified to clarify the requirements for collaboration, to change the due date for PIP projects, to remove the reference to annual, and to require the MCOs to complete progress reports.</p> <p>Section 8.1.2.1 is modified to change the due dates and to require MCOs to clarify restrictions and limitations to their VAS and notification process when deleting a VAS.</p> <p>Section 8.1.3 is modified to clarify the language. Network is redundant as Provider definition states they are contracted.</p> <p>Section 8.1.3.3 is modified to add requirements for a mandatory survey of Providers.</p> <p>Section 8.1.4.4 is modified to specifically refer to anti-discrimination requirements and to move the last sentence of the section to the end of the second paragraph.</p> <p>Section 8.1.4.6 is modified to clarify that if HHSC has not approved Provider Materials within 15 days, the MCO may use them only after first notifying HHSC of its intent to use. In addition, the section is modified to qualify the cultural competency training requirement, to add "Abuse, Neglect, or Exploitation" to the list, and to require training for BH Providers as required by SB 125.</p> <p>Section 8.1.4.10 is modified to require the MCOs to notify HHSC when a Provider termination impacts more than 10% of its Members.</p> <p>Section 8.1.7.8 is modified to change the section name to "Provider Credentialing and Profiling" and to add credentialing requirements.</p> <p>Section 8.1.9.4 is modified to reflect the new IFSP form and instructions developed by ECI.</p> <p>Section 8.1.9.5 is modified to reflect the new IFSP form and instructions developed by ECI.</p>

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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Section 8.1.11 is modified to clarify that the SSCC requirement only applies to categories 1-2 of the Target Population and when assessments must be further expedited. In addition, the section is modified to delete the MCO Liaison requirement and to clarify the MCOs responsibility related to court orders.</p> <p>Section 8.1.12.1 is modified to remove STAR Health Liaison.</p> <p>Section 8.1.17.8 is modified to change "authorize" to "must contract with" and to clarify eligibility requirements.</p> <p>Section 8.1.17.9 Mental Health Parity is added.</p> <p>Section 8.1.20.1 is modified to add certain LHHS and vitamins and minerals.</p> <p>Section 8.1.20.2 is modified to allow the MCO to reference the VDP formulary on Epocrates when the MCO's clinical edits are the same as or less stringent than VDP's.</p> <p>Section 8.1.20.4 is deleted in its entirety.</p> <p>Section 8.1.20.7 is modified to comply with the requirements of SB 94.</p> <p>Section 8.1.24.1 is modified to clarify the language and to add requirements for the Quarterly Encounter Reconciliation Report.</p> <p>Section 8.1.25 is modified to address issues of material misrepresentation. In addition, sub-section headings are added and the section is reorganized for clarity.</p> <p>Section 8.1.26.1 is modified to change the section name from "Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Other Statistical Performance Measures" to "Performance Measurement" and to remove unnecessary language.</p> <p>Section 8.1.33.3 is modified to clarify MCO payment responsibility for overturned DME prior authorization denials.</p> <p>Section 8.1.34 is amended to clarify requirement.</p>

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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Revision	2.2	March 1, 2016	<p>All references to Frew v. Janek are changed to Frew v. Traylor.</p> <p>All references to “abuse and neglect” are changed to “Abuse, Neglect, and Exploitation.”</p> <p>All references to “Fraud and Abuse” are changed to “Fraud, Waste, and Abuse”</p> <p>Section 8.1.1.1 is modified to require the MCO to allow HHSC access for remote monitoring.</p> <p>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.</p> <p>Section 8.1.3.2 is modified to add access requirements for CANS assessments per SB 125.</p> <p>Section 8.1.3.4.1 “School-based Telemedicine Services” is added.</p> <p>Section 8.1.4 is modified to add access requirements for CANS assessments per SB 125.</p> <p>Section 8.1.4.6 is modified to add provider training requirements for CANS assessments per SB 125.</p> <p>Section 8.1.4.10 is modified to clarify the timeframe.</p> <p>Section 8.1.5.5 is modified to update the UMCM references.</p> <p>Section 8.1.5.10 “Reporting Abuse or Neglect” is renamed “Abuse, Neglect, or Exploitation” and the text is deleted. In addition, Section 8.1.5.10.1 “Member Education on Abuse, Neglect, or Exploitation” is added.</p> <p>Section 8.1.5.10.2 “Abuse, Neglect, and Exploitation Email Notifications” is added.</p> <p>Section 8.1.6 is modified to correct the UMCM reference.</p> <p>Section 8.1.11 is modified to move assessment requirements to new Section 8.1.11.3 – Assessments; to move provider training and manual requirements to Section 8.1.4.6 Provider Relations Including Manual, Materials and Training; and to delete redundant language about Pre-Appeals, which is located in</p>

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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Section 8.1.33.2 Member Pre-Appeals Process per SB 125.</p> <p>Section 8.1.11.1 is modified to add training requirements for CANS assessments and to restructure requirements to meet needs and recommendations of the Children's Commission per SB 125.</p> <p>Section 8.1.11.3 Assessments is added.</p> <p>Section 8.1.12.1 is modified to add Health Passport submission requirements for CANS assessments and to add enhancements to be implemented at a later date per SB 125.</p> <p>Section 8.1.12.2 is modified to add requirement to develop a process to ensure forms and assessments are entered more timely.</p> <p>Section 8.1.12.3 is modified to change week to day.</p> <p>Section 8.1.12.4 is renamed Health Passport Mobile Accessibility and modified to change language, as this will not be an app, but access by mobile device only.</p> <p>Section 8.1.13.2 is modified to change telephonic assessment to "screening" to distinguish this from the new assessment process; to add requirement to discuss assessment requirement and schedule the assessment during the telephonic screening call; to add that HCSPs must incorporate the CANS results within 14 days of completion; and to add that SM or SC must be offered to the Member if the CANS indicates a need per SB 125.</p> <p>Section 8.1.17 is modified to add requirement for BH providers to either complete a DFPS CANS assessment or refer to a provider who is certified to do so per SB 125.</p> <p>Section 8.1.17.1 is modified to review entire section for impact to BH network requirements per SB 125.</p> <p>Section 8.1.17.4 is modified to add requirements for coordination regarding the results of the DFPS CANS assessment per SB 125.</p> <p>Section 8.1.20.1 is modified to change "Clinical Edits" to "Clinical PAs."</p> <p>Section 8.1.20.2 is modified to add language regarding VDP's Clinical PA process and dispensing or refilling a</p>

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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>prescription without a prior authorization during a Governor-declared disaster.</p> <p>Section 8.1.20.6 is modified to correct a CFR reference, to remove the prospective review and POS requirement, and to add a reference to UMCM Chapter 5.13.4</p> <p>Section 8.1.20.15 is modified to prohibit the use of extrapolation in pharmacy audits and to remove the requirement to comply with Texas Insurance Code § 843.3401</p> <p>Section 8.1.20.17 "Second Generation Direct Acting Antivirals for Hepatitis C" is deleted in its entirety.</p> <p>Section 8.1.26.2 is modified to add "Critical Incidents and Abuse, Neglect, and Exploitation Report."</p> <p>Section 8.1.28.8 is modified to remove DFPS Targeted Case Management.</p> <p>Section 8.1.33.5 is modified to require MCOs to ensure appropriate staff attends all Fair Hearings as scheduled.</p> <p>Section 8.1.40 is deleted in its entirety and the language moved to Section 8.1.5.10.1 in order to consolidate all ANE language in one location.</p>
Revision	2.3	September 1, 2016	<p>All references to Frew v. Traylor are changed to Frew v. Smith.</p> <p>Section 8.1.2.1 is modified to remove language referencing the transition phase.</p> <p>Section 8.1.2.2 is modified to remove the requirement to submit an implementation plan prior to the Operational Start Date.</p> <p>Section 8.1.3 is modified to add language specific to MDCP and CFC services.</p> <p>Section 8.1.3.1 is modified to add a standard for the Texas Comprehensive CANS 2.0 (child welfare).</p> <p>Section 8.1.4 is modified to remove the requirement to submit an implementation plan prior to the Operational Start Date; to change " in the MCO's proposed Service Area(s)" to " throughout the state"; to clarify the name of the CANS assessment; to remove "Home Health</p>

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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Services" and add "Community-Based Service Providers," "MDCP," "Durable Medical Equipment (DME) and Medical Supplies," and "Prescribed Pediatric Extended Care Centers (PPECC)."</p> <p>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.</p> <p>Section 8.1.4.4 is modified to require the MCO to identify a tracking process for BH Providers becoming certified to administer the Texas Comprehensive CANS 2.0 assessment tool.</p> <p>Section 8.1.4.4.1 is modified to add provider types for which the MCOs must expedite credentialing.</p> <p>Section 8.1.4.4.2 is modified to change item 7 "legally responsible person" to "Caregiver or Medical Consenter."</p> <p>Section 8.1.4.6 is modified to remove language referencing the transition phase; to add item 1 d; to modify item 8; to clarify the name of the CANS assessment tool in item 9 f; and to remove item 17.</p> <p>Section 8.1.4.8.1 Safety-net Hospital Incentives is added.</p> <p>Section 8.1.4.9 is modified to align the contract language with the Texas Government Code.</p> <p>Section 8.1.4.10 is modified to clarify the reporting requirement.</p> <p>Section 8.1.5.1 is modified to remove references to category 4.</p> <p>Section 8.1.5.2 is modified to remove the FFCHE program.</p> <p>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</p> <p>Section 8.1.5.5 is modified to add a reference to the Online Provider Directory and to add requirements for mobile devise use.</p> <p>Section 8.1.5.6 is modified to add Community-Based and LTSS to covered services; to correct typographical</p>

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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>errors; to clarify that the NEMT program is non-capitated; and to add SB 125 training requirement.</p> <p>Section 8.1.5.7 is modified to add SB 125, PCS, service delivery options, and MDCP services; and the list is reworked to be more concise with regard to covered services listed.</p> <p>Section 8.1.5.10.3 MCO Training on Abuse, Neglect, and Exploitation is added.</p> <p>Section 8.1.11.1 is modified to remove language requiring a training plan be submitted prior to the Operational Start Date.</p> <p>Section 8.1.11.2 is modified to remove the reference to category 4.</p> <p>Section 8.1.11.3 is modified to clarify the name of the CANS assessment.</p> <p>Section 8.1.12.1 is modified to remove Readiness Review language and to modify the SB125 required data elements.</p> <p>Section 8.1.12.4 is modified to align to the data elements in Section 8.1.12.1.</p> <p>Section 8.1.13.1 is modified to add language specific to STAR Kids and MDCP.</p> <p>Section 8.1.13.2 is modified to incorporate MDCP requirements into the Service Manager's role; to update the name of the child welfare CANS; to adjust service plan requirements to incorporate the child welfare CANS; and to clarify that MCOs must coordinate services to prevent duplication.</p> <p>Section 8.1.15 is modified to clarify that health home services do not apply to dual eligible Members.</p> <p>Section 8.1.15.1 is modified to remove requirement to submit an implementation plan prior to the Operational Start Date.</p> <p>Section 8.1.16.1 is modified to remove requirement to submit an implementation plan prior to the Operational Start Date.</p> <p>Section 8.1.17 is modified to update the name of the child welfare CANS and to remove the requirement to</p>

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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>submit the results of the child welfare CANS to the Health Passport.</p> <p>Section 8.1.17.1 is modified to remove requirement to submit an implementation plan prior to the Operational Start Date and to add the child welfare CANS to the list.</p> <p>Section 8.1.17.3 is modified to update the UMCM chapter name.</p> <p>Section 8.1.17.4 is modified to update the name of the child welfare CANS and to convert part of the second paragraph to a list and to update the title and URL for Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care.</p> <p>Section 8.1.17.8 is modified to add clinic/group practices to the list of qualified Network entities.</p> <p>Section 8.1.18.2 is modified to list the provider types that can serve as Main Dental Home Providers.</p> <p>Section 8.1.25 is modified to clarify MCO level of cooperation and assistance.</p> <p>Section 8.1.25.2 is modified to clarify and provide support to the Deliverables/Liquidated Damages Matrix.</p> <p>Section 8.1.26.2 is modified to update items (d) (f) and (g) to conform to updates to the UMCM; to delete items (e) (l) (m) and (t) and re-letter all subsequent items; and to add item (v).</p> <p>Section 8.1.27.1 "For MDCP Members" is added.</p> <p>Section 8.1.28.3.2 is modified to require the MCOs to educate providers on OEFV documentation.</p> <p>Section 8.1.28.3.5 is modified to update the requirements for items 8 and 9 and to remove the requirement for the MCO to educate and train Providers regarding the requirements of the <i>Frew v. Traylor</i> Consent Decree and Corrective Action Orders.</p> <p>Section 8.1.28.8 is modified to add item 16 "Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members."</p> <p>Section 8.1.28.10 is modified to require the MCOs to educate providers on documentation for immunizations.</p>

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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Section 8.1.29 is modified to add STP requirements for MDCP providers.</p> <p>Section 8.1.35 is modified to add requirements for MDCP and to update the minimum wage amount.</p> <p>Section 8.1.38 is modified to change the name from "Community First Choice (CFC) Services Available to Qualified Members" to "Community First Choice (CFC) Services" and language from Sections 8.1.39.1, 8.1.39.2, 8.1.39.3, 8.1.39.4, and 8.1.39.5 is incorporated.</p> <p>Section 8.1.39 Community First Choice Eligibility is deleted and replaced by Covered Community-Based Services.</p> <p>Section 8.1.39.1 For Members Who Have Physical Disabilities is deleted and the language is incorporated into Section 8.1.38.</p> <p>Section 8.1.39.2 For Members with an Intellectual or Developmental Disability is deleted and the language is incorporated into Section 8.1.38.</p> <p>Section 8.1.39.3 For Members with Severe and Persistent Mental Illness or Severe Emotional Disturbance is deleted and the language is incorporated into Section 8.1.38.</p> <p>Section 8.1.39.4 Eligibility is deleted and the language is incorporated into Section 8.1.38.</p> <p>Section 8.1.39.5 Annual Reassessment is deleted and the language is incorporated into Section 8.1.38.</p> <p>Section 8.1.40 Service Delivery Options is added.</p> <p>Section 8.1.40.1 Consumer Directed Services (CDS) Model is added.</p> <p>Section 8.1.40.2 Service Related Option Model is added.</p> <p>Section 8.1.40.3 Agency Model is added.</p> <p>Section 8.1.41 Facility Based Care is added.</p> <p>Section 8.1.42 Prescribed Pediatric Extended Care Centers is added.</p>

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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Section 8.1.42.1 Prior Authorization for PPECC Services is added.</p> <p>Section 8.1.43 Medicaid Wrap-Around Services is added.</p> <p>Section 8.1.44 Carve-in Readiness is added.</p> <p>Section 8.2 Additional Requirements Regarding the Medically Dependent Children Program (MDCP) is added.</p> <p>Section 8.2.1 Program Eligibility and Assessment is added.</p> <p>Section 8.2.2 Service Management Requirements for MDCP Members is added.</p> <p>Section 8.2.3 MDCP Provider Requirements is added.</p>
<p><sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions</p> <p><sup>2</sup> 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.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			

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## **8 OPERATIONS PHASE REQUIREMENTS AND GENERAL SCOPE OF WORK**

HHSC will select one MCO to provide statewide Healthcare Services to STAR Health Program Members. The MCO must have the appropriate Texas Department of Insurance (TDI) license to provide Healthcare Services in all counties in the State of Texas.

The MCO will begin providing Covered Services to Members on the Operational Start Date, September 1, 2015.

### **8.1 Administration and Contract Management**

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

#### **8.1.1 Performance Evaluation**

HHSC will provide the MCO with two Performance Improvement Project (PIP) topics. The MCO must develop one PIP per topic. The MCO must conduct one PIP per program 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 the NorthSTAR behavioral health organization (as appropriate) in the Service Area. HHSC will update the PIP topics as it determines it to be necessary, and the MCO must complete each PIP template in accordance with **UMCM Chapter 10.2.4**, "Performance Improvement Project Submission Instructions". Each MCO must also complete progress reports as outlined in the **UMCM Chapter 10.2.9**, "PIP Progress Report Template".

PIPs will follow CMS protocol, as described below. The purpose of healthcare quality PIPs is to assess and improve processes, and thereby outcomes, of care. In order for these projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

MCOs must use the following 10-step CMS protocol when conducting PIPs:

1. Select the study topic(s);
2. define the study question(s);
3. select the study indicator(s);
4. use a representative and generalizable study population;
5. use sound sampling techniques (if sampling is used);
6. collect reliable data;
7. implement intervention and improvement strategies;

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8. analyze data and interpret study results;
9. plan for “real” improvement; and
10. achieve sustained improvement.

(See **Uniform Managed Care Manual (UMCM) Chapter 10.2.4**, “Performance Improvement Project Submission Instructions,” and **10.2.5**, “Performance Improvement Project Template”).

The MCO must participate in semi-annual contract status meetings (CSMs) with HHSC for the primary purpose of reviewing progress toward the achievement of PIPs and Contract requirements. HHSC may request additional CSMs, as it deems necessary to address areas of noncompliance and other issues. HHSC will provide the MCO with reasonable advance notice of additional CSMs, generally at least five Business Days.

The MCO must provide to HHSC, no later than 14 Business Days prior to each semi-annual CSM, one electronic copy of a written report detailing and documenting the MCO’s progress toward and any barriers in meeting the PIPs.

HHSC will track MCO performance on the PIPs. HHSC will also track other key facets of MCO performance through the use of the Performance Indicator Dashboards (see **UMCM Chapters 10.1.3**, “STAR Health Performance Indicator Dashboard for Administrative and Financial Measures,” and **10.1.8**, “STAR Health Performance Indicator Dashboard for Quality Measures”). HHSC will compile the Performance Indicator Dashboard based on MCO submissions, data from the External Quality Review Organization (EQRO), and other data available to HHSC. HHSC will share the Performance Indicator Dashboard results with the MCO on a quarterly basis.

#### **8.1.1.1 Additional Readiness Reviews and Monitoring Efforts**

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During the Operations Phase, HHSC may conduct desk or onsite reviews as part of its normal Contract monitoring efforts. Additionally, if the MCO chooses to make a change to any operational system or undergoes any major transition, it may be subject to an additional Readiness Review(s). HHSC will determine whether the proposed changes will require a desk review or an onsite review. The MCO is responsible for all reasonable 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, “reasonable travel costs” include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. This provision does not limit HHSC’s ability to collect other costs as damages in accordance with **Attachment A, Section 12.02(e)**, “Damages.”

The MCO must provide HHSC secure access rights as an authorized or guest user to all Provider access points, including but not limited to its Provider portal and call monitoring system, for remote monitoring capability.

In addition, the MCO must provide HHSC secure access rights as an authorized or guest user to all Member access points, including but not limited to its Member portal and call monitoring system, for remote monitoring capability.

Refer to **Section 7.3.7**, “Operations Readiness,” and **Section 8.1.24**, “Management Information Systems,” for additional information regarding MCO Readiness Reviews. Refer to **Attachment A, Section 4.09(c)**, “Subcontractors and Agreements with Third Parties,” for information regarding Readiness Reviews of the MCO’s Material Subcontractors.

### 8.1.2 Covered Services

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The MCO is responsible for 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, or receipt of any prior Healthcare Services. The MCO must also comply with DFPS requirements related to Covered Services in laws, rules and regulations, including requirements for assessments and court ordered services (see [http://www.dfps.state.tx.us/Site\\_Map/rules.asp](http://www.dfps.state.tx.us/Site_Map/rules.asp)), as amended or modified during the Contract Term.

The MCO must not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any Member. The MCO must provide full coverage for Medically Necessary Covered Services to all Members without regard to the Member’s:

1. previous coverage, if any, or the reason for termination of the coverage;
2. health status;
3. confinement in a healthcare facility; or
4. any other reason.

The Span of Coverage requirements found in **Attachment A**, “STAR Health Contract Terms,” will apply.

Except for those services identified in **Section 8.1.28.8**, “Medicaid Non-capitated Services,” the MCO must provide Covered Services described in the most recent **Texas Medicaid Provider Procedures Manual (TMPPM)** and any updates.

The MCO must allow Covered Services to be provided by an Out-of-Network (OON) provider if a Network Provider is not available to provide the services.

Covered Services are subject to change due to changes in federal and state laws, rules or regulations; changes in Medicaid policy; and changes in medical practice, clinical protocols, or technology.

The MCO must have a process in place to monitor a Member’s claims history for acute and long-term care services that receive a prior authorization to ensure that these services are being delivered. On an ongoing basis, the MCO must monitor claims data for all approved prior authorizations for delivery of the services. The MCO must research and resolve any services not received as a result of the lack of claims data.

In the development of medical policies and medical necessity determinations, the MCO must adopt practice guidelines that:

1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
2. Consider the needs of the MCO's enrollees;
3. Are adopted in consultation with contracting health care professionals; and
4. Are reviewed and updated periodically as appropriate.

### **8.1.2.1 Value-added Services**

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The MCO may propose additional services for coverage. These are referred to as “Value-added Services.” Value-added Services may be Healthcare Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improved health outcomes among Members. These may include family or community support services and supports that may be identified through a wraparound service delivery approach provided to youth with complex mental health needs. Value-added Services that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra Home Health Services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

If offered, Value-added Services must be offered to all Members for whom the services are appropriate. Value-added Services that are approved by HHSC during the contracting process will be included in the Contract’s Scope of Work.

The MCO must provide Value-added Services at no additional cost to HHSC. The MCO may offer discounts on non-covered benefits to Members as Value-added Services, provided that the MCO complies with Texas Insurance Code § 1451.155 and § 1451.2065. The MCO must ensure that Providers do not charge Members for any other cost-sharing for a Value-added Service (including copayments or deductibles).

The MCO must not pass on the cost of the Value-added Services to Members or Providers. The MCO must specify the conditions and parameters regarding the delivery of each Value-added Service and must clearly describe any limitations or conditions specific to each Value-added Service in the MCO’s Member Handbook. The MCO must also include a disclaimer in its Marketing Materials and Provider Directory indicating that restrictions and limitations may apply.

The MCO must use HHSC’s template for submitting proposed Value-added Services. (See **UMCM Chapter 4.5**, “Physician and Behavioral Health Value-added Services Template”) Once approved by HHSC, this document is incorporated by reference into the Contract.

During the Operations Phase, Value-added Services can be added, enhanced, deleted or reduced only by written amendment of the Contract. The MCO will be given the opportunity to add or enhance Value-added Services twice per State Fiscal Year (SFY), with changes to be effective September 1 and March 1 of each year. The MCO will also be given the opportunity to delete or reduce Value-added Services once per SFY, with changes to be effective September 1 of each year. HHSC may allow additional modifications to Value-added Services if Covered Services are amended by HHSC during a SFY. An MCO’s request to add, enhance, delete, or

reduce a Value-added Service must be submitted to HHSC by March 15 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. A second request to add or enhance Value-added Services must be submitted to HHSC by September 15 of each year to be effective March 1 of the following year. 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.

An MCO's request to add a Value-added Service must:

1. define and describe the proposed Value-added Service;
2. identify the category or group of Members eligible to receive the Value-added Service if it is a type of service that is not appropriate for all Members;
3. note any limitations or restrictions that apply to the Value-added Service;
4. specify which staff will determine whether a Member is eligible to receive the Value-added Service, if the Value-added Service is not a Healthcare Service or benefit;
5. identify the Providers or entities responsible for providing the Value-added Service, including any limitation on Provider or other persons' capacity, if applicable;
6. describe how the MCO will identify the Value-added Service in administrative data (including Encounter Data) and/or in its Financial Statistical Report (FSR), as applicable, or will otherwise document delivery of the Value-added Service;
7. propose how and when the MCO will notify Providers, Members, Caregivers, Medical Consenters, and DFPS Staff about the availability of such Value-added Service;
8. describe the process by which a Member, Caregiver, or Medical Consenter may obtain or access the Value-added Service, including any action required by the Member, as appropriate; and
9. include a statement that the MCO will provide the Value-added Service for at least 12 months after the Operational Start Date.

An MCO cannot include a Value-added Service in any material distributed to Members or prospective Members until the Parties have amended the Contract to include that Value-added Service. If a Value-added Service is deleted by amendment, the MCO must notify the Medical Consenter and Caregiver of each Member receiving the service that the service is no longer available through the MCO. Similarly, if a Value-added Service is added by amendment, the MCO must notify the Medical Consenter and Caregiver of each Member of the availability of that service. Materials are subject to review and approval by HHSC. The MCO must also revise all materials distributed to members to reflect the change in Value-added Services.

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#### **8.1.2.2 Case-by-Case Added Services**

Except as provided below, the MCO may offer additional benefits that are outside the scope of services to individual Members on a case-by-case basis. Case-by-case services may be based on Medical Necessity, Functional Necessity, cost-effectiveness, the wishes of the Member/Member's family, and the potential for improved health status of the Member. The MCO must provide the following two Case-by-Case Added Services on an ongoing basis to members who meet requirements:

1. Non-Covered Supports for Members with Primary Needs: Children with Primary Medical Needs (PMN) are children who cannot live without mechanical supports or the services of others because of non-temporary, life-threatening conditions, including the:
  - a. inability to maintain an open airway without assistance, not including the use of inhalers for asthma;
  - b. inability to be fed except through a feeding tube, gastric tube, or a parenteral route;
  - c. use of sterile techniques or specialized procedures to promote healing, prevent infection, prevent cross-infection or contamination, or prevent tissue breakdown; or
  - d. multiple physical disabilities including sensory impairments.

The MCO must:

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

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

2. Crisis Stabilization and Hospitalization Diversion Program: Children with acute Behavioral Health needs require additional supports to improve placement stability and avert potentially preventable psychiatric hospitalizations.  
In areas where this service is available, the MCO must:
  - a. utilize Trauma Informed Mobile Crisis Outreach Teams (MCOTs) to provide assistance, education, and training to Members and their Medical Consenters and Caregivers; and
  - b. provide residential crisis stabilization services and enhanced wraparound services to Members who qualify.

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### **8.1.3 Access to Care**

All Covered Services must be available to Members on a timely basis in accordance with medically appropriate guidelines, and consistent with generally accepted practice parameters, and the requirements in this Contract. The MCO must comply with the access requirements as established by TDI for all MCOs doing business in Texas, except as otherwise required by this Contract.

The MCO must contractually require Providers to comply with medical consent and informed consent requirements in Texas Family Code § 266.004 that require the Member's Medical Consenter to consent to the provision of medical care and when the consent is considered valid. See **Procurement Library**. A Provider does not need the medical consent of the Member's Medical Consenter to provide Emergency Services for a Member that has an Emergency Medical Condition. The MCO must contractually require the Provider to notify the Medical Consenter about the provision of Emergency Services no later than the second Business Day after providing Emergency Services, as required by Texas Family Code § 266.009. The notification must be documented in the Member's Health Passport.

The MCO must provide coverage for Emergency Services to Members 24 hours a day and 7 days a week, without regard to prior authorization (PA) or the Emergency Service provider's contractual relationship with the MCO. The MCO's policy and procedures, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must comply with all applicable state and federal laws and regulations, whether the provider is in Network or Out-of-Network. An MCO is not responsible for payment for unauthorized non-emergency services provided to a Member by OON providers.

The MCO must also have an emergency and crisis BH Services Hotline available 24 hours a day, 7 days a week, toll-free throughout the state. The BH Services Hotline must meet the requirements described in **Section 8.1.17.3**, "Behavioral Health Hotline and Emergency Services." An MCO must also provide coverage for Emergency Services in compliance with 42 C.F.R. § 438.114, and as described in more detail in **Section 8.1.17.3**. The MCO may arrange Emergency Services and crisis BH Services through mobile crisis teams.

The MCO must require and make best efforts to ensure that Primary Care Providers (PCPs) are accessible to Members 24 hours a day, 7 days a week and that Network PCPs have after-hours telephone availability consistent with **Section 8.1.4.2**, "Primary Care Providers and the Medical Home." The MCO must ensure that Network Providers offer office hours to Members that are at least equal to those offered to the MCO's commercial lines of business or Medicaid fee-for-service participants, if the Provider accepts only Medicaid patients.

If Medically Necessary Covered Services are not available through Network Providers, the MCO must, upon the request of DFPS Staff, the Medical Consenter, or the Network Provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed 5 business days after receipt of reasonable request documentation, allow a referral to an OON provider in accordance with the OON methodology for Medicaid as defined by HHSC.

The MCO must ensure the provision of Covered Services meet the specific preventive, Acute Care, Community-Based Services, Long-Term Services and Supports (LTSS), and specialty healthcare needs appropriate for treatment of the Member's condition(s).

The MCO must provide such services within the timeframes specified in **Section 8.1.3.1**, "Waiting Times for Appointments," and within the time appropriate to the circumstances and Member's need. In such circumstances, the MCO must fully reimburse the OON provider in accordance with OON requirements found in 1 Tex. Admin. Code § 353.4.

The Member, the Medical Consenter, or the Caregiver will not be responsible for any payment for Medically Necessary Covered Services or Functionally Necessary Covered Services.

### **8.1.3.1 Waiting Times for Appointments**

Through its Provider Network composition and management, the MCO must ensure that the following standards are met. In all cases below, “day” is defined as a calendar day, and 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 OON and out-of-state facilities;
2. urgent care, including urgent specialty care, must be provided within 24 hours;
3. routine primary care and initial outpatient BH visits must be provided within 14 days;
4. PCPs must make referrals for specialty care on a timely basis, based on the urgency of the Member’s medical condition, but no later than 30 days;
5. non-urgent specialty care must be provided within 60 days of authorization;
6. prenatal care must be provided within 14 days, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists;
7. preventive health services for adults must be offered within 90 days;
8. preventive health services for children, such as Texas Health Steps medical checkups, should be offered to Members in accordance with the Texas Health Steps periodicity schedule and the requirements set forth in **Section 8.1.28.3**, “Texas Health Steps (EPSDT) Medical and Dental.”
9. The MCO must begin ensuring the Texas Comprehensive CANS 2.0 (child welfare) assessment is complete for each Member in category 1 of the Target Population ages 3 and older within 30 days of receipt of the Daily Notification File (DNF).

### **8.1.3.2 Access to Network Providers**

The MCO’s Network must include all provider types described in this section in sufficient numbers, and with sufficient capacity, to provide timely access to all Covered Services in accordance with the waiting times for appointments in **Section 8.1.3.1**. The MCO’s Network must provide timely access to regular and preventive care to all Members and Texas Health Steps services to all child Members.

This section includes distance standards for each provider type. For each provider type, the MCO must provide access to at least 90 percent of Members within the prescribed distance standard for each State Fiscal Quarter (SFQ). This 90 percent benchmark does not apply to pharmacy Providers (refer to the “Pharmacy Access” heading for applicable benchmarks).

HHSC will consider requests for exceptions to the distance standards for all provider types under limited circumstances. Each exception request must be supported by information and documentation as specified in HHSC’s exception request template, **UMCM Chapter 5.15**, “Special Exception Request Template for Variance of Mileage or Out-of-Network Utilization Standards.”

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**PCP Access:** At a minimum, the MCO must ensure that Members have access to two age-appropriate Network PCPs with an Open Panel within 30 miles of the Member's residence. For the purposes of assessing compliance with this requirement, an internist who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member under age 21, and a pediatrician is not considered an age-appropriate choice for a Member aged 21 and over.

**Dental Access:** At a minimum, the MCO must ensure that Members have access to two or more general dental Providers with an Open Practice within 30 miles of the Member's residence in urban counties and 75 miles of the Member's residence in rural counties. The MCO also must ensure that Members have access to two or more specialty Providers within 75 miles of the Member's residence. Exception: this standard can be increased to 125 miles with HHSC's approval if, despite best efforts by the MCO, it cannot contract with specialist Providers within 75 miles.

**OB/GYN Access:** At a minimum, the MCO must ensure that the following Members have access to a Network Obstetrics and Gynecology (OB/GYN) Provider within 75 miles of the Member's residence:

1. Female Members who may have experienced sexual abuse, and
2. female Members of childbearing age.

The MCO must allow female Members or their Medical Consenters to select both a PCP and an OB/GYN within its Network. The Member or their Medical Conserver may also select an OB/GYN to act as the Member's PCP. (If the OB/GYN is acting as the Member's PCP, the MCO must follow the access requirements for the PCP.) A female Member who has selected an OB/GYN, or whose Medical Conserver has selected an OB/GYN, must be allowed direct access to the OB/GYN's Healthcare Services without a referral from the Member's PCP or a PA. A pregnant Member with 12 weeks or less remaining before the expected delivery date past the 24th week of pregnancy must be allowed to remain under the Member's current OB/GYN care through the Member's post-partum checkup, even if the OB/GYN provider is, or becomes, OON.

**Outpatient BH Service Provider Access:** At a minimum, the MCO must ensure that Members have access to an outpatient BH Service Provider in the Network who has been trained and certified in the administration of the CANS assessment within 30 miles of the Member's residence for Members in a county with more than 50,000 residents, or within 75 miles of the Member's residence for Members in a county with 50,000 or fewer residents. Please see the following website for the estimated county population size:

<http://www.txcip.org/tac/census/index.php>.

Outpatient BH Service Providers must include psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; Licensed Clinical Social Workers (LCSWs); Licensed Marriage and Family Therapists (LMFTs); Licensed Professional Counselors (LPCs); Licensed Adolescent Chemical Dependency Treatment facilities; and Licensed Chemical Dependency Counselors (LCDCs) with experience treating adults and adolescents; and entities employing Qualified Mental Health Professionals for Community Services (QMHPs-CS). The MCO must also ensure that a Member has Network access to an

entity within 75 miles of the Member's residence that can provide Mental Health Rehabilitative Services through QMHP-CS. QMHPs-CS include Licensed Practitioners of the Healing Arts (LPHAs). QMHP-CS can also include Community Services Specialists (CSSP), Peer Providers, or Family Partners if acting under the supervision of an LPHA. In addition, day program Providers who address pharmacology issues must be certified as Licensed Medical Personnel.

**Other Specialist Provider Access:** At a minimum, the MCO must ensure that Members have access to a Network specialist Provider within 75 miles of the Member's residence for common medical specialties. For adult Members, common medical specialties must include general surgery, cardiology, orthopedics, urology, and ophthalmology. For child Members, common medical specialties must include orthopedics and otolaryngology. In addition, all Members or their Medical Consenters must be allowed to:

1. select an in-Network ophthalmologist or therapeutic optometrist to provide eye Healthcare Services, other than surgery, and
2. have access without a PCP referral to eye Healthcare Services from a Network specialist who is an ophthalmologist or therapeutic optometrist for non-surgical services.

**Hospital Access:** The MCO must ensure that Members have access to an Acute Care Hospital in the Provider Network within 30 miles of the Member's residence. The MCO also must ensure that Members have access by transfer to an appropriate Network or Out-of-Network facility providing the needed level of care.

**Pharmacy Access:** For purposes of this requirement only, the terms urban, suburban, and rural counties have the following meaning:

**Urban** – Counties that have been designated as metropolitan by the Office of Management and Budget (OMB), and that contain the most populated city within a metropolitan area, also known as Metropolitan Statistical Area. HHSC Strategic Decision Support (SDS) classifies these counties as Metro Central City counties. A county meets the definition of metropolitan if it has a central city, or pair of twin cities in it, with a minimum population of 50,000.

**Suburban** – Counties that have been designated as metropolitan by the OMB, and that are adjacent (share a boundary) to a Metro Central City county. The SDS classifies these counties as Metro Suburban counties.

**Rural** – Non-metropolitan counties of the state, regardless of whether they are adjacent or non-adjacent to a metropolitan county.

1. In urban counties, at least 80 percent of Members must have access to a Network pharmacy within 2 miles of the Member's residence;
2. In suburban counties, at least 75 percent of Members must have access to a Network pharmacy within 5 miles of the Member's residence;
3. In rural counties, at least 90 percent of Members must have access to a Network pharmacy within 15 miles of the Member's residence; and
4. In urban, suburban, and rural counties, at least 90 percent of Members must have access to a 24-hour pharmacy within 75 miles of the Member's residence.

Note: MCO may request exceptions to these requirements on a case-by-case basis. Mail order pharmacies, including specialty pharmacies that only mail prescriptions, will not be included when calculating these percentages. However, MCO will be required to report on the number of prescriptions filled and number of clients served through mail order/specialty pharmacies.

**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 at least 1 Network Provider for each of the remaining Covered Services described in **Attachment B-2**, “Covered Services” within 75 miles of the Member’s residence. This access requirement includes, but is not limited to, specialists, Hospitals with specialized children’s services, Children’s Hospitals and Special Hospitals, Psychiatric Hospitals, diagnostic and therapeutic services, and single or limited service healthcare Providers.

The MCO is not precluded from making arrangements with providers outside the state for Members to receive a higher level of skill or specialty than the level available within the state, including but not limited to, treatment of cancer, burns, and cardiac diseases.

### **8.1.3.3 Monitoring Access**

Section  
8.1.3.3  
modified by  
Version 2.1

The MCO is required to systematically and regularly verify that Covered Services furnished by Network Providers are available and accessible to Members in compliance with the standards described in **Sections 8.1.3**, “Access to Care,” and **8.1.4**, “Provider Network.” For Covered Services furnished by PCPs, the MCO must also comply with standards described in **Section 8.1.4.2**, “Primary Care Providers and the Medical Home.”

The MCO is required to design, develop, and implement a mandatory challenge survey to verify Provider information and monitor adherence to Provider requirements. The MCO must design the survey so that on a periodic, randomized basis, a Provider's input is required before accessing the MCO Provider portal functionalities. At a minimum, the challenge survey must include verification of the following elements:

- 1) Provider Name;
- 2) Address;
- 3) Phone Number;
- 4) Office Hours;
- 5) Days of Operation;
- 6) Practice Limitations;
- 7) Languages Spoken;
- 8) Provider Type / Provider Specialty;
- 9) Length of time a patient must wait between scheduling an appointment and receiving treatment;
- 10) Accepting new patients (PCPs only); and
- 11) Texas Health Steps Provider (PCP only).

The MCO must collect, analyze, and submit survey results as specified in UMCM Chapter 5.4.1.10, "Provider Network Examination."

The MCO must enforce access any other Network standards required by the Contract and take appropriate action with Providers whose performance is determined by the MCO to be out of compliance.

#### **8.1.3.4 Telemedicine Access**

Telemedicine is defined by the **TMPPM**. The MCO must contract with Providers with telemedicine capabilities to increase access to specialty care. The MCO must include in its hard copy and electronic provider directory information on Providers with telemedicine capabilities. **Section 8.1.17.1**, “Behavioral Health Network,” provides additional information regarding telemedicine.

The MCO will determine the exact number and locations of all telemedicine end points and the number of rural Providers who will commit to working with the MCO’s telemedicine contractors. The MCO will outreach to their telemedicine Providers to encourage the increase and availability of end points in medically underserved areas. In addition, the MCO will actively recruit additional rural providers in order to increase Member access to the services that telemedicine can provide.

##### **8.1.3.4.1 School-based Telemedicine Services**

Section  
8.1.3.4.1  
added by  
Version 2.2

As required by Texas Government Code § 531.0217, school-based telemedicine medical services are a covered service for Members. MCOs must reimburse the distant site physician providing treatment even if the physician is not the patient’s primary care physician or provider, or is an out-of-network physician. To be eligible for reimbursement, distant site physicians providing treatment must meet the service requirements outlined in Texas Government Code § 531.0217 (c-4).

MCO’s may not request prior authorization for school-based telemedicine medical services.

#### **8.1.4 Provider Network**

Section  
8.1.4  
modified by  
Versions  
2.2 and 2.3

The MCO must enter into written contracts with properly credentialed providers as described in this Section. The Provider Contracts must comply with the **UMCM’s** requirements, and include reasonable administrative and professional terms.

The MCO must maintain a Provider Network sufficient to provide all Members with access to the full range of Covered Services required under the Contract. The MCO must ensure its Providers and Subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules or regulations related to the Contract.

The MCO must implement programs and incentives that will develop the Provider Network's expertise in child welfare and Trauma Informed Care (TIC).

The Provider Network must be responsive to the linguistic, cultural, and other unique needs of any minority, or disabled individuals, or other special populations served by the MCO. This includes the capacity to communicate with Members in languages other than English, when necessary, as well as with those who are deaf or hearing impaired.

The MCO must seek to obtain the participation in its Provider Network of qualified providers currently serving the Medicaid and CHIP Members throughout the state. Medicaid MCOs

utilizing OON providers to render services to their Members must not exceed the utilization standards established in 1 Tex. Admin. Code § 353.4. HHSC may modify this requirement for Medicaid MCOs that demonstrate good cause for noncompliance, as set forth in § 353.4(e)(3).

**All Providers:** If licensure or certification is required to provide a Covered Service, then a Network Provider must be licensed or certified in Texas, except as provided in **Section 8.1.4.12**, “Out-of-State Providers.” Network Providers cannot be under sanction or exclusion from the Medicaid Program. All Acute Care Providers must be enrolled as Medicaid providers and have a Texas Provider Identification Number (TPIN). All pharmacy Providers must be enrolled with HHSC’s Vendor Drug Program (VDP). All Providers must also have a National Provider Identification Number (NPI) (see 45 C.F.R. Part 162, Subpart D).

**Inpatient Hospital and medical services:** The MCO must ensure access to Acute Care Hospitals and Specialty Hospitals in the MCO’s Network. Covered Services provided by such Hospitals must be available and accessible 24 hours per day, 7 days per week, within the MCO’s Network throughout the state. The MCO must enter into a Network Provider Contract with any willing State Hospital that meets the MCO’s credentialing requirements and agrees to the MCO’s contract rates and terms.

**Children’s Hospitals/Hospitals with specialized pediatric services:** The MCO must ensure Member access to Hospitals designated as Children’s Hospitals by Medicare and Hospitals with specialized pediatric services, such as teaching Hospitals and Hospitals with designated children’s wings. Covered Services provided by these Hospitals must be available and accessible 24 hours per day, 7 days per week. If the MCO does not have a designated Children’s Hospital or Hospital with specialized pediatric services in proximity to the Member’s residence in its Network, the MCO must enter into written arrangements for services with OON Hospitals. Provider directories including the online Provider Directory, Member Materials, and Marketing Materials must clearly distinguish between Hospitals designated as Children’s Hospitals and Hospitals that have designated children’s units.

**Trauma:** The MCO must ensure Member access to Texas Department of State Health Services (DSHS) designated Level I and Level II trauma centers within the state or Hospitals meeting the equivalent level of trauma care in the state. The MCO must make written OON reimbursement arrangements with the DSHS-designated Level I and Level II trauma centers or Hospitals meeting equivalent levels of trauma care if the MCO does not include such a trauma center in its Network. For additional information on the Emergency Medical Service (EMS) Trauma System in Texas, click on this link: <http://www.dshs.state.tx.us/emstraumasystems/default.shtm>.

**Transplant centers:** The MCO must ensure Member access to HHSC-designated transplant centers or centers meeting equivalent levels of care. A list of HHSC-designated transplant centers can be found in the **Procurement Library**. HHSC-designated transplant centers also include members of the United Network for Organ Sharing (UNOS), which can be accessed at <http://optn.transplant.hrsa.gov/members/search.asp>. If the MCO’s Network does not include a designated transplant center or center meeting equivalent levels of care in proximity to the Member’s residence, the MCO must make written arrangements with OON providers for such care.

**Hemophilia centers:** The MCO must ensure Member access to hemophilia centers supported by the Centers for Disease Control and Prevention (CDC). A list of these hemophilia centers can be found at [https://www2a.cdc.gov/ncbddd/htcweb/Dir\\_Report/Dir\\_Search.asp](https://www2a.cdc.gov/ncbddd/htcweb/Dir_Report/Dir_Search.asp). If the MCO's Network does not include CDC-supported hemophilia centers in proximity to the Member's residence, the MCO must make written arrangements with OON providers for such care.

**Outpatient BH Service Provider Access:** The MCO must ensure Member access to outpatient BH Service Providers in the Network, including psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; LCSWs; LMFTs; LPCs; Licensed Adolescent Chemical Dependency Treatment Facilities; LCDCs with experience treating adults and adolescents; and entities employing QMHPs-CS. QMHPs-CS include LPHAs. QMHPs can also include CSSPs, Peer Providers, or Family Partners if acting under the supervision of an LPHA. The Provider Network can include both Local Mental Health Authorities (LMHAs) employing QMHPs-CS as well as other entities employing QMHPs-CS. In addition, day program Providers who address pharmacology issues must be certified as Licensed Medical Personnel.

The MCO must ensure Member access to outpatient BH Service Providers who are trained and certified in the administration of the Texas Comprehensive CANS 2.0 (child welfare) assessment.

**Physician services:** The MCO must ensure that PCPs are available and accessible 24 hours per day, 7 days per week, within the Provider Network. The MCO must contract with a sufficient number of participating physicians and specialists within the state to comply with the access requirements described in **Section 8.1.3** and meet Members' needs for all Covered Services.

The MCO must ensure that an adequate number of participating physicians and specialty physicians have admitting privileges at one or more participating Acute Care Hospitals in the Provider Network to ensure that necessary admissions are made. There must always be at least one Network PCP with admitting privileges available and accessible 24 hours per day, seven days per week for each Acute Care Hospital in the Provider Network. The MCO must require that all physicians who admit to Hospitals maintain Hospital access for their patients through appropriate call coverage.

**Urgent Care Clinics:** The MCO must ensure that Urgent Care Clinics, including multi-specialty clinics serving in this capacity, are included within the Provider Network.

**Laboratory services:** The MCO must ensure that Network reference laboratory services are of sufficient size and scope to meet Members' non-emergency and emergency needs and the access requirements in **Section 8.1.3**. Reference laboratory specimen procurement services must facilitate the provision of clinical diagnostic services for physicians, Providers and Members through the use of convenient reference satellite labs, strategically located specimen collection, and the use of a courier system under the management of the reference lab. For Medicaid Members, Texas Health Steps requires Providers to use the DSHS Laboratory Services for specimens obtained, as part of a Texas Health Steps medical checkup, including Texas Health Steps newborn screens; blood lead testing; hemoglobin electrophoresis; total hemoglobin tests that are processed at the Austin Laboratory; and Pap Smear, gonorrhea, and

chlamydia screening processed at the Women’s Health Laboratories in San Antonio. Providers may submit specimens for glucose, cholesterol, High-density Lipoprotein (HDL), lipid profile, HIV, and Rapid Plasma Reagin (RPR) to the DSHS Laboratory or to a laboratory of the Provider’s choice. Hematocrit may be performed at the Provider’s clinic if the Provider needs an immediate result for anemia screening. Providers should refer to the Texas Health Steps Online Provider Training Modules referencing specimen collection on the DSHS website and the **TMPPM, Children’s Services Handbook** for the most current information and any updates.

**Pharmacy Providers:** The MCO must ensure that all pharmacy Network Providers meet all requirements under 1 Tex. Admin. Code § 353.909. Providers must not be under sanction or exclusion from the Medicaid or CHIP Programs. The MCO must enter into a Network Provider Contract with any willing pharmacy provider that meets the MCO’s credentialing requirements and agrees to the MCO’s contract rates and terms. However, the MCO may enter into selective contracts for specialty pharmacy services with one or more pharmacy provider, subject to the following conditions. These arrangements must comply with Texas Government Code § 533.005(a)(23)(G) and 1 Tex. Admin. Code § 353.905, § 354.1853, and § 370.701.

**Diagnostic imaging:** The MCO must ensure that diagnostic imaging services are available and accessible to Members in accordance with the access standards in **Section 8.1.3**. The MCO must ensure that diagnostic imaging procedures that require the injection or ingestion of radiopaque chemicals are performed only under the direction of physicians qualified to perform those procedures.

**Community-Based Service Providers:** The MCO must ensure that all Members have access to at least two Providers of each category of Community-Based Services, not including MDCP service Providers referenced in this Section. If the MCO determines it is unable to provide Member access to more than one Provider of Community-Based Services, the MCO must submit and receive an exception as described in this Section.

**MDCP:** The MCO must have a sufficient number of contracts with MDCP service Providers so that all Members who receive MDCP have access to Medically Necessary and Functionally Necessary Covered Services.

**Ambulance providers:** The MCO must enter into a Network Provider Contract with any willing ambulance provider that meets the MCO’s credentialing requirements and agrees to the MCO’s contract terms and rates.

**Durable Medical Equipment (DME) and Medical Supplies:** The MCO must ensure Members have access to DME and Medical Supplies.

**Prescribed Pediatric Extended Care Centers (PPECC):** MCOs must make reasonable effort to contract with qualified PPECCs within the service delivery area, if available.

#### **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.

Section  
8.1.4.1  
modified by  
Version 2.3

The MCO's contract with healthcare Providers must be in writing; must be in compliance with applicable federal and state laws, rules, and regulations; and must include minimum requirements specified in **Attachment A**, "STAR Health Contract Terms," and **UMCM Chapter 8.1**, "Provider Contract Checklist." 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.

As described in **Section 7**, "Transition Phase Requirements," the MCO must submit model Provider Contracts to HHSC for review during Readiness Review. The MCO must resubmit the model Provider Contracts any time it makes substantive modifications to such agreements. HHSC retains the right to reject or require changes to any Provider Contract that does not comply with MCO Program requirements or the STAR Health Contract.

#### **8.1.4.2 Primary Care Providers and the Medical Home**

The MCO must provide Medical Home services for Members through PCPs or Specialty Care Providers.

The MCO must promote, monitor, document, and make best efforts to ensure that PCPs and Specialty Care Providers comply with the use of the Medical Home Services Model, which is an approach to providing comprehensive primary care and is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

The MCO must also promote the development of Integrated Primary Care (IPC) at the Member's Medical Home. IPC involves the integration of BH Services into primary care during the regular provision of primary care services where appropriate. IPC occurs at the same time and by the same Provider ideally, or by the BH Provider seeing the Member in tandem with the PCP. The MCO must regularly measure Member BH improvement using psychometrically-sound instruments. The IPC is a model distinct from co-location of services, which is considered to be parallel care rather than integrated care. IPC is also distinct from sequential care, which denotes BH care that occurs either before or after the primary care and at the same or a different location. Information on IPC, integrated physical and BH care, and other useful resources and tools can be found online at [www.integratedprimarycare.com](http://www.integratedprimarycare.com).

As a Medical Home, the PCP works with Members, Medical Consenters, Caregivers, Providers, Service Coordinators, Service Managers and other state and non-state entities to assure that all the Member's medical and BH needs are met. This includes screening, identification, and referral to Medically Necessary services, and assessment and coordination of non-clinical services that impact the Member's health.

The MCO's PCP Network may include Providers from any of the following practice areas: General Practice; Family Practice; Internal Medicine; Pediatrics; OB/GYN; Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) (when APRNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or OB/GYN who also qualifies as a PCP under this contract); Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and similar community clinics;

and specialist physicians who are willing to provide a Medical Home to selected Members with special needs and conditions. Texas Government Code § 533.005(a)(13) and Texas Health & Safety Code § 62.1551 require the MCO to use APRNs and PAs practicing under the supervision of a Network physician. The MCO must treat APRNs and PAs in the same manner as other Network PCPs with regard to:

1. selection and assignment as PCPs,
2. inclusion as PCPs in the MCO's Provider Network, and
3. inclusion as a PCP in any Provider directory maintained by the MCO.

An internist or other Provider who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member birth through age 20. An internist or other Provider who provides primary care to adults and children may be a PCP for children if:

1. the Provider assumes all MCO PCP responsibilities for such child Members in a specific age range from birth through age 20;
2. the Provider has a history of practicing as a PCP for the specified age range, as evidenced by the Provider's primary care practice including an established patient population within the specified age range; and
3. the Provider has admitting privileges to a local Hospital that includes admissions to pediatric units.

A pediatrician is not considered an age-appropriate choice for a Member aged 21 and over.

For Members with Special Healthcare Needs (MSHCN) that require services from specialists or BH Providers, the PCP may choose to use an interdisciplinary team approach to managing the Member's care. The PCP and other Providers that agree to function as an interdisciplinary team would constitute a PCP Team. If requested by the PCP Team, the MCO must assign a Service Coordinator or Service Manager to assist the PCP Team. The PCP Team must include the Medical Consenter, and, if appropriate, a young adult Member. If requested by the Member's Medical Consenter, the Member's Caregiver may be included in the PCP Team. The PCP Team may also include a Member's DFPS caseworker and MCO Service Coordinator or MCO Service Manager. The PCP Team must:

1. develop specialty care and support service recommendations to be incorporated into the Member's Healthcare Service Plan (HCSP), including evaluation and coordination of prescriptions ordered by the PCP Team and other Providers;
2. participate in Hospital discharge planning;
3. participate in pre-admission Hospital planning for non-emergency hospitalizations; and
4. provide information to the Medical Consenter, Caregiver, DFPS caseworker, and, if applicable, the young adult Member concerning the specialty care recommendations.

The PCP for an MSHCN, or for a Member with Disabilities, special healthcare needs, or Chronic (or Complex) Conditions, may be a specialist physician who agrees to provide PCP services to the Member. The specialist physician must agree to perform all PCP duties required in the Contract and such PCP duties must be within the scope of the specialist's license. The Medical Consenter, Caregiver, or Member may initiate the request through the MCO for a specialist to serve as a PCP for MSHCN or a Member with Disabilities, special healthcare needs, or Chronic (or Complex) Conditions. The MCO shall process such requests in accordance with 28 Tex. Admin. Code Chapter 11, Subchapter J. Specialists may limit the number of Members for which they will serve as a PCP.

PCPs must either have admitting privileges at a Hospital that is part of the MCO's Provider Network or make referral arrangements with a Provider who has admitting privileges to a Network Hospital. The MCO may cover this requirement through the use of hospital lists.

The MCO must require, through contract provisions, that PCPs are accessible to Members 24 hours a day, seven days a week. The MCO is encouraged to enter into Network Provider Contracts with sites that offer primary care services during evening and weekend hours. The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours.

Acceptable after-hours coverage:

1. The PCP's office telephone is answered after-hours by an answering service that meets language requirements of the Major Population Groups and can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
2. The PCP's office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the patient to call another number to reach the PCP or another Provider designated by the PCP. Someone must be available to answer the designated Provider's telephone. Another recording is not acceptable.
3. The PCP's office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable after-hours coverage:

1. The PCP's office telephone is only answered during office hours.
2. The PCP's office telephone is answered after-hours by a recording that tells patients to leave a message.
3. The PCP's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed.
4. Returning after-hours calls outside of 30 minutes.

The MCO must contractually require PCPs:

1. to either be enrolled as Texas Health Steps providers or refer Members due for a Texas Health Steps checkup to a Texas Health Steps provider;
2. to provide Members with preventive services in accordance with the Texas Health Steps periodicity schedule published in the **TMPPM, Children's Services Handbook** and **Section 8.1.28.3**, "Texas Health Steps (EPSDT) Medical and Dental;" and
3. to refer for follow-up assessments or interventions clinically indicated as a result of the Texas Health Steps checkup, including the developmental and behavioral components of the screening.

Specialists who serve as PCPs are encouraged, but not required, to be Texas Health Steps providers. The MCO must contractually require PCPs to submit information from Texas Health Steps forms and documents to the Health Passport. The MCO must also contractually require PCPs to provide Members with preventive services in accordance with the U.S. Preventive Services Task Force requirements. The MCO must make best efforts to ensure that PCPs

comply with these periodicity requirements for children and young adult Members. Best efforts must include, but not be limited to, Provider education, Provider reviews, monitoring, and feedback activities.

The MCO must contractually require PCPs to assess the medical and BH needs of Members for referral to specialty care Providers and provide referrals as needed. Members, Caregivers or Medical Consenters can access BH treatment without prior approval from the PCP. PCPs must coordinate Members' care with specialty care Providers after referral. The MCO must make best efforts to ensure that PCPs are capable of appropriately assessing Member needs for referrals and make such referrals. Best efforts must include, but not be limited to, Provider education activities centered around TIC and child welfare and review of Provider referral patterns.

#### **8.1.4.3 PCP Notification**

The MCO must furnish each PCP with a current list of Members enrolled or assigned to that PCP no later than five Business Days after the MCO receives the monthly Enrollment File. The MCO may offer and provide such enrollment information in alternative formats, such as through access to a secure internet site, when such format is acceptable to the PCP.

#### **8.1.4.4 Provider Credentialing and Re-credentialing**

At least once every three years, the MCO must review and approve the credentials of all participating licensed and unlicensed Providers who participate in the MCO's Provider Network.

The MCO may subcontract with another entity to which it delegates credentialing activities if the delegated credentialing is maintained in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and any comparable requirements defined by HHSC.

At a minimum, the scope and structure of the MCO's credentialing and re-credentialing processes must be consistent with recognized MCO industry standards and relevant state and federal regulations including 28 Tex. Admin. Code §§ 11.1902 and 11.1402(c), relating to provider credentialing and notice. Medicaid MCOs must also comply with 42 C.F.R. § 438.12 and 42 C.F.R. § 438.214(b). The MCO must complete the initial credentialing process, and its claim systems must be able to recognize the provider as a Network Provider, no later than 30 calendar days after receiving a complete application requiring expedited credentialing, and no later than 90 calendar days after receiving all other complete applications. If an application does not include required information, the MCO must provide the provider written notice of all missing information no later than five Business Days after receipt. For new Providers, the MCO must complete the credentialing process prior to the effective date of the Network Provider Contract. The re-credentialing process must take into consideration Provider performance data including Member Complaints and Appeals, quality of care, and utilization management.

Outpatient BH therapy Providers, including LCSWs, LMFTs, LPCs, LCDCs, and some Psychologists, completing the credentialing and re-credentialing processes must submit to a DFPS Background History Check. DFPS will conduct the Background History Check and provide the findings to the MCO. A finding of physical or sexual abuse of a child or adult will result in an automatic bar from participation as a STAR Health Network Provider. For all other

Section  
8.1.4.4  
modified by  
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2.1 and 2.3

finding types, the MCO will collaborate with DFPS to review the findings and decide whether participation in the Network will be allowed. The MCO must consider the following prior to issuing a decision to include or bar a provider from the STAR Health Network:

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

The credentialing profile sheet that is completed by a primary care, specialty care, BH care, or dental Provider's office during the credentialing and re-credentialing process must include foster care specific questions that address to the Provider's experience with conditions that are prevalent in the foster care population, such as the treatment of physical or sexual abuse, developmental disabilities, and Post-traumatic Stress Disorder (PTSD), as well as experience with evidenced-based practices (EBPs) or promising practices that utilize a trauma informed approach. The credentialing profile sheet that is completed by a BH Provider must also track training and certifications in EBPs and promising practices such as Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Parent Child Interaction Therapy (PCIT), Trust-Based Relational Intervention (TBRI), and Child Parent Psychotherapy (CPP).

The MCO must also identify a process to track BH Providers becoming certified to administer the Texas Comprehensive CANS 2.0 (child welfare) assessment tool. BH Providers must recertify annually to continue administering the assessment. The MCO must ensure that Providers performing this assessment have not allowed their certification to lapse.

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

#### **8.1.4.4.1 Expedited Credentialing Process**

The MCO must comply with the requirements of Texas Insurance Code Chapter 1452, Subchapters C, D, and E, regarding expedited credentialing and payment of physicians, podiatrists, and therapeutic optometrists who have joined established medical groups or professional practices that are already contracted with the MCO.

The MCO must also establish and implement an expedited credentialing process, as required by Texas Government Code § 533.0064, that allows applicant providers to provide services to Members on a provisional basis for the following provider types: 1) dentists and 2) dental specialists (including dentists and physicians providing dental specialty care). To qualify for expedited credentialing the provider must: (1) be a member of an established health care provider group that has a current contract in place with an MCO, (2) be a Medicaid enrolled provider, (3) agree to comply with the terms of the contract between the MCO and the health

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

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

#### **8.1.4.4.2 Minimum Credentialing Requirements for Unlicensed or Uncertified LTSS Providers**

Section  
8.1.4.4.2  
modified by  
Version 2.3

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

1. has not been convicted of a crime listed in Texas Health and Safety Code § 250.006;
2. is not listed as "unemployable" in the Employee Misconduct Registry or the Nurse Aide Registry maintained by DADS by searching or ensuring a search of such registries is conducted, before hire and annually thereafter;
3. is not listed on the following websites as excluded from participation in any federal or state health care program:
  - [HHS-OIG Exclusion](#); and
  - [HHSC-OIG Exclusion Search](#);by searching or ensuring a search of such registries is conducted, before hire and at least monthly thereafter;
4. is knowledgeable of acts that constitute Abuse, Neglect, or Exploitation of a Member;
5. is instructed on and understands how to report suspected Abuse, Neglect, or Exploitation;
6. adheres to applicable state laws if providing transportation; and
7. is not a spouse of, Caregiver or Medical Consenter for, or employment supervisor of the Member who receives the service, except as allowed in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver.

#### **8.1.4.5 Board Certification Status**

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

#### **8.1.4.6 Provider Relations Including Manual, Materials and Training**

Section  
8.1.4.6  
modified by  
Versions  
2.1, 2.2,  
and 2.3

The MCO must maintain a Provider manual, including any necessary specialty manuals (e.g., BH) for all existing Network Providers. The MCO must notify newly contracted Providers about the Provider manual and how to access it within five business days from inclusion of the Provider into the Network. The Provider manual must contain the critical elements defined in

UMCM Chapter 3, "Critical Elements," including the special requirements of the STAR Health Program and Members.

The MCO must collaborate with HHSC and DFPS and receive HHSC's approval on any substantive changes to the Provider Manual and training materials prior to their publication and use.

The MCO must submit, for HHSC's review, all other Provider Materials relating to Medicaid prior to publication or distribution. If HHSC has not responded to MCO's request for review within 15 Business Days, the MCO may use the submitted materials provided the MCO first notifies HHSC of its intended use. HHSC reserves the right to require discontinuation or correction of any Provider Materials, including those previously approved by HHSC. Provider Materials include the MCO's Provider manual, training materials regarding MCO Program requirements, and mass communications directed to all or a large group of Network Providers (e-mail or fax "blasts"). Provider Materials do not include written correspondence between the MCO or its Administrative Services Subcontractors and a Provider regarding individual business matters.

The MCO will seek to partner with groups that provide direct services to the foster care population, or represent direct service providers in order to deliver effective training programs to Providers. The MCO will collaborate with DFPS, Single Source Continuum Contractors (SSCCs), the Court, and other child welfare stakeholders to provide Providers with additional insight into the STAR Health Program.

The MCO will hire a minimum of two internal trainers who have experience in healthcare and in BH for the STAR Health population. The MCO will provide training on an ongoing basis through web-based sessions and regional outreach. The MCO will design its training program to ensure that participating Providers understand the unique needs of the STAR Health population, including the sensitivities associated with the foster care population and expectations surrounding care and coordination for this population.

The MCO must provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The MCO's training must be completed within 30 days of placing a newly contracted Provider on active status. The MCO must provide ongoing training to new and existing Providers as required by the MCO or HHSC to comply with the Contract. The MCO must maintain and make available upon request enrollment or attendance rosters dated and signed by each attendee or other written evidence of training of each Provider and their staff.

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

1. Covered Services and the Provider's responsibilities for providing or coordinating those services;
  - a. with special emphasis placed on areas that vary from commercial coverage rules (e.g., ECI, therapies and DME/Medical Supplies, referrals and coordination with Non-capitated Services);
  - b. pharmacy services and processes, including information regarding outpatient drug benefits, HHSC's drug formulary, preferred drugs, PA processes, and 72-hour emergency supplies of prescription drugs;

- c. the availability of Mental Health Rehabilitative Services and Mental Health Targeted Case Management for qualified Members;
  - d. required referrals for SED, mental illness, or chemical dependency, and for Members 3 years of age and older suspected of having a developmental delay or developmental disability;
  - e. the availability of Community First Choice (CFC) services for qualified members;
  - f. billing for services for hospice recipients; and
  - g. effective November 1, 2016, billing for services for Dual Eligible members;
2. Medical Home Services Model and the IPC Model (see [www.integratedprimarycare.com](http://www.integratedprimarycare.com));
3. relevant requirements of the Contract, including the Health Passport;
4. Cultural Competency Training, based on National Standards for Culturally and Linguistically Appropriate Services (CLAS), including the need for Providers and their staff to address Medical Consenters, Caregivers, DFPS Staff and Members with dignity, sensitivity and respect;
5. availability of Service Management, Service Coordination, and DM;
6. the MCO's QAPI program and the Provider's role in the program;
7. the MCO's policies and procedures, especially regarding Network and Out-of-Network referrals;
8. Texas Health Steps benefits, periodicity, forms, required components of a checkup, the importance of documenting all required components of the checkup in the medical record, and the necessity of documentation to support a complete checkup qualifying for reimbursement is provided;
9. Population-specific issues related to the STAR Health Population, including:
  - a. Health Passport, as defined in **Section 8.1.12**, "Health Passport;"
  - b. coordinating care with:
    - i. Medical Consenters;
    - ii. Guardians ad litem;
    - iii. Case workers;
    - iv. Attorneys ad litem;
    - v. Judges;
    - vi. Law enforcement officials;
    - vii. SSCC staff; and
    - viii. other involved parties from DFPS and other state agencies;
  - c. requirements for providing Healthcare Services to the STAR Health Population, including:
    - i. medical consent and informed consent requirements as defined in Texas Family Code and DFPS policies (see **Procurement Library**);
    - ii. required timelines for scheduling physical and BH Services appointments as defined in DFPS policies;
    - iii. specific medical information required for judicial review of medical care under Texas Family Code § 266.007;
    - iv. provision of medical records to DFPS staff; and
    - v. compliance with the *Psychotropic Medication Utilization Parameters for Foster Children* found at [http://www.dfps.state.tx.us/documents/Child\\_Protection/pdf/TxFosterCareParameters-September2013.pdf](http://www.dfps.state.tx.us/documents/Child_Protection/pdf/TxFosterCareParameters-September2013.pdf);
  - d. Evidence-based practices (EBPs) and promising practices, including

- i. or Behavioral Health Providers, TF-CBT , PCIT, TBRI and CPP;
    - ii. for all other Providers, TIC, PTSD and Attention-Deficit/Hyperactivity Disorder (ADHD);
  - e. specific behavioral and physical health needs of the STAR Health Population;
  - f. requirements for screenings and assessments, such as:
    - i. the administration of the Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 days of entering conservatorship to each Member in category 1 of the Target Population ages 3 and older;
    - ii. the provision of or referral for all physical and BH services indicated by the results and recommendations of the Texas Comprehensive CANS 2.0 (child welfare) assessment; and
  - g. recognition of Abuse, Neglect, and Exploitation and the mandatory reporting requirements under the Texas Family Code.
- 10. specific training related to Utilization Management (UM) reviews, fraud, and abuse, including oversight activities such as pre-payment reviews, audits, and monitoring;
- 11. the MCO's policy and procedures for a PA;
- 12. Non-Emergency Medical Transportation (NEMT) Program services available to Medicaid members such as rides to services by bus, taxi, van, airfare; gas money; mileage reimbursement; and meals and lodging when away from home;
- 13. the importance of updating contact information to ensure accurate Provider directories and the Medicaid Online Provider Lookup;
- 14. missed appointment referrals and assistance provided by the Texas Health Steps Outreach and Informing Unit;
- 15. administrative issues such as detailed claims filing and how to receive assistance with claims;
- 16. services available to Members; and
- 17. Providers' obligation to identify and report a Critical Event or Incident such as Abuse, Neglect, or Exploitation to the State related to LTSS delivered in the STAR Health Program.

Training in all the topics above must be offered and made available within a reasonable time after the date the Provider begins providing services, and according to the implementation plan required by **Section 8.1.4**, "Provider Network."

The MCO must make available to Network Providers a variety of web-based training modules. Such trainings will include those suggested by HHSC and DFPS, such as the effect of Abuse, Neglect, and Exploitation on the developing brain, the effect of intrauterine assault, fetal alcohol syndrome, and shaken baby syndrome. The MCO will consult with experts in the field, including its foster care Medical Advisory Committee (MAC), to determine which additional topics may be relevant to Providers in providing services to the STAR Health Population.

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

#### **8.1.4.7 Continuing Education Credits**

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

#### **8.1.4.8 Provider Hotline**

The MCO must operate a toll-free telephone line for Provider inquiries from 8 a.m. to 5 p.m. local time for all areas of the state, Monday through Friday, except for state-approved holidays. . The State-approved holiday schedule is updated annually and can be found at <http://sao.hr.state.tx.us/compensation/holidays.html>. The Provider Hotline must be staffed with personnel who are knowledgeable about Covered Services, Non-capitated Services, and Value-added Services as applicable. The content of Provider Hotline staff training related to Texas Health Steps (EPSDT) is subject to HHSC approval.

The MCO must ensure that after regular business hours the line is answered by an automated system with the capability to provide callers with operating hours' information and instructions on how to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition. The MCO must have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition, provided, however, that the MCO and its Providers must not require verification prior to providing Emergency Services. Refer to **Section 8.1.5.6**, "Nurse and Member Hotline Requirements," for information regarding Provider access to the 24-hour Nurse Hotline.

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

1. Ninety-nine percent of calls are answered by the fourth ring or an automated call pick-up system is used;
2. no more than one percent of incoming calls receive a busy signal;
3. the average hold time is two minutes or less; and
4. the call abandonment rate is seven percent or less.

The MCO must conduct ongoing call quality assurance to ensure these standards are met. The MCO must monitor its performance regarding Provider Hotline standards and submit performance reports summarizing call center performance for the Hotline as indicated in **Section 8.1.26.2**, "Reports." If the MCO subcontracts with a Behavioral Health Organization (BHO) that is responsible for Provider Hotline functions related to BH Services, the BHO's Provider Hotline must meet the requirements in **Section 8.1.17.3**, "Behavioral Health Hotline and Emergency Services," and the MCO must provide performance reports regarding its performance.

If HHSC determines that it is necessary to conduct onsite monitoring of the MCO's Provider Hotline functions, the MCO is responsible for all reasonable travel costs incurred by HHSC or its authorized agent(s) relating to such monitoring. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring.

#### **8.1.4.8.1 Safety-net Hospital Incentives**

Section  
8.1.4.8.1  
added by  
Version 2.3

On an annual basis, HHSC shall provide a list to MCOs that identifies the safety-net hospitals that are awarded incentive payments specified in H.B. 1, 84th Legislature, Regular Session, 2015, Article II, Special Provisions Sec. 59(b). This list will consist of hospitals that are recipients of incentives funds, based on exemplary performance on Potentially Preventable Complications and Potentially Preventable Readmissions. The program and methodology for determining awards for hospitals is developed by HHSC. The list provided by HHSC will contain the hospital NPI, hospital name, and amount of incentive payments awarded to each hospital based on PPC and PPR performance. HHSC shall build in costs for these incentives into the MCO capitation payments. Consistent with HHSC direction, MCOs shall pay the amount identified by HHSC to the eligible hospitals identified by HHSC.

#### **8.1.4.9 Provider Reimbursement**

Section  
8.1.4.9  
modified by  
Version 2.3

The MCO must pay for all Medically Necessary Covered Services provided to Members. The MCO must also pay for all Functionally Necessary Covered Services provided to Members. The MCO's Network Provider Contract must include a complete description of the payment methodology or amount, as described in **UMCM Chapter 8.1**, "Provider Contract Checklist."

The MCO must pay OON providers using the Medicaid methodology as defined by HHSC in 1 Tex. Admin. Code § 353.4, and ensure claims payment is timely and accurate as described in **Section 8.1.24.5** "Claims Processing Requirements," and **UMCM Chapters 2.0**, "Claims Manual," and **2.2**, "Pharmacy Claims Manual." The MCO must require tax identification numbers (TINs) from all participating Providers. The Provider may use the federal TIN of the residential treatment center (RTC) where he or she is an employee and provides services. The MCO is required to do back-up withholding from all payments to Providers who fail to give TINs or who give incorrect numbers.

Provider payments must comply with all applicable state and federal laws, rules, and regulations, including the following sections of the Patient Protection and Affordable Care Act (PPACA) and, upon implementation, corresponding federal regulations:

1. Section 2702 of PPACA, entitled "Payment Adjustment for Healthcare Acquired Conditions;"
2. Section 6505 of PPACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United States;" and
3. Section 1202 of the Healthcare and Education Reconciliation Act as amended by PPACA, entitled "Payments to Primary Care Physicians."

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

As required by Texas Government Code § 533.005(a)(25), the MCO cannot implement significant, non-negotiated, across-the-board Provider reimbursement rate reductions unless it receives HHSC’s prior approval, or 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. The MCO must submit a written request for an across-the-board rate reduction to HHSC’s Director of Program Operations and provide a copy to the 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 no later than 60 days after the Medicaid fee schedule change, and any retroactive claim adjustments must be completed within 60 days after HHSC retroactively adjusts the Medicaid fee schedule.

#### **8.1.4.9.1 Provider Preventable Conditions**

MCO must identify Present on Admission (POA) indicators as required in the **UMCM Chapter 2**, “Claims Manual,” and must reduce or deny payments for Provider Preventable Conditions that were not POA. This includes any hospital-acquired conditions or healthcare acquired conditions identified in the Texas Medicaid Provider Procedures Manual.

#### **8.1.4.9.2 Supplemental Payments for Qualified Providers**

In accordance with PPACA as amended by Section 1202 of the Healthcare and Education Reconciliation Act and corresponding federal regulations at 42 C.F.R §§ 438.6 and 438.804, the MCO will make supplemental payments to qualified Medicaid providers for dates of service beginning on January 1, 2013, and ending on December 31, 2014. The **UMCM Chapter 13.1**, “Supplemental Payments for Qualified Providers,” will identify the types of providers and services that qualify for the supplemental payments.

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

The MCO will pay claims from qualified Network Providers at the MCO's contracted rates, and OON providers in accordance with [1 Tex. Admin. Code § 353.4](#). The MCO's encounter data should reflect the actual amount paid to providers, and should not be adjusted to include supplemental payment amounts.

As described in **Attachment A, Section 10.15**, "Pass-through Payments for Provider Rate Increases," the MCO must pay the full amount of supplemental payments to qualified Providers no later than 30 calendar days after receipt of HHSC's supplemental payment report, contingent upon MCO's receipt of payment of the allocation. The MCO must submit a report and certification, in the form and manner identified in **UMCM Chapter 13.1**, to validate that payments have been made to qualified Providers in accordance with HHSC's calculations. In addition, the MCO must provide reports, in the manner and frequency prescribed in the **UMCM**, documenting all claims adjustments that alter the supplemental payment amounts, including documentation of recoupments of overpaid amounts. The MCO must collect and refund all overpayments of supplemental payments to HHSC in the format and manner prescribed in the **UMCM**. In cases where a third party is responsible for all or part of a Covered Service and the MCO recovers only part of the amount paid by the MCO, then the amount recovered must be applied first to the supplemental payment and returned to HHSC. If the amount recovered is less than the supplemental payment, then the MCO will return the full amount of the recovery to HHSC.

#### **8.1.4.10 Termination of Provider Contracts**

Section  
8.1.4.10  
modified by  
Versions  
2.1 and 2.3

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 the Provider Termination Report under UMCM Chapter 5.4.1, "Provider Network Reports."

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 (terminations initiated by the MCO), the MCO must provide notice within 15 days after the effective date of termination unless state or federal law, including Texas Insurance Code § 843.308, permits or requires notice to be provided under a different timeframe.
2. For voluntary terminations (terminations initiated by the Provider), the MCO must provide notice at least 30 days before the effective date of the termination. In the event that the Provider sends untimely notice of termination to the MCO making it impossible for the MCO to send Member notice within the required timeframe, the MCO must provide notice as soon as practical but no more than 30 days after the MCO was notified.

The MCO must send notice to: (1) all its Members in a PCP's panel; and (2) all its Members who have had two or more visits with the Network Provider for home-based or office-based care in the past 12 months.

#### **8.1.4.11 This Section Intentionally Left Blank**

#### **8.1.4.12 Out-of-State Providers**

To participate in Medicaid, the provider must be enrolled with HHSC as a Medicaid provider. The MCO may enroll out-of-state providers in its Medicaid Network in accordance with 1 Tex. Admin. Code § 352.17 and pharmacy Network Providers in accordance with 1 Tex. Admin. Code § 353.909.

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

#### **8.1.4.13 Provider Protection Plan**

The MCO must comply with HHSC's provider protection plan requirements for reducing the administrative burdens placed on Network Providers, and ensuring efficiency in Network enrollment and reimbursement. At a minimum, the plan must comply with the requirements of Texas Government Code § 533.0055, and:

1. provide for timely and accurate claims adjudication and proper claims payment in accordance with **UMCM Chapters 2.0**, "Claims Manual," and **2.2**, "Pharmacy Claims Manual;"
2. include Network Provider training and education on the requirements for claims submission and appeals, including the MCO's policies and procedures and see also **Section 8.1.4.6**, "Provider Relations Including Manual, Materials, and Training;"
3. ensure Member access to care, in accordance with **Section 8.1.3**, "Access to Care," and the **UMCM's** Geo-Mapping requirements (see **UMCM Chapters 5.14.4**, "STAR Health Geo-Mapping Report," and **5.14.5**, "STAR Health and Medicaid Dental Geo-Mapping Report.");
4. ensure prompt credentialing, as required by **Section 8.1.4.4**, "Provider Credentialing and Re-credentialing;"
5. ensure compliance with state and federal standards regarding PA, as described in **Sections 8.1.8**, "Utilization Management," and **8.1.20.2**, "Prior Authorization (PA) for Prescription Drugs and 72-Hour Emergency Supplies;"
6. provide 30 days' notice to Providers before implementing changes to policies and procedures affecting the PA process. However, in the case of suspected fraud, waste, or abuse by a single Provider, the MCO may implement changes to policies and procedures affecting the PA process without the required notice period;
7. include other measures developed by HHSC or a provider protection plan workgroup, or measures developed by the MCO and approved by HHSC; and
8. participate in HHSC's work group, which will develop recommendations and proposed timelines for other components of the provider protection plan.

#### **8.1.5 Member Services**

The MCO must maintain a Member Services Department to assist Members in obtaining Covered Services. The MCO must maintain employment standards and requirements (e.g.,

education, training, and experience) for Member Services Department staff and provide a sufficient number of staff for the Member Services Department to meet the requirements of this Section, including Member Hotline response times, and Linguistic Access capabilities (Refer to **Section 8.1.5.6**, “Nurse and Member Hotline Requirements”).

#### **8.1.5.1 Member Materials**

Section  
8.1.5.1  
modified by  
Version 2.3

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

For all Members in DFPS conservatorship and Members with voluntary agreements (categories 1 and 2 in the definition of “Target Population,”) no later than the fifth Business Day following the receipt of the Daily Eligibility File, the MCO must mail a Member’s ID card and enrollment packet (welcome letter, Provider directory, Member handbook, and informational and training materials on how to access the Health Passport) to the Caregiver for each new Member. When a Caregiver represents two or more new Members, the MCO is required to send only one enrollment packet to the Caregiver. Thereafter, a new enrollment packet should not be mailed to the Caregiver’s address for a new Member more frequently than every three months. Each time a Member moves to a new placement, the MCO must send a new Member ID card and welcome letter to the new Caregiver’s address.

For all Members in category 3 in the definition of “Target Population,”) no later than the fifth Business Day following receipt of the Daily Eligibility File, the MCO must mail a Member’s ID card and enrollment packet (welcome letter, Provider directory, Member handbook, and informational and training materials on how to access the Health Passport) to the new Member, as appropriate.

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

The DNF is a file used to provide notification on a daily basis to the MCO concerning each client that is taken into DFPS conservatorship and Members with voluntary agreements (i.e., Members included in category 1 and 2 of the “Target Population” definition). The MCO should begin providing STAR Health services to the Member upon receipt of the DNF. The DNF is not an official eligibility file, and does not contain information concerning Members included in category 3 of the “Target Population” definition.

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

The MCO welcome letter must provide Members with information regarding the Program and how to locate more detailed information in their Member handbooks. The welcome letter must

provide the name of the PCP the MCO has auto-assigned to the Member and provide information regarding how Members may:

1. access their PCP;
2. change their PCP;
3. seek help scheduling Texas Health Steps appointments;
4. access the Member and Nurse Hotlines, including Hotline numbers;
5. provide information to the MCO regarding the Member's special healthcare needs and specific services the MCO may need to coordinate; and
6. access Service Management and Service Coordination services.

Member Materials must be at or below a 6th grade reading level, as measured by the appropriate score on the Simple Measure of Gobbledygook (SMOG) test. Member Materials must be written and distributed in English, Spanish, and the languages of other Major Population Groups making up 10 percent or more of the managed care eligible population, as specified by HHSC. HHSC will provide the MCO with reasonable notice when the population reaches the 10 percent threshold. All Member Materials must be available in a format accessible to the visually impaired, which may include large print, Braille, and CD or other electronic format. Member Materials must comply with the requirements set forth in **UMCM Chapter 1.1**, "Materials Submitted for HHSC Review," **Chapter 3**, "Critical Elements," and **Chapter 4**, "Uniform Managed Care Marketing Policy and Procedures."

The MCO must submit Member Materials to HHSC for approval prior publication or distribution, including revisions to previously approved Member Materials. If HHSC has not responded to a request for review within 15 Business Days, the MCO may use the submitted materials provided the MCO first notifies HHSC of its intended use. HHSC reserves the right to require discontinuation, revision, or correction of any Member Materials, including those previously approved by HHSC.

The MCO's Member Materials and other communications cannot contain discretionary clauses, as described in Section 1271.057(b) of the Texas Insurance Code.

#### **8.1.5.2 Member Identification (ID) Card**

All Member ID cards must, at a minimum, include the following information:

1. The Member's name;
2. the Member's Medicaid number, if known (for categories 1–3 of the "Target Population" definition);
3. the effective date of the PCP assignment;
4. the PCP's name and telephone number;
5. the name of the MCO;
6. the 24-hour, seven-day a week toll-free Member services telephone number and BH Hotline number; and
7. any other critical elements identified in **UMCM Chapter 3.16**, "STAR Health Member ID."

The MCO must reissue the Member ID card if a Member, DFPS Staff, Caregiver or Medical Consenter reports a lost card; there is a Member name change; if the Member, their Medical

Consenter, or DFPS Staff requests a new PCP; the Member moves to a new placement; or for any other reason that results in a change to the information disclosed on the Member ID card.

### **8.1.5.3 Member Handbook**

HHSC must approve the Member handbook, and any substantive revisions, prior to publication and distribution. As described in **Section 7**, “Transition Phase Requirements,” the MCO must develop and submit to HHSC the draft Member handbook for approval during the Readiness Review and must submit a final Member handbook, incorporating changes required by HHSC, prior to the Operational Start Date.

The Member handbook must, at a minimum, meet the Member Materials requirements specified by **Section 8.1.5.1** above and must include critical elements in the **UMCM Chapter 3.15**, “STAR Health Member Handbook,” including the Member Pre-Appeals, Member Complaints and Member Appeals processes.

The MCO must produce and distribute a revised Member handbook, or an insert, informing Members and their Caregivers of changes to Covered Services, upon HHSC notification and at least 30 days prior to the effective date of such change in Covered Services. In addition to modifying the Member Materials for new Members, the MCO must notify the Members and the Caregivers of all existing Members of the Covered Services change during the timeframe specified in this subsection.

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

### **8.1.5.4 Provider Directory**

Section  
8.1.5.4  
modified by  
Version 2.3

The Provider Directory for each MCO Program, including substantive revisions, must be approved by HHSC before publication and distribution. Substantive revisions are revisions to the information required by UMCM Chapter 3 (with the exception of information contained in actual the Provider listings and indices) and any additional information that the MCO adds to the directory at its discretion.

As described in **Section 7**, “Transition Phase Requirements,” during the Readiness Review, the MCO must develop and submit to HHSC the draft Provider directory template for approval and must submit a final Provider directory, incorporating changes required by HHSC, prior to the Operational Start Date. Draft and final Provider directories must be submitted according to the deadlines established in **Section 7**.

The Provider Directory must comply with HHSC’s marketing policies and procedures, as set forth in the UMCM Chapter 4, “Marketing Policies and Procedures.”

The Provider directory must, at a minimum, meet the Member Materials requirements specified by **Section 8.1.5.1** above and must include critical elements in the **UMCM Chapter 3.14**, “STAR

Health Provider Directory.” The Provider directory must include only Network Providers credentialed by the MCO in accordance with **Section 8.1.4.4**, “Provider Credentialing and Recredentialing.” If the MCO contracts with limited Provider Networks, the Provider directory must comply with the requirements of 28 Tex. Admin. Code § 11.1600(b)(11), relating to the disclosure and notice of limited Provider Networks.

#### **8.1.5.4.1 Hard Copy Provider Directory**

Section  
8.1.5.4.1  
added by  
Version 2.3

The hard copy Provider Directory must contain the requirements of UMCM Chapter 3.1 MMC Provider Directory Critical Elements and UMCM Chapter 3.2 CHIP Provider Directory Critical Elements as applicable.

The MCO must update the Provider directory on a quarterly basis. The MCO must make the updates available to existing Members, Caregivers, DFPS staff, and Medical Consenters upon request. The MCO must, at least annually, include written and verbal offers of the Provider directory in its Member outreach and education materials.

The MCO is responsible for all Provider directory mailings.

Section  
8.1.5.4.2  
added by  
Version 2.3

#### **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 procedures for systematically updating the Provider Network database which must include predictable scheduled algorithms. The MCO Online Provider Directory must be updated on a weekly basis to reflect the most current MCO Provider Network.

The online Provider Directory must contain the requirements of UMCM Chapter 3.34 MMC/CHIP Online Provider Directory Critical Elements.

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 include the functionality as required by the UMCM 3.34 MMC/CHIP Online Provider Directory Critical Elements.

#### **8.1.5.5 Internet Website**

Section  
8.1.5.5  
modified by  
Versions  
2.2 and 2.3

The MCO must develop and maintain, consistent with HHSC standards and Texas Insurance Code § 843.2015 and other applicable state laws, a website to provide general information about the MCO, its Provider Network (including an online Provider Directory as outlined in UMCM Chapter 3.34, "Online Provider Directory Search Tool Required Critical Elements"), its customer services, and its Complaints and Appeals process. The website must contain a link to financial literacy information on the Office of Consumer Credit Commissioner's webpage. The MCO may develop a page within its existing website to meet the requirements of this section. The MCO must also maintain a mobile optimized site for mobile device use.

The MCO must minimize download and wait time and not use tools or techniques that require significant memory, disk resources, or special user interventions.

The MCO must maintain a Provider directory for the STAR Health Program on its website. The online Provider directory or online Provider search functionality must designate PCPs with open versus closed panels and behavioral health providers certified in EBPs and promising practices, such as TF-CBT, PCIT, CPP, and TBRI.

The MCO may develop a page within its existing website to meet the requirements of this section. The MCO's website must also:

1. maintain an updated Member handbook; and
2. include a link to the STAR Health Contract located on the HHSC website.

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

The website's content for Providers must provide:

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

The MCO's internet website must contain the requirements of **UMCM Chapter 3.32**, "MMC/CHIP Website Critical Elements."

The MCO's pharmacy website must contain the requirements of **UMCM Chapter 3.29**, "MMC/CHIP Pharmacy Website Required Critical Elements."

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

#### **8.1.5.6 Nurse and Member Hotline Requirements**

The MCO must operate a toll-free Nurse Hotline that Providers, Members, DFPS Staff, Caregivers, and Medical Consenters can call 24 hours a day, 7 days a week. The Nurse Hotline must be staffed with nurses who are knowledgeable about the STAR Health Program, Covered Services, Non-capitated Services, the STAR Health Population, the child welfare system, Medical Consenter requirements, and Provider resources. Nurses must be available 24 hours per day and able to respond to calls from Providers, Members, DFPS Staff, Caregivers, and Medical Consenters seeking clinical information, guidance on specialty referrals or requests for specialty Provider consultations. Nurses must have access to an on-call licensed BH clinician

24 hours per day to assist with crisis calls. Only those persons who can identify themselves through the caller verification process approved by HHSC may obtain personal health information through the Nurse Hotline.

At a minimum, the MCO's Nurse Hotline representatives must be trained and knowledgeable about:

1. Covered Services, including BH Services, Texas Health Steps, pharmacy, dental and vision, Community-Based Services, and Long-Term Services and Supports (LTSS);
2. the Medical Home Services Model and IPC Model, and able to identify PCPs who Members may access who operate according to these models;
3. the role of the PCP;
4. referrals or the process for receiving authorization for procedures or services;
5. issues related to child abuse and how to assist Members and Medical Consenters seeking care and services;
6. Providers in a particular geographical area;
7. Cultural Competency;
8. triaging and assisting MSHCN and Medical Consenters, DFPS Staff, and Caregivers;
9. accessing Non-capitated Services, community and social service resources, and community-based case management services for which the STAR Health population may be eligible;
10. responding to Provider questions regarding specialty referrals and to arrange for consultations with MCO clinical staff, Service Coordinators or Service Managers, or other Providers. For example, a PCP with a Member in their office may call with a need for an immediate consult with MCO clinical staff or a BH Provider;
11. the DM programs included in the STAR Health Program;
12. the emergency prescription process and what steps to take to immediately address Members' problems when pharmacies do not provide a 72-hour supply of emergency medicines, and responding immediately to problems concerning emergency medicines, by explaining the rules to Members so that they understand their rights and, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy and DME processes;
13. the HHSC-OIG Lock-in Program (OIG-LP) pharmacy override process, which ensures Member access to Medically Necessary outpatient drugs;
14. processes for obtaining DME services and how to address common problems;
15. Non-Capitated services, including the NEMT program;
16. Processes to ensure that each Member in category 1 of the Target Population ages 3 and older receives a Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 days of receipt of the DNF; and
17. responding to questions regarding the availability of and access to substance abuse treatment services, including information on self-referral.

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

<http://sao.hr.state.tx.us/compensation/holidays.html>. Member Service representatives must be knowledgeable about the STAR Health Program, Covered Services, Non-capitated Services, the STAR Health Population, the child welfare system, and Medical Consenter requirements. Only those persons who can identify themselves through the caller verification process approved in writing by HHSC may obtain personal health information through the Member Hotline.

The MCO must ensure, at a minimum, that after business hours and on weekends and holidays, the Member Services Hotline is answered by an automated system with the capability to provide callers with operating hours, instructions regarding how to access the Nurse Hotline, and instructions on what to do in cases of emergency. All recordings must be in English and in Spanish, and the languages of any Major Population Group. A voice mailbox must be available after-hours for callers to leave messages. The MCO's Member Services representatives must return Member calls received by the automated system on the next Business Day.

If the Member Hotline does not have a voice-activated menu system, the MCO must have a menu system that will accommodate Members who cannot access the system through other physical means, such as pushing a button.

The MCO must ensure that its Member Service representatives treat all callers with dignity and respect the callers' need for privacy. At a minimum, the MCO's Member Service representatives must be trained and knowledgeable about:

1. Covered Services, including BH Services, Texas Health Steps, the NEMT Program, pharmacy, dental and vision;
2. the emergency prescription process and what steps to take to immediately address problems when pharmacies do not provide a 72-hour supply of emergency medicines;
3. how Members in the OIG LP can fill prescriptions at a non-designated pharmacy in an emergency situation;
4. processes for obtaining DME services and how to address common problems
5. answering non-technical questions pertaining to the role of the PCP, Medical Home Services Model and IPC Model;
6. answering non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services;
7. issues related to child abuse and how to assist Members and Medical Consenters seeking care and services;
8. Providers in a particular geographical area;
9. Fraud, Waste, and Abuse including the OIG-LP and the requirements to report any conduct that, if substantiated, may constitute Fraud, Waste, and Abuse in the Program;-
10. Cultural Competency;
11. confirming the status of MSHCN and transferring these Members or their Medical Consenters to Service Managers for clinical triage and enrollment;
12. triaging calls to the appropriate MCO staff person;
13. answering non-clinical questions pertaining to accessing Non-capitated Services, community and social service resources, and community-based case management services for which the STAR Health population may be eligible;

14. processes to ensure that each member in category 1 of the Target Population ages 3 and older receives a Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 days of receipt of the DNF;
15. referring callers to Covered Services and Non-capitated Services, as appropriate;
16. providing information on Member Appeals and Complaints;
17. responding to questions regarding the availability of and access to substance abuse treatment services, including information on self-referral; and
18. how to identify and report a Critical Event or Incident such as Abuse, Neglect, or Exploitation to the state.

Nurse Hotline and Member Hotline services must meet Cultural Competency requirements and must appropriately handle calls from non-English speaking (and particularly, Spanish-speaking) callers, as well as calls from individuals who are deaf or hard-of-hearing. To meet these requirements, the MCO must employ bilingual Spanish-speaking Member Services representatives and must secure the services of other contractors as necessary to meet these requirements. The MCO must provide these oral interpretation services to all Hotline callers free of charge.

For both Hotlines, the MCO must process all incoming correspondence and telephone inquiries in a timely and responsive manner. The MCO cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Providers, Medical Consenters, DFPS Staff, Caregivers, and Members. The MCO must ensure that both toll-free Hotlines meet the following minimum performance requirements:

1. At least 99 percent of calls are answered by the fourth ring or an automated call pick-up system;
2. no more than 1 percent of incoming calls receive a busy signal;
3. 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;
4. the call abandonment rate is seven percent or less; and
5. the average hold time is two minutes or less.

The MCO must conduct ongoing quality assurance to ensure these standards are met.

Members, DFPS Staff, Caregivers, and Medical Consenters may access the Nurse Hotline and the Member Hotline through the same toll-free number, but must be given the option to direct their calls based on whether they are related to a clinical or non-clinical issue, an emergent issue, or a routine issue. However, the MCO must report Hotline call statistics separately for both the Member Hotline and the Nurse Hotline. The Nurse and Member Hotlines must be dedicated to serving only the Members, DFPS Staff, Caregivers and Medical Consenters. Staff trained to manage general calls may provide back-up to dedicated Hotline staff during peak periods or in cases of emergency, in order to maintain Hotline performance standards and respond to urgent Member calls, but at least 95 percent of calls must be answered by dedicated Hotline staff.

The MCO must monitor its performance regarding the Nurse and Member Hotline standards and submit performance reports summarizing call center performance for the Nurse and

Member Hotlines as indicated in **Section 8.1.26.2**, “Reports,” and **UMCM Chapter 5.4.3**, “Hotline Reports.”

If HHSC determines that it is necessary CO is responsible for all reasonable travel costs incurred by HHSC or its authorized agent(s) relating to such monitoring. For purposes of this section, “reasonable travel costs” include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring.

### **8.1.5.7 Member Education**

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

1. how the MCO system operates, including the role of the PCP, referrals for services using Network Providers, and access to OON providers;
2. Covered Services, including BH services, Texas Health Steps, pharmacy, dental, vision, Community-Based Services and LTSS;
3. any Value-added Services offered by the MCO, and limitations placed on such Value-added Services;
4. the value of screening, preventive care, and other Medical Home services;
5. how to obtain services, including:
  - a. contacting the MCO’s Hotlines;
  - b. the MCO’s Complaint, grievance and Appeals policies and procedures;
  - c. requesting a Medicaid Fair Hearing;
  - d. Emergency Services;
  - e. OB/GYN and specialty care;
  - f. the availability of and access to substance abuse treatment services, Mental Health Rehabilitation and Mental Health Targeted Case Management services, and information on self-referral;
  - g. processes to ensure each Member in category 1 of the Target Population ages 3 and older receives a Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 days of receipt of the DNF;
  - h. Non-capitated Services, including the NEMT program;
  - i. dental services;
  - j. DM programs;
  - k. Service Coordination and Service Management for MSHCN, pregnant Members, Dual Eligibles, hospice recipients, and other special populations;
  - l. Service Coordination;
  - m. ECI Services;
  - n. Texas Health Steps medical and dental checkups;
  - o. suicide prevention;
  - p. identification and health education related to Obesity;
  - q. how to obtain 72-hour supplies of emergency prescriptions from Network pharmacies;
  - r. vision;
  - s. information maintained in the Health Passport;

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8.1.5.7  
modified by  
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- t. how Members in the OIG LP can receive outpatient drugs in an emergency situation;
- u. the availability of Transitioning Youth Program (TYP) services and supports; and
- v. Community-Based Services and LTSS such as PCS, CFC, and MDCP, and the availability of different service delivery options.

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

The MCO also must provide condition and disease-specific information and educational materials to Members, Medical Consenters, DFPS Staff or Caregivers, including information on its Service Management, Service Coordination and DM programs described in **Sections 8.1.13.2**, “Medicaid Non-capitated Services,” **8.1.14**, “Service Coordination,” and **8.1.16**, “Disease Management.” Condition and disease specific information must be oriented to various groups within the STAR Health Population, such as persons with Disabilities and non-English speaking Members.

Per Texas Health & Safety Code § 48.052(c), MCOs may use certified Community Health Workers to conduct outreach and Member education activities.

#### **8.1.5.8 Cultural Competency Plan**

The MCO must have a comprehensive written Cultural Competency Plan describing how the MCO will ensure culturally competent services, and provide Linguistic Access and Disability-related Access. The Cultural Competency Plan must 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 36.303, 42 C.F.R. § 438.10(f)(6)(i), and 1 Tex. Admin. § 353.411.

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, 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. Modifications and amendments to the plan must be submitted to HHSC no later than 30 days prior to implementation. The Plan must also be made available to the MCO’s Provider Network. HHSC may require the MCO to update the plan to incorporate new or amended requirements based on HHSC guidance. In that event, the MCO has 60 days to submit the updated plan to HHSC.

As required by 1 Tex. Admin. Code § 353.411, the MCO must arrange and pay for Competent Interpreter services for Members to ensure effective communication regarding treatment, medical history, or health condition. The MCO must maintain policies and procedures outlining the manner in which Members can access Competent Interpreter services (including when the Member is in a Provider's office or accessing emergency services).

#### **8.1.5.9 Member Complaint and Appeal Process**

The MCO must develop, implement and maintain a system for tracking, resolving, and reporting Member Complaints regarding its services, processes, procedures, and staff. The MCO must ensure that Member Complaints are resolved within 30 calendar days after receipt. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 days of receipt of the Complaint by the MCO. The state will refer Member Complaints that it receives regarding the MCO to the MCO for resolution. Please see **Attachment A**, "STAR Health Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix."

The MCO must develop, implement, and maintain a system for tracking, resolving, and reporting Member Appeals regarding the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service. Within this process, the MCO must respond fully and completely to each Appeal and establish a tracking mechanism to document the status and final disposition of each Appeal.

The MCO must ensure that Member Appeals are resolved within 30 calendar days of receipt, unless the MCO can document that the Member requested an extension or the MCO shows there is a need for additional information and the delay is in the Member's interest. The MCO is subject to liquidated damages if at least 98 percent of Member Appeals are not resolved within 30 days of receipt of the Appeal by the MCO. Please see **Attachment A**, "STAR Health Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix."

The MCO must follow the Member Complaint and Appeal Process described in **Section 8.1.33**, "Member Complaint and Appeal System."

Section  
8.1.5.10  
modified by  
Version 2.2

#### **8.1.5.10 Abuse, Neglect, or Exploitation**

##### **8.1.5.10.1 Member Education on Abuse, Neglect, or Exploitation**

Section  
8.1.5.10.1  
added by  
Version 2.2

At the time of assessment but no later than when the Medicaid Member is approved for LTSS, the MCO must ensure that the Member is informed orally and in the Member Handbook of the processes for reporting allegations of Abuse, Neglect, or Exploitation. The toll-free numbers for DADS and DFPS must be provided.

##### **8.1.5.10.2 Abuse, Neglect, and Exploitation Email Notifications**

Section  
8.1.5.10.2  
added by  
Version 2.2

The MCO must provide HHSC with an email address to receive and respond to APS notifications involving Abuse, Neglect or Exploitation notifications. The MCO must respond to emails received by this email address by providing the information requested by Adult Protective Services (APS) within 24 hours of delivery seven days a week to the MCO's email address.

### **8.1.5.10.3 MCO Training on Abuse, Neglect, and Exploitation**

Section  
8.1.5.10.3  
added by  
Version 2.3

By September 30, 2016, the STAR and STAR+PLUS MCOs must provide Abuse, Neglect, and Exploitation training to all MCO staff who have direct contact with a Member. Direct contact includes face-to-face and telephone contact. MCOs must use the approved training materials provided by HHSC as set forth in the UMCM Chapter 16.1 regarding Policy Guidance. All newly hired staff who have direct contact with a Member must be trained no later than 30 calendar days from the date of hire. All employees that receive the required training must sign, upon completion of the training, an acknowledgement of their understanding of their duty to report. The MCOs must retain records of the training (including copies of all training materials) during the employment of the staff member and for 3 years thereafter.

### **8.1.6 Marketing and Prohibited Practices**

Section  
8.1.6  
modified by  
Version 2.2

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

### **8.1.7 Quality Assessment and Performance Improvement (QAPI)**

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

#### **8.1.7.1 QAPI Program Overview**

The MCO must develop, maintain, and operate a QAPI Program consistent with the Contract and TDI requirements (including 28 Tex. Admin. Code § 11.1901(b)(5) and § 11.1902). The MCO must also meet the requirements of 42 C.F.R. § 438.240.

The MCO must have on file with HHSC an approved plan describing its QAPI Program, including how the MCO will accomplish the activities required by this section. The MCO must submit a QAPI Program Annual Summary in a format and timeframe specified by HHSC or its designee. The MCO must keep participating physicians and other Network Providers informed about the QAPI Program and related activities. The MCO must include a requirement securing cooperation with the QAPI in its Network Provider Contracts.

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

1. evaluate performance using objective quality indicators;

2. foster data-driven decision-making;
3. recognize that opportunities for improvement are unlimited;
4. involve Member, stakeholder, DFPS Staff, Caregiver, Medical Consenter and Provider in the quality management and improvement process and QAPI activities;
5. support continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;
6. support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and
7. support re-measurement of effectiveness and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

#### **8.1.7.2 QAPI Program Structure**

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

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

#### **8.1.7.3 Clinical Indicators**

The MCO must engage in the collection of clinical indicator data. The MCO must use such clinical indicator data in the development, assessment, and modification of its QAPI Program.

#### **8.1.7.4 QAPI Program Subcontracting**

If the MCO subcontracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the MCO must maintain a file of the Subcontractors. The file must be available for review by HHSC or its designee upon request.

#### **8.1.7.5 Behavioral Health (BH) Services Integration into QAPI Program**

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

### **8.1.7.6 Clinical Practice Guidelines**

The MCO must adopt not fewer than four evidence-based clinical practice guidelines that apply to the STAR Health population, two for physical health and two for BH. These practice guidelines must be based on valid and reliable clinical evidence; consider the needs of the MCO's Members; be adopted in consultation with contracting healthcare professionals, and; be reviewed and updated periodically, as appropriate. The MCO must develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program. The MCO must disseminate the practice guidelines to all affected Providers and, upon request, to Medical Consenters, DFPS Staff, Caregivers, and Members.

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

### **8.1.7.7 Medical Advisory Committee (MAC)**

The MCO will establish MACs comprised of community providers and other physical health and BH experts, and chaired by the MCO. The MCO will require that all provider members of the MAC have experience working with the STAR Health Population. The MCO may either establish separate and multiple MACs, which will be composed of members with specific expertise in major areas, such as dental and BH Services, or one MAC that is composed of various provider types to enable it to provide specialized review, expertise and consultation on a variety of health issues. Membership in the MACs must include, at a minimum, acute, BH, and pharmacy providers, as well as a specialist or pediatrician experienced in the needs of medically fragile children. The MCO must maintain a record of MAC meetings, including agendas and minutes, for at least three years. The MAC will assist the MCO in:

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

### **8.1.7.8 Provider Credentialing and Profiling**

In accordance with Section 8.1.4.4, the MCO must review and approve the credentials of all participating licensed and unlicensed Providers who participate in the MCO's Network. Through the QAPI process, the MCO must report annually to HHSC the results of any credentialing activities conducted during the reporting year. The MCO must use the QAPI form found in UMCM Chapter 5.7.1.

Section  
8.1.7.8  
modified by  
Version 2.1

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

Provider review activities must include:

1. developing PCP and Provider-specific reports that include a multi-dimensional assessment of a PCP or Provider's performance using clinical, administrative, and Member satisfaction indicators of care that are accurate, measurable, and relevant to the STAR Health population;
2. including the MACs in reviewing general Provider practice patterns and preparing recommendations for categories of Providers who are not in compliance with clinical practice guidelines;
3. establishing PCP, Provider or group Benchmarks for areas reviewed, where applicable. The MCO can compare the performance of its Providers to providers delivering similar types of services in other states; and
4. providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Provider Network.

#### **8.1.7.9 Network Management**

The MCO must:

1. use the results of its Provider review activities to identify areas of improvement for individual PCPs and Providers, and groups of Providers;
2. establish Provider-specific Quality Improvement goals for priority areas in which a Provider or Providers do not meet established MCO standards or improvement goals;
3. develop and implement incentives to motivate Providers to improve performance on profiled measures, which may include financial incentives and non-financial incentives;
4. at least annually, measure and report to HHSC on the Provider Network and individual Providers' progress, or lack of progress, towards such improvement goals, and submit a plan to HHSC for quarterly monitoring of Providers who are not meeting goals; and
5. implement action plans and modify incentives for Providers who are not meeting improvement goals and conduct quarterly evaluations of the Provider's progress until the Provider has met improvement goals or the MCO determines the Provider should be terminated.

##### **8.1.7.9.1 Physician Incentive Plans**

If the MCO implements a physician incentive plan under 42 C.F.R. §438.6(h), the plan must comply with all applicable law, including 42 C.F.R. § 422.208, and § 422.210. The MCO cannot make payments under a physician incentive plan if the payments are designed to induce Providers to reduce or limit Medically Necessary Covered Services to Members.

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

The MCO must make information regarding physician incentive plans available to Members upon request, in accordance with the **UMCM**. The MCO must provide the following information to the Member:

1. Whether the Member's PCP or other Providers are participating in the MCO's physician incentive plan;
2. whether the MCO uses a physician incentive plan that affects the use of referral services;
3. the type of incentive arrangement; and
4. whether stop-loss protection is provided.

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

1. Whether the physician incentive plan covers services that are not furnished by a physician or physician group. (The MCO is only required to report on items 2–4 below if the physician incentive plan covers services that are not furnished by a physician or physician group);
2. the type of incentive arrangement (e.g., withhold, bonus, capitation);
3. the percent of withhold or bonus (if applicable);
4. the panel size, and if patients are pooled, the method used (HHSC approval is required for the method used); and
5. if the physician or physician group is at substantial financial risk, the MCO must report proof that the physician or group has adequate stop-loss coverage, including the amount and type of stop-loss coverage.

#### **8.1.7.9.2 MCO Value-Based Contracting**

The MCO must develop and submit to HHSC a written plan for expansion of value-based contracting with its physician and non-physician Providers that encourages innovation and collaboration, and increases quality and efficiency. Contracting and payment structures should be focused on incentivizing quality outcomes, shared savings, or both resulting from the reduction of inappropriate utilization of services, including inappropriate admissions and readmissions rather than be based on volume. The plan will include mechanisms by which the MCO will provide incentive payments to hospitals, physicians and other health care providers for quality care resulting in reductions of inappropriate services. The plan will include quality metrics required for incentives, recruitment strategies of providers, and a proposed structure for incentive payments, shared savings, or both. Beginning with SFY15, the MCO must submit its state fiscal year plan to HHSC no later than November 1 of each year using UMCM Chapter 8.4, "Plan for Value-Based Contracting." HHSC will evaluate the plan and provide feedback to the MCO. Upon HHSC's approval of the plan, HHSC will retrospectively evaluate the MCO on its execution of the written plan. Modifications can be made to the plan after submission but are subject to HHSC review and approval. Plan approval is based on the following criteria: the number of providers, diversity of selected providers, geographic representation, and the methodology of the shared savings, data sharing strategy with providers, and other factors. Each year, the annual plan must show a measurable increase in the percent of business (providers, dollars, or other) being incentivized from the previous year.

HHSC's retrospective review of the execution of the plan may include a review of encounter data, MCO financial statistical reports, and surveys or interviews with MCO representatives or providers. The MCO must submit additional information upon HHSC's request. HHSC may delay or reduce payments to the MCO if it does not submit a plan that meets the HHSC requirements by the required deadline or if it does not effectively execute a plan that has been approved by HHSC.

#### **8.1.7.10 Collaboration with the External Quality Review Organization (EQRO)**

The MCO will collaborate with HHSC's EQRO to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to Members and to identify opportunities for MCO improvement. To facilitate this process, the MCO will supply claims data to the EQRO in a format identified by HHSC in consultation with the MCO, and will supply medical records for focused clinical reviews conducted by the EQRO. The MCO must also work collaboratively with HHSC and the EQRO to annually measure selected HEDIS measures that require chart reviews if requested by the EQRO.

#### **8.1.8 Utilization Management (UM)**

The MCO must have a written UM program description, which includes, at a minimum:

1. procedures to evaluate the need for Medically Necessary Covered Services, including BH Services;
2. the clinical review criteria used, the information sources, and the process used to review and approve the provision of Covered Services, including BH Services;
3. the method for periodically reviewing and amending the UM clinical review criteria; and
4. the staff position functionally responsible for the day-to-day management of the UM function.

The MCO must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UM determinations. When making UM determinations, the MCO must comply with the requirements of 42 C.F.R. § 456.111 (Hospitals) and 42 CFR § 456.211 (Mental Hospitals), as applicable. UM should specifically assess prescribing patterns for psychotropic medications against the *Psychotropic Medication Utilization Parameters for Foster Children* found at [http://www.dfps.state.tx.us/documents/Child\\_Protection/pdf/TxFosterCareParameters-September2013.pdf](http://www.dfps.state.tx.us/documents/Child_Protection/pdf/TxFosterCareParameters-September2013.pdf). The MCO must maintain the ability to assess prescribing patterns for psychotropic medications through both an automated and manual process. UM that requires direct contact with the actual Provider must be scheduled at times convenient to the Provider's schedule, so as not to interrupt regular clinical care duties.

The MCO must issue coverage determinations, including Adverse Determinations, according to the following timelines:

1. Within three Business Days after receipt of the request for authorization of services;
2. within one Business Day for concurrent hospitalization decisions; and

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3. within one hour for post-stabilization or life-threatening conditions, except that for Emergency Medical Conditions and Emergency BH Conditions, the MCO must not require a PA.

The MCO must follow extended timelines specified under the partial settlement agreement of *Alberto N., et al. v. Smith, et al.* and described in **UMCM Chapter 3.22**, "Notification Process for Incomplete Prior Authorization Requests," in situations in which a request for prior authorization for a member under age 21 does not contain complete documentation or information.

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. appropriate personnel are available to respond to UR inquiries 8:00 a.m. to 5:00 p.m. local time throughout the state, Monday through Friday, and respond to calls within one Business Day, with a telephone system capable of accepting UM inquiries after normal business hours;
4. confidentiality of clinical information;
5. compensation to individuals or entities conducting UR activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services as required by 42 C.F.R. § 438.210(e), and quality is not adversely impacted by financial and reimbursement related processes and decisions;
6. the effectiveness and the efficiency of the UM Program is routinely assessed;
7. the appropriate use of medical technologies, including medical procedures, drugs and devices, is evaluated;
8. areas of suspected inappropriate service utilization are targeted;
9. over- and under-utilization is detected;
10. reports regarding Provider utilization patterns and compliance with UM criteria and policies are routinely generated;
11. Member and Provider utilization is compared with norms for comparable individuals.
12. inpatient admissions, emergency room use, ancillary, and out-of-state services are routinely monitored.
13. peer-to-peer consultation is provided among the MCO's Providers and between Providers and the MCO's clinical staff.
14. when Members are receiving BH Services from the LHMA the MCO is using the same UM guidelines as those prescribed by DSHS for use by LHMA's and published at: <http://www.dshs.state.tx.us/mhsa/trr/um/>.
15. suspected cases of Provider or Member Fraud, Waste, and Abuse are referred to the Office of Inspector General (OIG) as required by **Section 8.1.25**, "Fraud, Waste and Abuse."

At the MCO's discretion, pharmacy PA determinations may be made by pharmacists, subject to the limitations described in **Attachment A, Section 4.04**, "Medical Director."

Qualified medical professionals must supervise UM Program staff making preauthorization and concurrent review decisions.

### **8.1.8.1 Compliance with State and Federal Prior Authorization (PA) Requirements**

The MCO must adopt PA requirements that comply with state and federal laws governing authorization of healthcare services and prescription drug benefits, including 42 U.S.C. § 1396r-8 and Texas Government Code §§ 531.073 and 533.005(a)(23). In addition, the MCO must comply with Texas Human Resources Code § 32.073 and Texas Insurance Code §§ 1217.004 and 1369.256, which require MCOs to use national standards for electronic PA of prescription drug and healthcare benefits no later than two years after adoption, and accept PA requests submitted using the TDI's standard form, once adopted.

### **8.1.8.2 Toll-free Fax Line for Service Authorizations**

The MCO must provide access to a toll-free fax line 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). The MCO must require Network Providers to identify and provide ECI referral information to the Medical Consenter of any Member under the age of three suspected of having a developmental delay or disability or otherwise meeting eligibility criteria for ECI services in accordance with 40 Tex. Admin. Code Chapter 108 within seven calendar 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, 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 the Department of Assistive and Rehabilitative Services (DARS) Division for ECI Services for these child find activities.

The MCO must inform the Member's Medical Consenter that ECI participation is voluntary. The MCOs is required to provide medically necessary services to a Member if the Member's Medical Consenter chooses not to participate in ECI.

#### **8.1.9.2 Eligibility**

The local ECI program will determine eligibility for ECI services using the criteria contained in 40 Tex. Admin. Code Chapter 108.

The MCO must cover medical diagnostic procedures required by ECI, including discipline specific evaluations, so that ECI can meet the 45-day timeline established in 34 C.F.R. § 303.342(a). The MCO must require compliance with these requirements through Provider contract provisions. The MCO must not withhold authorization for the provision of such medical

diagnostic procedures. Further, the MCO must promptly provide relevant medical records available as needed.

### **8.1.9.3 Providers**

The MCO must contract with an adequate number of qualified ECI Providers to provide ECI services to Members under the age of three who are eligible for ECI services. The MCO must allow an Out-of-Network provider to provide ECI covered services if a Network Provider is not available to provide the services in the amount, duration, scope and service setting as required by the Individual Family Service Plan (IFSP).

### **8.1.9.4 Individual Family Service Plan (IFSP)**

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8.1.9.4  
modified by  
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The IFSP identifies the Member's present level of development based on assessment, describes the services to be provided to the child to meet the needs of the child and the family, and identifies the person or persons responsible for each service required by the plan. The IFSP is developed by an interdisciplinary team that includes the Member's LAR; the ECI service coordinator; ECI professionals directly involved in the eligibility determination and Member assessment; ECI professionals who will be providing direct services to the child; other family members, Caregivers, advocates, or other persons as requested by the authorized representative. If the Member's family or Caregiver provides written consent, the Member's PCP or MCO staff may be included in IFSP meetings. The IFSP is a contract between the ECI contractor and Member's LAR.

Ongoing case management does not include ECI Targeted Case Management services.

The Member's LAR signs the IFSP to consent to receive the services established by the IFSP. The IFSP contains information specific to the Member, as well as information related to family needs and concerns. If the Member's LAR provides written consent, the ECI program may share a copy of IFSP sections relevant only to the Member with the MCO and PCP to enhance coordination of the plan of care. These sections may be included in the Member's medical record or service plan.

The MCO must allow services to be provided by an OON provider if a Network Provider is not available to provide the services in the amount, duration, scope and service setting as required by the IFSP.

### **8.1.9.5 Covered Services and Reimbursement**

Section  
8.1.9.5  
modified by  
Version 2.1

The interdisciplinary team, including a licensed professional of the healing arts (as defined in 40 Tex. Admin. Code § 108.103) 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 Individual Family Service Plan (IFSP).

ECI Targeted Case Management services and Early Childhood Intervention Specialized Skills Training are Non-capitated Services, as described in **Section 8.1.28.8**.

Members in ECI will be classified as Members with Special Healthcare Needs (MSHCN) as described in **Section 8.1.13**. MCOs must offer Service Management and develop a Service Plan as appropriate for these Members. With the consent of the Member's authorized representative, the MCO must include key information from the IFSP in the development of the Member's Service Plan.

#### **8.1.10 Special Supplemental Nutrition Program for Women, Infants, and Children (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 of Members potentially eligible for WIC. The MCO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract.

#### **8.1.11 Coordination with the Department of Family and Protective Services (DFPS)**

Section  
8.1.11  
modified by  
Versions  
2.1 and 2.2

DFPS is responsible for the care of children and young adults in DFPS conservatorship who have been removed from the home because of abuse or neglect. It is essential to the success of this initiative that the MCO and DFPS develop a positive and productive relationship to ensure that the STAR Health population receives the best possible physical and BH outcomes.

The MCO must cooperate and coordinate with DFPS for the care of a child or young adult who is receiving services from or has been placed in DFPS conservatorship. The MCO Service Coordinators and Service Managers must be available to provide information to and assist Members, Medical Consenters and DFPS Staff with access to care and coordination of services as required in **Sections 8.1.13.2**, "Access to Care and Service Management," and **8.1.14**, "Service Coordination," including development of the Case Plan. The MCO will also provide training opportunities including web-based and trainings at the regional level to DFPS staff.

The MCO must cooperate and coordinate with staff from the SSCCs when doing so would improve the coordination of Medically Necessary Healthcare Services for Members in categories 1 and 2 of the Target Population. The MCO must ensure that its staff understand the

roles and responsibilities of the SSCCs and develop positive working relationships with these organizations. The SSCC is not responsible for the case management function of foster care, but should coordinate with STAR Health Providers and DFPS to ensure the provision of relevant eligible services to children under SSCC care.

The MCO must require Service Managers, Service Coordinators, Member Advocates, CONNECTIONS Representatives, and any other staff positions that may have direct contact with Members or Member information to pass a background check as a condition of hire, and every two years thereafter. These staff members will not be placed in contact with Members, nor be permitted to access Member information, until DFPS has completed the initial background check. All staff not having passed a background check, and all staff alleged to have committed a criminal offence that would prohibit him or her from having contact with Members pursuant to DFPS regulations in 40 Tex. Admin. Code, Chapter 745, Subchapter F, Division 3, will be removed from all STAR Health functions in which direct contact with Members or Member information is expected.

The MCO must contractually require Providers to testify in court as needed for child protection litigation. The MCO must comply with all provisions related to Covered Services included in a Court Order. DFPS is responsible for ensuring the MCO receives timely a copy of any newly issued Court Order.

The MCO cannot deny, reduce, or controvert the Medical Necessity of any Covered Service included in a Court Order. Any modification or termination of a Court Ordered service must be presented to and approved by the court having jurisdiction over the matter.

If there is a dispute over the Medical Necessity of any Covered Services for any Member, the Member, the Member's Medical Consenter, or DFPS Staff, as appropriate, will use the HHSC MCO Complaint and Appeal processes or the Fair Hearing process as described in **Sections 8.1.33**, "Member Complaint and Appeal Process," and **8.1.33.5**, "Access to Fair Hearing for Members."

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

#### **8.1.11.1 Training for Law Enforcement Officials and Judges**

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

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

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

1. Role of law enforcement officials, judges, district and county attorneys representing DFPS, and attorneys ad litem as it relates to the behavioral and healthcare needs of the STAR Health population;
2. requirements for providing Medically Necessary Covered Services; to the STAR Health population including:
  - a) required timelines for Healthcare Services and assessments as defined in the contract and in DFPS policies;
  - b) legal review of Member needs, treatment plans and healthcare progress as part of court hearings; and
  - c) other DFPS policies as required;
3. how to access resources available to the judiciary, such as
  - a) requesting Health Passport records to obtain Healthcare and assessment information;
  - b) requesting additional training from MCO trainers; and
  - c) emailing the MCOs judicial email box for questions about psychotropic medication utilization issues, and other concerns.

### **8.1.11.2 STAR Health Liaisons**

Section  
8.1.11.2  
modified by  
Version 2.3

The MCO must employ a team of dedicated STAR Health Liaisons who are responsible for coordinating with Regional DFPS Well-Being Specialists to promptly resolve issues identified by the MCO, DFPS, or HHSC that arise related to STAR Health or to the individual healthcare of a Member. STAR Health Liaisons must be housed regionally and be available to coordinate with DFPS to develop work flows and processes, including those related to the transmission of clinical and non-clinical Member information. STAR Health Liaisons will also take a leading role in identifying training needs for the MCO and DFPS staff.

STAR Health Liaisons will outreach to and assist Members who are transitioning into Target Population category 3, and will refer Members to the Transitioning Youth Program (TYP) as appropriate. STAR Health Liaisons will coordinate with DFPS Transitioning Services staff and with DFPS contracted Transition Centers listed at <https://www.dfps.state.tx.us/txyouth/contacts/transition.asp> to develop work flows and processes that will ensure outreach to this population is successful.

### **8.1.11.3 Assessments**

Section  
8.1.11.3  
added by  
Version 2.2  
and  
modified by  
Version 2.3

The MCO must ensure that all Members in category 1 of the Target Population age 3 and older are assessed by a BH Provider using the Texas Comprehensive CANS 2.0 (child welfare) tool within 30 days of receipt of the DNF. For Members enrolled in Service Management, the results of the assessment must be used to inform the Member's Healthcare Service Plan.

The MCO must establish a process to ensure that the results of the Texas Comprehensive CANS 2.0 (child welfare) assessment tool are communicated to the Member's PCP, PCP Teams, BH Providers, Caregivers, Medical Consenters, and DFPS Staff.

Members who meet the criteria for treatment services, outlined in 40 Tex. Admin. Code Part 749, Subchapter B, Division 2, “Services”, may require expedited assessments, as determined by DFPS Staff or SSCC staff. The MCO must work with DFPS Staff or SSCC staff to determine which assessment(s) it will authorize, and schedule the requested assessment(s) within three Business Days. The MCO must provide the resulting diagnosis and recommendations from the Provider performing the assessment to DFPS staff or SSCC staff within two Business Days of MCO receipt. Expedited assessments may include psychosocial, psychological, psychiatric, neurological, physical or other assessments that would assist DFPS or its agent in identifying needed treatment services for a Member.

### **8.1.12 Health Passport**

The MCO must develop and maintain a web-based Health Passport system to provide an Electronic Health Record (EHR) for all Members. The Health Passport will facilitate Service Management and Continuity of Care for Members, as well as streamline data sharing and coordination between the Members’ Providers and DFPS. The Health Passport will function as an easily accessible, paperless repository of information related to each Member, his or her Providers, demographics, medical services rendered, and pertinent administrative documentation.

#### **8.1.12.1 Required Features and Data Elements**

The Health Passport must be structured in a manner to provide the data in a summarized, user-friendly, printable format and must employ hierarchical security measures to limit access to designated persons as defined by HHSC in the Contract. The Health Passport must be available 24 hours per day, seven days per week, except during limited scheduled system downtime. Routine scheduled downtime must be posted on the MCO website. The MCO must communicate non-routine scheduled downtime to HHSC and the DFPS Help Desk before the scheduled downtime occurs.

The Health Passport must be maintained in a web-based electronic format with the following minimum system functions and features:

1. Advanced security capabilities to protect patient confidentiality and comply with security and privacy rules adopted by the U.S. Department of Health and Human Services (HHS) under HIPAA, 45 C.F.R. §§ 164.302–.318; 164.500–.534, the HITECH Act, all applicable state and federal laws, including Texas Administrative Code Chapter 390, and current Enterprise Information Security Standards and Guidelines (EISSG), which can be found in the **Procurement Library**;
2. retention of records until the Member reaches age 26 or the timeframe prescribed in **Attachment A, Section 9.01**, “Financial record retention and audit,” (whichever occurs later);
3. role-based access to Health Passport data by designated parties as defined by HHSC, in which the Member’s designated PCP and additional Providers must be clearly identifiable by role in the Health Passport;
4. additional security layer for cases deemed sensitive by DFPS to allow access only by personnel as designated by DFPS;

Section 8.1.12.1 modified by Versions 2.1, 2.2, and 2.3

5. secure user access to prevent unauthorized use of data, data loss, tampering and destruction;
6. audit trail functionality to include security audits (logging of Health Passport access attempts) and data audits (logging when, and by whom, records are created, viewed, updated, extracted, or deleted), in which the MCO must report any security breach in the Health Passport system to HHSC and DFPS within 24 hours of the breach;
7. integration of the Health Passport with the 24-hour Nurse Hotline and BH Hotline to allow case-specific access to Health Passport records by designated Hotline staff;
8. integration of the Health Passport with the MCO's Provider portal;
9. sorting and printing capacity supported at a record and data category basis;
10. ad hoc reporting functionality;
11. transferability and exportability of the complete Health Passport database in a file format designated by HHSC; and
12. export of patient clinical data to a portable, electronic format that can be imported into Certified Electronic Health Record Technology (CEHRT) to allow providers to maximize their use of electronic patient data. Implementation of this functionality should carefully follow up-to-date guidance of the Office of the National Coordinator for Health IT, which specifies the standards and criteria for interoperability of software involved in patient care. Current criteria call for the use of Consolidated Clinical Document Architecture (CCDA) to describe clinical data elements and the use of the XML-based Continuity of Care Document (CCD) template as the format by which the data elements are organized.

The MCO must establish a Health Passport Steering Committee and processes by which potential enhancements, new functionality, or additional features can be proposed, reviewed, and prioritized for implementation. The Committee must include representation from HHSC, DFPS, and stakeholders who use the application on a regular basis. The MCO must maintain a record of Steering Committee meetings, including agendas, minutes, and timelines for project completion.

The MCO is required to include the following data items in the Health Passport:

1. Member-specific information including name, address of record, date of birth, race/ethnicity, gender, and other demographic information, as appropriate, for each Member;
2. name and address of each Member's Primary Care Physician, Caregiver and Medical Consenter with clear designation of Member's authorized Medical Consenter;
3. name and contact information of each Member's DFPS caseworker as well as non-medical personnel such as Service Coordinator and Service Manager, as appropriate;
4. acquisition and retention of the Member's Medicaid ID and DFPS personal identification number ("Person ID") , when available, are required;
5. the initial HCSP, as well as any updates, for each Member who is receiving Service Management, including the plan of treatment to address the Member's physical, psychological, and emotional healthcare problems and needs, and identification of enrollment in a Disease Management (DM) program, the

- Transitioning Youth Program (TYP) or other type of specialized assistance the Member is receiving;
6. record of all Psychotropic Medication Utilization Reviews (PMUR), to include the outcome of each review and any actions taken to address identified concerns with the Member's medication regimen;
  7. provider-specific information including, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and credentials;
  8. record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Texas Health Steps program, that include the date of the service event, location, Provider name, the associated problem(s) or diagnosis, and treatment given, including drugs prescribed;
  9. record of future scheduled service appointments and referrals, when known;
  10. record of all diagnoses applicable to the Member, with emphasis on BH diagnoses utilizing either the applicable DSM or ICD national code sets as based on claims submitted;
  11. record of current and past medications and doses (including psychotropic medications), interaction alerts, and where available, the prescribing physician, date of prescription(s) and target symptoms;
  12. record and results of all Texas Health Steps medical, dental, and BH exams, including all required information from Texas Health Steps forms;
  13. monthly progress notes from BH exams or treatments, submitted more frequently if necessary to document significant changes in a Member's treatment or progress. Notes must include the following:
    - a. Primary and secondary (if present) diagnosis;
    - b. assessment information;
    - c. brief narrative summary of Member's progress or status;
    - d. scores on each outcome rating form(s);
    - e. referrals to other Providers or community resources; and
    - f. any other relevant care information;
  14. Family Strengths and Needs Assessment (FSNA) assessment, as submitted by DFPS;
  15. The Texas Comprehensive CANS 2.0 (child welfare) assessment, including:
    - a. scores from the rating sheet; and
    - b. the results page, including narrative and recommendation fields;
  16. listing of Member's known health problems and allergies;
  17. complete record of all immunizations, supplemented by and exchangeable with data from ImmTrac, the Texas Immunization Registry that meets the requirements of Texas Health & Safety Code Chapter 161as well as the recommended immunization schedules for Members age birth through 18 years, and the catch-up immunization schedule as posted on the Centers for Disease Control and Prevention (CDC) website;
  18. listing of Member's DME must be reflected in the claims or "Visits" module, and in the Member's HCSP, if Member is in Service Management;
  19. record of notification within two Business Days of the provision of Emergency Services to a Member if the Medical Consenter did not provide consent;
  20. any utilization of an informational code set, such as ICD-10, should provide the used code value as well as an appropriate and understandable code description

(this is applicable to codes pertaining to a service event, healthcare Provider, and Member records.);

21. laboratory test results; and
22. functionality that assists DFPS Caseworkers.

The Health Passport may contain additional information proposed by the MCO and approved by HHSC.

#### **8.1.12.2 Usage Requirements**

Section  
8.1.12.2  
modified by  
Version 2.2

The MCO and the Member's Providers, as appropriate, will be responsible for updating each Member's Health Passport with the required medical information. The MCO must contractually require Providers to submit information for the Health Passport. The MCO shall design an efficient system that will allow Providers to either input data directly into the Health Passport at the point of service through a web-based interface or submit the required information to the MCO for entry into the Health Passport.

The MCO must develop a process to encourage that Providers submit monthly BH progress notes, required forms, and assessment information to the Health Passport in a timely manner.

The MCO may design the Health Passport in such a way as to allow for electronic communication via the Health Passport among the Member's Network Providers for Service Management and service planning purposes.

If the status of an authorized user of the Health Passport changes, the MCO must terminate the user's access to the Health Passport system within 24 hours of notification of the user's change in status. Examples of status changes include a Provider leaving the MCO's Network, or a DFPS employee leaves employment with DFPS. When a Member is disenrolled from the MCO, web access to the Member's Health Passport shall be suspended. However the MCO shall retain the Member's records in a manner such that the Health Passport may be readily reinstated should the Member return to conservatorship and be re-enrolled in the MCO. Before web access is suspended, DFPS will be responsible for providing a copy (paper or electronic) of the Member's authorized Health Passport records to the parties specified in Texas Family Code § 266.006(f). In the event that DFPS cannot access a Member's Health Passport record before web access is suspended, the MCO will make available the means for DFPS to access the Member's Health Passport records or will provide to DFPS an electronic or hard copy as requested by DFPS.

To facilitate Service Management, the MCO will provide a daily upload to HHSC/DFPS of designated Health Passport data, as determined by HHSC, via the use of an exchange File Transfer Protocol (FTP) site that will be designated by HHSC.

The MCO must develop instructional and training materials for Health Passport users, including web-based materials.

### 8.1.12.3 Health Passport Reporting Requirements

Section  
8.1.12.3  
modified by  
Version 2.2

The MCO is required to report to HHSC on measures of Health Passport usage and compliance by Providers. The MCO must produce the following deliverables for this purpose:

**Passport Usage Summary Report**—The MCO must submit this deliverable on a quarterly basis. The report is utilized to show the overall usage of the Health Passport system. The report must include the following data elements for each user role, and including geographical trending of the data:

1. Number of registered Health Passport users,
2. number of unique patient charts viewed,
3. number of forms used, and
4. number of log ins.

**Care Coordination Report**—The MCO must submit this deliverable on a quarterly basis. The report is utilized to show the extent to which the Health Passport system is assisting in the coordination of BH and physical health services. The report must include the number and percentage of:

1. Member records that have been accessed by both the Member's BH Provider and physical health provider, and
2. Members who have received both BH and physical health services, as demonstrated by claims data.

**Quarterly Forms Review**—The MCO must submit this deliverable on a quarterly basis. The report is utilized to show the extent to which Providers are submitting contractually required documents for Texas Health Steps and BH visits. The report must include the following data elements:

1. The number of compliant and non-compliant Health Passport form submissions for Texas Health Steps and Behavioral Health,
2. a list of Providers, and their provider type, responsible for the highest number of non-compliant submissions.

**Excessive Usage Report**—The MCO must submit this deliverable on a daily basis. The report is utilized to show users who have exceeded the typical number of log-ons to the Health Passport system. The MCO must maintain standardized usage thresholds for each user type (e.g., Medical Consenter, DFPS Caseworker, CASA staff, physician) that will be used to measure excessive usage. The MCO must review a user exceeding his or her assigned threshold in a given day to ensure the user's use of the Health Passport is appropriate. The MCO must refer situations involving the possible abuse of the Health Passport system to HHSC and DFPS for their additional review. This report must include the following data elements:

1. The names of the users and user types that appear to that exceed the usage threshold within a specified date range.
2. The number of times each user accessed the system within a specified date range.
3. The date and time of each access.

**Full Access Report** —The MCO must submit this deliverable on a daily basis. The report contains detailed information on each Member associated to an excessive usage incident recorded in the Excessive Usage Report. This report is utilized to assist HHSC and DFPS in

determining the appropriateness of a user's use of the Health Passport system. The report must include the following data elements:

1. The name of each Member accessed.
2. The name of the user and user type that accessed each Member's record.
3. Each area of that Member's record that was accessed during the incident.

#### **8.1.12.4 Health Passport Mobile Accessibility**

Section  
8.1.12.4  
modified by  
Versions  
2.2 and 2.3

The MCO must develop and maintain accessibility and secure viewing of Health Passport EHRs on users' mobile devices. At a minimum, this mobile accessibility must meet requirements for usability, security, availability, and downtime described in items 1-6 of the minimum system functions and features listed in **Section 8.1.12.1, "Required Features and Data Elements."** The mobile accessibility must be implemented by the Operational Start Date. At a minimum, the mobile access must be capable of displaying all data items listed in **Section 8.1.12.1 "Required Features and Data Elements."**

#### **8.1.13 Services for Members with Special Healthcare Needs (MSHCN)**

##### **8.1.13.1 Identification**

Section  
8.1.13.1  
modified by  
Version 2.3

The MCO must develop and maintain a system and procedures for identifying Members with Special Health Care Needs (MSHCN). HHSC requires that the MCO designate Members in the following groups as MSHCN:

1. Members with Severe Emotional Disturbance (SED);
2. Members with disabilities or Chronic (or Complex Conditions, including high-cost catastrophic cases);
3. Members with high-risk pregnancies;
4. ECI program participants;
5. Dual Eligibles;
6. Members enrolled in DADS hospice services; and
7. Medically Dependent Children's Program (MDCP) recipients.

The MCO must use data obtained through its Service Management screening process, or other methods such as predictive modeling and medical history data, to identify Members who qualify as MSHCN. The MCO must contact a Member identified as MSHCN, as well as DFPS Staff, Caregivers, and Medical Consenters to inform them that the Member meets the MCO's MSHCN criteria and has conditions requiring special services described in **Section 8.1.13.2 and 8.1.14.** The MCO's screening process and other mechanisms to evaluate MSHCN must use appropriate healthcare professionals.

Except in designated foster care redesign areas, DFPS contracts with Youth for Tomorrow to identify service levels for the STAR Health population for the purposes of determining placement. DFPS will provide this information to the MCO in the event this information is helpful in designing HCSPs for Members.

The MCO must provide information to the HHSC Administrative Services Contractor that identifies Members assessed to be MSHCN by the MCO. The information must be provided to HHSC as specified in the Joint Interface Plan (JIP) found in the **UMCM Chapter 7.1, "Joint**

Interface Plans (JIP),” The information must be updated with newly identified MSHCN by the 10th day of each month.

In the event that a MSHCN is disenrolled from the MCO and enrolled in another health plan, such as in STAR, STAR+PLUS, STAR Kids, CHIP, or commercial insurance, the MCO must provide the receiving health plan with information concerning the results of the MCO’s identification and assessment of that Member’s needs, to prevent duplication of those activities.

Once the MCO has identified a Member as MSHCN, it must have effective systems in place to ensure the provision of Covered Services to meet the special, preventive, Community-Based Services, LTSS, primary Acute Care, and specialty health care needs appropriate for treatment of the Member’s condition. The MCO must provide Service Management to MSHCN, including the development of a Health Care Service Plan and ensuring access to a multidisciplinary team when necessary, as described in **Section 8.1.14**.

To ensure Continuity of Care, if a MSHCN is transitioning from another health plan, the MCO must contact the Member’s prior health plan and request information regarding the Member’s needs, current medical necessity determinations, authorized care and treatment plans. To ensure Continuity of Care for a MSHCN receiving services authorized in a treatment plan by their prior health plan, the Service Manager will authorize the Member to continue with his or her provider, and allow an OON authorization to ensure the Member’s condition remains stable and services are consistent to meet the Member’s needs. The OON authorization will continue until the authorized treatment plan is completed or the MCO can provide comparable services to transition the Member to a Provider who will be able to meet the Member’s complex needs.

The MCO must have Network PCPs and specialty care Providers that have demonstrated experience with MSHCN, including SED, in pediatric specialty centers such as Children’s Hospitals, teaching Hospitals, and tertiary care centers, and in community mental health centers or other venues for treatment of SED.

The MCO must provide access to PCPs and specialty care Providers with experience serving MSHCN, including SED and Members who have experienced trauma, Abuse or Neglect. Such Providers must be board-qualified or board-eligible in their specialty. The MCO may request exceptions from HHSC for approval of traditional Providers who are not board-qualified or board-eligible but who otherwise meet the MCO’s Credentialing requirements.

The MCO must have a mechanism in place to allow MSHCN to have direct access to specialists as appropriate for the Members’ conditions and identified needs, such as a standing referral to a specialty physician. The MCO must also provide MSHCN with access to non-primary care physician specialists as PCPs, as required by 28 Tex. Admin. Code § 11.900 and **Section 8.1.4.2**, “Primary Care Providers and the Medical Home.”

The MCO must provide information and education in its Member handbook and Provider manual about treatment planning available for MSHCN, including the availability of Service Management.

### **8.1.13.2 Access to Care and Service Management**

Section  
8.1.13.2  
modified by  
Versions  
2.2 and 2.3

The MCO must provide Service Management to facilitate the provision of integrated Covered Services to meet the special preventive, primary Acute Care, Community-Based Services, LTSS, and specialty healthcare needs appropriate for treatment of the individual Member's condition(s). The MCO Service Managers must identify Members who may benefit from Service Management, conduct a screening and provide Service Management when appropriate. The MCO must contact the identified Member, Caregiver, DFPS Staff or Medical Consenter to communicate the benefits of Service Management and encourage the Member's participation in Service Management. Service Management is not solely for MSHCN. PCPs, PCP Teams, Caregivers, Medical Consenters, and DFPS Staff can request Service Manager assistance at any time to coordinate healthcare planning and the integrated delivery of all Covered Services. Service Management includes coordination of services and authorizations to prevent duplication for clients who require THSteps - Comprehensive Care Program Services, such as coordination between private duty nursing and PPECC providers.

To ensure Continuity of Care for MSHCN receiving services authorized in a treatment plan, transition plan, or Individual Service Plan (ISP) by their prior health plan, the MCO and Service Managers will work with the Member's current PCP and specialists to ensure the Member's condition remains stable and services are consistent to meet the Members ongoing needs. The Service Manager will authorize the transitioning Member's OON providers to continue with the current treatment plan authorized by the Member's prior health plan until the initial HCSP is completed or the MCO can provide comparable services to transition the Member to a Provider who will be able to meet the Member's complex needs.

For Dual Eligible Members, the Service Manager must work with the Member's PCP to coordinate all Covered Services and any applicable Non-capitated Services, regardless of whether the PCP is in the MCO's Network. Dual Eligible Members receive most Acute Care services through Medicare, rather than Medicaid. Service Managers must coordinate Medicare and Medicaid services for Dual Eligible Members.

The MCO will complete Service Management screenings for all new Members to establish the degree to which Service Management is needed. During this telephonic screening, the MCO must ensure that the Medical Consenter is aware that Members in category 1 of the Target Population age 3 and older must receive the Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 days of receipt on the DNF. The MCO must assist in scheduling this assessment with a BH Provider that is trained and certified in the administration of the CANS assessment tool.

An initial HCSP must be completed within 45 days of receipt of the Member on the DNF for each new Member whose screening indicates a need for Service Management. The initial HCSP must include recommend services indicated on the results page of the Texas Comprehensive CANS 2.0 (child welfare) assessment. Service Management or Service Coordination must be offered to the Member or the Member's Caregiver if the results of the Service Management screening or the Texas Comprehensive CANS 2.0 (child welfare) assessment indicate a need for either of these services.

The MCO will complete a new Service Management screening each time a Member moves to a new placement. If the screening indicates the need for Service Management, an HCSP must be completed or updated by the MCO within 30 days of notification of the Member's move to a new placement.

The MCO will develop a process by which Members' HCSPs are reviewed and updated on a regular basis. The HCSP must be updated each time an annual Texas Comprehensive CANS 2.0 (child welfare) assessment is completed. The HCSP for Members with an SED must include a contingency crisis plan.

The MCO must provide information and education in its Member handbook and Provider manual explaining how Members, Caregivers and Medical Consenters may access Service Management. The MCO is responsible for providing Service Management to assist in developing a HCSP for Members enrolled in Service Management, and to facilitate access to clinical treatment and services recommended by the PCP Team or the results of the Texas Comprehensive CANS 2.0 (child welfare) and approved by the DFPS Caseworker, Member, or their Medical Conserter. A refusal to utilize Service Management and the development of a HCSP for a Member must be authorized by the DFPS caseworker.

Service Managers who provide assistance to MDCP Members must be trained in the following:

1. The full MDCP service array and program requirements;
2. Provider requirements for each service described in **Section 8.2**, "Additional Requirements Regarding the Medically Dependent Children Program (MDCP)"; and
3. The three service delivery options described in **Section 8.1.41**, "Service Delivery Options".

For all MDCP Members, the HCSP must include the MDCP plan of care and meet all additional requirements in **Section 8.2**, "Additional Requirements Regarding the Medically Dependent Children Program (MDCP) and subsections.

Service Managers will work with the PCP Team to avoid separate and fragmented evaluations, HCSPs and treatment. The MCO's Service Management process and procedures for assisting Members must include how the Service Manager will:

1. work with DFPS staff, SSCC staff, Members, Medical Consenters, PCPs, specialists, other Providers and DM staff to ensure that the Member's medical and BH needs are coordinated;
2. ensure that the Texas Comprehensive CANS 2.0 (child welfare) has been completed timely, and the results and recommendations shared with Members, DFPS Staff, Medical Consenters, and PCP Teams and included in the Member's HCSP;
3. identify Members who are suspected of having an SED and arrange for an assessment by a comprehensive provider using the Child and Adolescent Needs (CANS) or other appropriate standardized clinical instrument;
4. work with the Member, DFPS Staff, Caregiver and Medical Conserter to assist them in accessing Non-capitated Services;
5. prepare and present specialty care recommendations to the PCPs and specialists or PCP Teams to consider including in the Member's HCSP;

6. participate in Hospital pre-admission planning for non-emergency hospitalizations and discharge planning;
7. evaluate and report Member's clinical progress and adherence to the HCSP and include this information in the Health Passport after discussing with the PCP or PCP Team and other parties involved in the healthcare planning process;
8. provide information, and involvement from MCO staff, as requested by DFPS Staff to facilitate development of the DFPS Case Plan and coordination with DFPS Case Management Services, including participation in DFPS Family Group Conferences (FGCs), where professionals share information, concerns, and resources with the family and assist the family in the development of a Service Plan;
9. encourage BH Providers to use EBPs and promising practices and confirm that BH Providers and PCPs are sharing information as required in **Section 8.1.17.4**, "Coordination between the BH Provider and the PCP;"
10. serve as a Member Advocate as indicated in **Section 8.1.33.10**, "Member Advocates;"
11. outreach to Members transitioning into Target Population categories 3-4, refer to the Transitioning Youth Program (TYP) and develop Transition Plans, as needed;
12. for MDCP Members, the development of an MDCP plan of service as described in **Section 8.2**;
13. ensuring that services such as private duty nursing and PPECC are coordinated to prevent duplication between home health agencies, PPECCs, therapy providers, and other Comprehensive Care Program (CCP) providers; and
14. provide other clinical Service Management functions as required to meet Member's healthcare needs.

The MCO Service Managers may request and review DFPS case plans, safety plans and permanency plans during the HCSP development and monitoring process.

#### **8.1.14 Service Coordination**

Section  
8.1.14  
modified by  
Version 2.3

The MCO must implement a systematic administrative process to coordinate access to services, including Non-capitated Services, and information at the request of a Member, DFPS Staff, Caregiver, Medical Consenter, or PCP. The MCO must also coordinate with DFPS Case Management Services, whose function is to enlist the involvement of community organizations that may not be providing Covered Services but are otherwise important resources to help Members in maintaining health and well-being.

The MCO's Service Coordination process and procedures for assisting Members, Caregivers and Medical Consenters must include how the MCO will:

1. facilitate access to primary, dental and specialty care and support services, including assisting Members, Caregivers and Medical Consenters with locating Providers and scheduling appointments as necessary;
2. expedite the scheduling of assessments used to determine residential placements as requested by DFPS, and as required in **Section 8.1.11**, "Coordination with the Department of Family and Protective Services." (The MCO must give top priority to this function in its Service Coordination operations);
3. clarify and provide access to information regarding the PA process;

4. clarify Program requirements and processes, including the Member Pre-Appeals and Appeals processes and how the MCO will provide assistance with navigating these processes;
5. educate the MCO's staff that when medical information is required by DFPS or is necessary for court hearings, and the Provider has not timely responded to a DFPS request or a court's subpoena or request for medical information, the MCO's Provider Relations Representatives must timely contact the Provider in question to encourage him or her to provide the requested information, and remind the Provider of his or her legal obligations to produce this information, including those obligations arising out of the Network Provider Contract with the MCO;
6. coordinate with DFPS Case Management Services, which facilitate referrals and access to services provided by other agencies and community resources;
7. assist Members, Caregivers and Medical Consenters with other coordination needs as needed;
8. coordinate the sharing of health information between Providers and other Programs, such as ECI;
9. ensure coordination with and referral to DSHS Case Management for CPW, per the *Frew v. Smith, et. al.* consent decree;
10. ensure Members with transportation needs for medical appointments receive assistance through the HHSC's NEMT Program;
11. share information with DFPS Forensic Assessment Centers; and
12. represent the MCO at meetings with Community Resource Coordination Groups (CRCGs).

The MCO will contact all Members, Caregivers and Medical Consenters upon enrollment to notify them of the availability of Service Coordination and its functions. The MCO will provide additional outreach about the availability of Service Coordination (such as additional phone calls or mailings) to Caregivers and Medical Consenters of Members identified by DFPS as having special healthcare needs, to parents of children in their own home, and to Caregivers and Medical Consenters of Members in relative placements. The MCO will also encourage Caregivers and Medical Consenters to use Service Coordination services.

Members, DFPS Staff, Caregivers, Medical Consenters, or PCPs may request Service Coordination from the MCO. A Service Coordinator will contact the Member, DFPS Staff, Caregiver, Medical Consenter, or PCP by the next Business Day upon receipt of a request for Service Coordination.

The MCO will maintain an adequate number of Service Management and Service Coordination personnel and management having expertise in physical health, BH, and the STAR Health population to meet the needs of the population, as measured by the timely completion of assessments and HCSPs and successful coordination of services as required by **Section 8.1.13.2**, "Coordination Between the BH Provider and the PCP." The MCO will continue to assess the staff's ability to complete these functions in a timely nature, and will take corrective action as necessary.

The MCO's Service Management and Coordination model will offer specialized teams having additional expertise to assist those experiencing acute episodes or severe complex conditions.

The MCO will maintain a sufficient number of regional offices in which Service Management and Service Coordination teams will be housed. Regional offices will be located in areas throughout the state that are determined by agreement between the MCO and HHSC to have the greatest member density.

### **8.1.15 Health Home Services**

Section  
8.1.15  
modified by  
Version 2.3

The MCO must provide Health Home Services. The MCOs must include a designated Provider to serve as the health home. The designated Provider must meet the qualifications as established by the U.S. Secretary of HHS. The designated Provider may be a Provider operating with a team of health professionals, or a health team selected by the enrollee. The Health Home Services must be part of a person-based approach and holistically address the needs of persons with multiple Chronic (or Complex) Conditions or a single serious and persistent mental or health condition.

Health home services must include:

1. patient self-management education;
2. Provider education;
3. EBPs and minimum standards of care;
4. standardized protocols and participation criteria;
5. Provider-directed or Provider-supervised care;
6. a mechanism to incentivize Providers for provision of timely and quality care;
7. implementation of interventions that address the continuum of care;
8. mechanisms to modify or change interventions that are not proven effective;
9. mechanisms to monitor the impact of the Health Home Services over time, including both the clinical and the financial impact.
10. comprehensive care management;
11. care coordination and health promotion;
12. comprehensive traditional care, including appropriate follow-up, from inpatient to other settings;
13. patient and family support (including authorized representatives);
14. referral to community and social support services, if relevant; and
15. use of health information technology to link services, as feasible and appropriate.

The health home services requirements do not apply to Dual Eligible Members.

#### **8.1.15.1 Health Home Services and Participating Providers**

Section  
8.1.15.1  
modified by  
Version 2.3

HHSC encourages MCOs to develop provider incentive programs for designated Providers who meet the requirements for patient-centered health homes found in Texas Government Code § 533.0029.

At a minimum, the MCO must:

1. maintain a system to track and monitor all Health Home Services participants for clinical, utilization, and cost measures;
2. implement a system for Providers to request specific Health Home interventions;

3. inform Providers about differences between recommended prevention and treatment and actual care received by Members enrolled in a Health Home Services program and Members' adherence to a Service Plan;
4. incentivize Health Home Providers to develop their expertise in child welfare and their experience in TIC; and
5. provide reports on changes in a Member's health status to his or her PCP for Members enrolled in a Health Home Services program.

The MCO must make efforts to develop a series of enhanced clinics that have expertise in child welfare, TIC, and disorders and conditions prevalent in the STAR Health population, and are capable of providing peer-to-peer consultation and support to less experienced Providers, according to the HHSC approved implementation plan.

#### **8.1.16 Disease Management (DM)**

The MCO must provide, or arrange to have provided to Members, comprehensive DM services consistent with state statutes and regulations. Such DM services must be part of a person-based approach to DM and holistically address the needs of Members with multiple Chronic (or Complex) Conditions. The MCO must develop and implement DM services that relate to Chronic (or Complex) Conditions that are prevalent in Members. The MCO must have DM Programs that address Members with Chronic (or Complex) Conditions. The MCO must evaluate the priority needs of the STAR Health population on a regular basis with the goal of determining the relevancy and impact of additional or alternative DM programs. HHSC will not identify the Members with Chronic (or Complex) Conditions. The MCO must implement policies and procedures to ensure that Members that require DM services are identified and enrolled in a DM program.

The MCO must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of Members at risk for or diagnosed with Chronic (or Complex) Conditions identified the MCO as candidates for DM. The MCO must ensure that all Members identified for DM are enrolled into a DM Program with the opportunity to opt out of these services within 30 days while still maintaining access to all other Covered Services. A refusal to utilize Disease Management for a Member must be authorized by the DFPS caseworker.

The DM Program(s) must include:

1. patient self-management or Caregiver and Medical Consenter care management education;
2. provider education;
3. EBPs and minimum standards of care;
4. standardized protocols and participation criteria;
5. physician-directed or physician-supervised care;
6. a continuum of interventions to address individualized need;
7. mechanisms to modify or change interventions that are not proven effective; and
8. mechanisms to monitor the clinical and financial impact of the DM Program over time.

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

The MCO must provide designated staff to implement and maintain DM Programs and to assist participating Members and their Medical Consenters in accessing DM services. The MCO must educate Members, Caregivers, Medical Consenters, DFPS staff, and Providers about the MCO's DM Programs and activities. Additional requirements related to the MCO's DM Programs and activities are found in **UMCM Chapter 9.3**, "STAR Health Disease Management Requirements."

For all new Members not previously enrolled in the MCO and who require DM services, the MCO must evaluate and ensure continuity of care with any previous DM services in accordance with the requirements in **UMCM Chapter 9.3**, "STAR Health Disease Management Requirements."

#### **8.1.16.1 Special Populations**

Section  
8.1.16.1  
modified by  
Version 2.3

The MCO is required to have a specialized program for targeting, outreach, education and intervention for Members who have excessive utilization patterns that indicate typical DM approaches are not effective. For the purposes of this contract, this group of Members is called "super-utilizers." The MCO must have the following infrastructure in place to address super-utilizers' needs, using, at a minimum, the following criteria:

1. Methodology for identification of super-utilizers on an ongoing basis, based on cost, utilization of the ER, utilization of inpatient or pharmacy, services, physical and behavioral health comorbidities, or other specified basis;
2. resources dedicated to ongoing targeting and identification of super-utilizers such as staff, specialized analytical tools, etc.;
3. staff resources for effective outreach and education of Providers and super-utilizers;
4. specialized intervention strategies for super-utilizers. The interventions must include an option for in-person interactions with the Member that occur outside of a standard clinical setting. This in-person intervention may be performed by medical care Providers or other non-medical providers that are employed by the MCO or are subcontracted with the MCO; and
5. evaluation process to determine effectiveness of super-utilizer program. As part of the annual evaluation of effectiveness, the MCO should include a description or example of an intervention it found effective. It can be a member case study with a description of the interventions and improvements or a specific project with demonstrated effectiveness.

No later than November 1 of each year, the MCO must provide a plan for management of super-utilizers including the criteria listed above using **UMCM Chapter 9.4**, "Plan for Special Populations Program." HHSC will evaluate the plan and provide feedback to the MCO. Upon HHSC's approval of the plan, each MCO will be retrospectively evaluated on their execution of the written plan, as described in **Section 8.1.16.3**, "Disease Management Evaluation." An MCO may reuse elements of the same plan from year to year as long as submission reflects the current state of their special population program and is updated as necessary on evaluation methodologies and key findings. HHSC may request updates to the plan during the state fiscal year as part of ongoing quality improvement efforts.

The MCO is also required to have a specialized program for targeting and providing outreach, education and intervention for Members who are transitioning to adulthood. Members approaching age 18 will require additional education and supports to understand their rights and responsibilities as adult Members, including actions they will need to take in order to stay connected to their benefits and services. Members approaching age 21 will require additional education and supports to understand the service and benefit changes that will occur following their 21st birthday.

The MCO must provide ongoing transition planning that includes:

1. health and wellness education,
2. assistance with self-management of their own healthcare services,
3. identifying adult healthcare providers, particularly for Members with Special Healthcare Needs,
4. transitioning Medicaid services and benefits from STAR Health to the STAR or STAR+PLUS Medicaid managed care models without a break in service, when applicable, and
5. ensuring the Member, the Member's Medical Consenter, Caregiver, and DFPS are aware of available programs, services, and supports the Member may utilize to improve their well-being as an adult.

#### **8.1.16.2 Disease Management (DM) Services and Participating Providers**

At a minimum, the MCO must:

1. implement a system for Providers to request specific DM interventions;
2. give Providers and Service Managers information, including information about differences between recommended prevention and treatment and actual care received by Members enrolled in a DM Program, and information concerning such Members' adherence to an HCSP; and
3. for a Member enrolled in a DM Program, provide reports on changes in a Member's health status to their PCP and Service Manager.

HHSC encourages MCOs to develop Provider incentive programs for designated Providers who meet the requirements for patient-centered medical homes found in Texas Government Code § 533.0029.

#### **8.1.16.3 Disease Management (DM) Evaluation**

HHSC or its EQRO will evaluate the MCO's DM Program. The MCO must provide all information HHSC deems necessary for such evaluation.

HHSC or its EQRO will also evaluate DM as it relates to specialized populations identified in **Section 8.1.16.1**, "Special Populations." These evaluations will be on a retrospective basis, and will include an analysis of MCO Encounter Data and other relevant data (e.g., reports). Evaluations could also include interviews with MCO staff that oversee the program as well as identified Providers. Based on HHSC's retrospective evaluation, MCOs may be required to submit a Corrective Action Plan if directed by HHSC.

It is HHSC's intent to hold quarterly collaborative calls or webinars with MCO medical directors to discuss plan implementation, barriers, successful strategies, etc.

### **8.1.17 Behavioral Health (BH) Services and Network**

Section  
8.1.17  
modified by  
Versions  
2.2 and 2.3

The MCO must provide or arrange for the delivery of all Medically Necessary community-based, rehabilitative, and inpatient Hospital BH Services. BH Services include Covered Services for the treatment of mental, emotional, or clinical dependency disorders. As is allowed in Medicaid Fee-for-Service, the MCO must cover up to three five-day extensions in a Psychiatric Hospital after treatment is completed if DFPS Staff is in the process of finalizing the Member's placement. The MCO will encourage all contracted Psychiatric Hospitals that have psychiatric bed capacity to expand their inpatient BH service capacity. PA processes for BH Services must recognize the intensive or ongoing need for these services often present among the STAR Health population, and should not be unnecessarily burdensome to Providers or Members. Therefore, the MCO will not require a PA for all outpatient medication management services, and a PA will not be required for the first ten outpatient BH sessions, to include the initial evaluation.

The MCO must comply with DFPS rules and licensing standards regarding the provision of Covered Services, including certain BH Services, to the STAR Health population. Information on these requirements is available at [http://www.dfps.state.tx.us/Site\\_Map/rules.asp](http://www.dfps.state.tx.us/Site_Map/rules.asp). The MCO also must comply with 28 Tex. Admin. Code Chapter 3, Subchapter HH, regarding standards for chemical dependency treatment, and understand that to comply with Texas Family Code § 266.012, the MCO must ensure each Member in category 1 of the Target Population age 3 and older receives a Texas Comprehensive CANS 2.0 (child welfare) assessment within 30 days of receipt of the DNF. Medicaid BH Services are described in further detail in the **TMPPM**.

The MCO may provide BH Services not only in offices and clinics, but also in schools, homes, and other locations as appropriate. A continuum of services, as indicated by the BH needs of Members, must be available. The MCO must include Providers in its Network who utilize EBPs and promote Provider use of EBPs.

BH assessments must include a primary and secondary (if present) diagnosis using the Diagnostic and Statistical Manual (DSM) multi-axial classification. Because BH and substance abuse problems commonly occur in Members, the MCO must screen all such Members for both types of problems. Diagnostic information and outcome measurement information must be documented in the Member's Health Passport.

The MCO must contractually require BH Providers to:

1. assess applicable Members using the Texas Comprehensive CANS 2.0 (child welfare) assessment tool within 30 days of entering conservatorship, or refer to a provider who is trained and certified to perform this assessment;
2. evaluate each Member's progress using a standardized outcome measurement instrument, to be provided by the MCO, quarterly at a minimum, and at termination of the HCSP, or as significant changes are made in the HCSP;
3. document the outcome measurement scores in the Health Passport;
4. function as a member of the PCP Team by coordinating with the PCP and Service Manager as appropriate; and

5. testify in court as needed for child protection litigation.

The MCO must contractually require BH Providers to provide the following information for the Health Passport:

1. Primary and secondary (if present) diagnosis;
2. assessment information;
3. brief narrative summary of clinical visits/progress;
4. scores on each outcome rating form(s);
5. referrals to other Providers or community resources;
6. evaluations of each Member's progress at intake, monthly, and at termination of the HCSP, or as significant changes are made in the treatment plan; and
7. any other relevant care information.

The BH Provider must also submit an initial and monthly (or more frequently, if a Member's medical condition indicates) narrative summary report of a Member's BH status for inclusion in the Health Passport. This information will be available to the Member's Providers, the Service Management Team, and DFPS staff.

The MCO must contractually require that PCPs use the Texas Health Steps BH forms, at a minimum, for the detection and treatment of, or referral for, any known or suspected BH problems and disorders. Members must be screened for BH problems, including possible substance abuse or chemical dependency. The PCP must submit completed Texas Health Steps screening and evaluation results to the MCO to include in the Health Passport.

Children and young adults in the STAR Health population often have been victims of severe physical and emotional trauma, including sexual abuse. The MCO must encourage Providers to use EBPs and promising practices that are demonstrated through research to be effective with these traumas, such as TF-CBT, PCIT, CPP, and TBRI, and to address risk factors and stressors that influence future Abuse, Neglect, and Exploitation. BH treatment may require family counseling, when family reunification is planned.

#### **8.1.17.1 Behavioral Health (BH) Provider Network**

Due to the significant BH needs of the STAR Health population, appropriate access to BH Services is considered a critical component of effective healthcare for this population. The MCO must contract with BH Providers specializing in treatment of issues that are common to children and young adults in the STAR Health population such as abuse, neglect, sexual offender behavior, and exposure to complex and multiple traumas, in order to meet the BH needs of the STAR Health population. To the extent available, the Network must include Providers that utilize EBPs and promising practices specific to the diagnoses of the STAR Health population. The Network must also include Providers that are trained and certified in the administration of the CANS assessment.

The MCO must continue to make efforts to train BH Providers in Parent Child Interaction Therapy (PCIT), according to the HHSC approved implementation plan.

The MCO must include Significant Traditional Providers (STPs) of these benefits in its Network, and provide such STPs with expedited credentialing. The MCO must enter into Provider

Agreements with any willing STP of these benefits that meets the Medicaid enrollment requirements and MCO credentialing requirements, and agrees to the MCO's contract terms and rates.

The MCO must maintain a Provider education process to inform BH Providers in the MCO's Network on how to refer Members for treatment.

Provider Network capacity and distribution must permit Members to have ready access to services as specified in **Sections 8.1.3**, "Access to Care," and **8.1.4**, "Provider Network."

The Network must include psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; LCSWs; LMFTs; LPCs; QMHPs working under the authority of an LMHA and as defined in TAC Title 25, Part 1, Chapter 412; Licensed Adolescent Chemical Dependency Treatment facilities; and LCDCs with experience treating adults and adolescents. The Network must include Providers who are trained in and knowledgeable about:

1. screening and treating co-occurring BH and substance abuse disorders;
2. treating physical and sexual abuse and in providing sex offender treatment, such as registered sex offender treatment Providers;
3. Lesbian, Gay, Bi-sexual, Transgender (LGBT) related issues;
4. eating disorders;
5. TF-CBT screening, treatment, and assessment;
6. the diagnosis and treatment of Intellectual or Developmental Disabilities (IDD);
7. treating young children;
8. treating children dually diagnosed with IDD and BH issues;
9. treating children with autism;
10. screening and treating children with Fetal Alcohol Syndrome (FAS) or related disorders; and
11. administration of the Texas Comprehensive CANS 2.0 (child welfare) assessment tool.

The MCO must use available televideo technology, i.e., telemedicine, to increase access to specialty BH assessment and treatment Providers.

To best address the special needs of the STAR Health population and provide effective treatment, Network Providers must be culturally competent and sensitive to Member issues. The MCO must ensure equal access to services by all racial and ethnic populations, and improve service delivery to underserved populations. The Network must also include clinicians and early intervention specialists who use EBPs for disorders common to the STAR Health population. To the extent possible, the diversity of the Network should reflect the cultural groups of children and young adults in the STAR Health population.

#### **8.1.17.2 Self-referral for Behavioral Health (BH) Services**

The MCO must permit Members, DFPS Staff, or Medical Consenters to participate in the selection of appropriate BH Providers. The MCO must allow Members or their Medical Consenters to self-refer to any Network BH Provider. If the Member has not been assessed as needing BH Services, the MCO must require an assessment to authorize treatment. The MCO

policies and procedures, Provider manual, and Member handbook must clearly specify how the Member may self-refer for services.

### **8.1.17.3 Behavioral Health (BH) Hotline and Emergency Services**

Section  
8.1.17.3  
modified by  
Version 2.3

This Section discusses BH Hotline functions pertaining to Member Hotlines. BH Provider Hotline requirements are referenced in **Section 8.1.4.8**, "Provider Hotlines."

The MCO must operate a toll-free BH Hotline to handle routine behavioral-health related calls. The MCO cannot impose maximum call duration limits, and must allow that calls can be of sufficient length to provide adequate information to Members, DFPS Staff, Providers, Caregivers and Medical Consenters. Only those persons who can identify themselves through the caller verification process approved by HHSC may obtain personal health information through the BH Services Hotline. Hotline services must meet Cultural Competency requirements and provide linguistic access to all Members, including interpretive services required for effective communication. Hotline staff must be trained regarding: a) emergency prescription process and what steps to take to immediately address Members' problems when pharmacies do not provide a 72-hour supply of emergency medicines; and b) DME processes for obtaining services and how to address common problems. The 24-hour BH Hotline will attempt to respond immediately to problems concerning emergency medicines by means at its disposal, including explaining the rules to Members so that they understand their rights and, if need be, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy processes. Hotline staff must also be trained regarding the availability of and access to substance abuse treatment services, including information on self-referral.

The MCO must conduct ongoing quality assurance activities to ensure the following standards are met:

1. At least 99 percent of calls are answered by the fourth ring or an automated call pick-up system;
2. 0 percent of incoming calls receive a busy signal;
3. at least 80 percent of calls are answered within 30 seconds;
4. the call abandonment rate is seven percent or less; and
5. the average hold time is two minutes or less.

The MCO must monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated in **Section 8.1.26.2**, "Reports," and the "Behavioral Health Services Hotline Report" in **UMCM Chapter 5.4.3**, "Hotline Reports".

The MCO must have a BH Services Hotline, answered by a live voice, staffed by trained personnel and available 24 hours per day, 7 days a week, toll-free throughout the state which addresses routine and crisis BH calls. The Hotline must be staffed by or have access to qualified BH professionals to assess emergencies. Clinicians staffing the BH Services Hotline must be available to accept emergency and crisis calls. The MCO may operate one Hotline to handle behavioral health calls (including emergency and crisis behavioral health calls) and other routine calls unrelated to behavioral health as long as requirements related to emergency and crisis calls are met. However, the MCO must submit hotline performance reports separately as required by **UMCM Chapter 5.4.3**, "Hotline Reports." Routine calls received from Providers,

Members, DFPS Staff, Caregivers and Medical Consenters on an emergency Hotline after normal business hours will be returned the next Business Day. The MCO may use mobile crisis teams to provide on-site emergency response services.

If HHSC determines that it is necessary to conduct onsite monitoring of the MCO's BH Services Hotline functions, the MCO is responsible for all reasonable travel costs incurred by HHSC or its authorized agent(s) relating to such monitoring. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring.

#### **8.1.17.4 Coordination between the BH Provider and the PCP**

Section  
8.1.17.4  
modified by  
Versions  
2.2 and 2.3

The MCO must ensure that the behavioral and physical health clinical Member information is shared efficiently and effectively between the PCP and BH Providers. If the MCO uses a BHO as a Material Subcontractor, the MCO must ensure that MCO and BHO have shared, integrated data systems to facilitate Service Management, Service Coordination and the timely sharing of Member information with PCPs and BH specialists.

The MCO must require, through Provider Contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected BH problems and disorders. The MCO must provide training to Network PCPs on:

1. using the results and recommendations of the Texas Comprehensive CANS 2.0 (child welfare) assessment tool to guide treatment decisions,
2. the MCO's referral process for BH Services and clinical coordination requirements for such services, and
3. coordination and quality of care such as BH screening techniques for PCPs and new models of BH interventions.

The MCO shall develop and disseminate policies regarding clinical coordination and the sharing of Member information between BH Providers and PCPs, as clinically indicated. The MCO must require that BH Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment. The MCO must require that PCPs and BH Providers engage in an appropriate level of communication and consultation necessary to properly assess, evaluate, refer, or treat a Member with both a physical health and BH condition. The MCO must develop in concert with PCPs, child psychiatrists and other relevant BH Providers a simple communication format for sharing information between BH Providers and PCPs and other subspecialty Providers, and require the use of such form for sharing necessary information among the PCP Team. The MCO must educate all Members of the PCP Team to understand the role of Service Coordinator and Service Manager in the coordination and sharing of health information and status. BH Providers may only provide physical Healthcare Services if they are licensed in Texas to do so.

The MCO must require that BH Providers and PCPs send each other initial and quarterly (or more frequently if clinically indicated, directed by a PCP Team, or court-ordered) summary reports of a Members' physical and BH status, as agreed to by the PCP Team members. The reports must include information required for judicial review of medical care under Texas Family

Code § 266.007. This requirement must be specified in Provider Contracts, handbooks and manuals.

PCPs must screen Members for any BH condition, and may treat Members within the appropriate scope of their practice and refer Members for treatment through the Provider Network.

The MCO must use evidence-based integrated healthcare practices. These practices include, for example, the use of an appropriate outcome measurement instrument to monitor effectiveness of medication and psychotherapy, and access to psychiatric consultation for the PCP and Service Manager. The MCO must contractually require all Providers to comply with the most recent version of the *Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care* found at [https://www.dfps.state.tx.us/Child\\_Protection/Medical\\_Services/guide-psychotropic.asp](https://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp).

The MCO should seek to recruit PCPs and BH Providers who are located in the same office or clinic to facilitate access to treatment and services. The MCO will include in its trainings, Provider Materials and handbooks guidelines, policies and procedures related to physical and BH coordination of treatment and services. The MCO should seek to recruit providers who practice using the Medical Home Services Model and IPC Model. The MCO should actively promote these models, provide training in these models, and may differentially reimburse for these models as they have been shown to be more fiscally efficient and clinically effective in the early identification and treatment of BH problems.

MCO training for PCPs must include the use of valid screening and assessment instruments as well as the use of the Texas Health Steps Forms. The MCO must provide training to Network PCPs on identifying and referring Members three years of age and older suspected of having a developmental delay or developmental disability, SED, mental illness, or chemical dependency. The MCO must ensure that PCPs have valid screening and assessment instruments to identify and refer children to Providers specializing in evaluations to determine whether a child or young adult has a developmental disability, or is at risk for or has a serious emotional disturbance or mental illness. The MCO must also ensure that Members who may need access to ICF/IIDs and home and community-based 1915(c) waiver services receive the appropriate evaluation and psychometric testing required for admission to these facilities or approval of waiver services.

The MCO must provide training to Network PCPs on identifying and referring Members for BH assessments and for neuropsychological assessments to determine if Members have suffered trauma to the brain. The MCO will provide information on EBPs for BH problems commonly seen in primary care (e.g., depression and anxiety disorders). The MCO will encourage PCPs to contact MCO Service Managers to discuss the Member's needs, referral and treatment options, and request names of specialty BH Providers to address the Member's special needs. For rural areas, the MCO must assist PCPs and other Providers with access by facilitating specialty consults through the use of telemedicine technology. Provider training must include information on how to access televideo resources.

The MCO shall require BH Providers to refer Members with known or suspected and untreated physical health problems or disorders to their PCP.

### **8.1.17.5 Follow-up after Hospitalization for BH Services**

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

### **8.1.17.6 Substance Abuse and Dependency Treatment Services**

The MCO must comply with 28 Tex. Admin. Code § 3.8001 *et seq.*, regarding UR for Substance Abuse and Dependency Treatment. Substance Abuse and Dependency Treatment must conform to the standards set forth in 28 Tex. Admin. Code Chapter 3, Subchapter HH. Substance use disorder includes substance abuse and dependence as defined by the current DSM.

#### **8.1.17.6.1 Providers**

Providers for the substance abuse and dependency treatment benefit include: Hospitals, chemical dependency treatment facilities licensed by the DSHS, and practitioners of the healing arts.

The MCO must include STPs of these benefits in its Network, and provide such STPs with expedited credentialing. The MCO must enter into Provider Contracts with any willing Significant Traditional Provider (STP) of these benefits that meets the Medicaid enrollment requirements, the MCO's credentialing requirements, and agrees to the MCO's contract terms and rates. For purposes of this section, STPs are providers who meet the Medicaid enrollment requirements and have a contract with the DSHS to receive funding for treatment under the Federal Substance Abuse Prevention and Treatment block grant. The STP requirements described in this section are not limited to the first three years of operations.

MCOs must maintain a Provider education process to inform substance abuse treatment Providers in the MCO's Network on how to refer Members for treatment.

#### **8.1.17.6.2 Care Coordination**

The MCO must ensure care coordination is provided to Members with a substance use disorder. The MCO must work with Providers, facilities, and Members to coordinate care for Members with a substance use disorder and to ensure Members have access to the full continuum of Covered Services (including without limitation assessment, detoxification, residential treatment, outpatient services, and medication therapy) as Medically Necessary and appropriate. The MCO must also coordinate services with the DSHS, DFPS, Members and Medical Consenters for Members requiring Non-Capitated Services. Non-Capitated Services include services that are not available for coverage under the Contract, State Plan, or Waiver that are available under the Federal Substance Abuse and Prevention and Treatment block grant when provided by a DSHS-funded provider or covered by the DFPS under direct contract with a treatment provider. The MCO must work with DSHS, DFPS, and providers to ensure payment for Covered Services

is available to OON providers who also provide related Non-capitated Services when the Covered Services are not available through Network Providers.

#### **8.1.17.7 Court-ordered Services**

The MCO must provide inpatient psychiatric services to Members who have been ordered to receive the services by a court of competent jurisdiction under Texas Health & Safety Code Chapters 573 and 574, relating to Court-Ordered Commitments to inpatient BH facilities. The MCO is not obligated to cover placements as a condition of probation that are authorized by the Texas Family Code. These placements are Non-capitated services.

The MCO cannot deny, reduce or controvert the Medical Necessity of inpatient BH services provided pursuant to a Court-ordered Commitment for Members. 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 under Texas Health & Safety Code Chapter 573 or 574 can only appeal the commitment through the court system.

#### **8.1.17.8 Mental Health Rehabilitative Services and Mental Health Targeted Case Management Services**

Mental Health Rehabilitative Services and Mental Health Targeted Case Management Services must be available to eligible STAR Health Members based on the appropriate standardized assessment (the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS) through a qualified Network of entities. Qualified entities can include both LMHAs and other entities, such as multi-specialty groups and clinic/group practices that employ providers of these services.

Section  
8.1.17.8  
modified by  
Versions  
2.1 and 2.3

Mental Health Rehabilitative Services include training and services that help the Member maintain independence in the home and community, such as the following.

1. **Medication training and support** – curriculum-based training and guidance that serves as an initial orientation for the Member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community.
2. **Psychosocial rehabilitative services** – social, educational, vocational, behavioral, or cognitive interventions to improve the Member's potential for social relationships, occupational or educational achievement, and living skills development.
3. **Skills training and development** – skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers.
4. **Crisis intervention** – intensive community-based one-to-one service provided to Members who require services in order to control acute symptoms that place the Member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting.
5. **Day program for acute needs** – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize

acute psychiatric symptoms of prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting.

The MCO must provide Mental Health Rehabilitative Services and Mental Health Targeted Case Management in accordance with **UMCM Chapter 15.1**, “Mental Health Targeted Case Management and Mental Health Rehabilitative Services,” including provider training requirements and the use of the RRUMG to determine whether a change in the Member’s condition or needs warrants a reassessment or change in service. If the Member’s condition warrants a change in service, the Provider must submit a new plan of care to the MCO for authorization. Additionally, the MCO must ensure that providers of Mental Health Rehabilitative Services and Mental Health Targeted Case Management use and are trained and certified to use the Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) tools for assessing a Member’s needs.

The MCO must ensure that it coordinates with providers of Targeted Case Management to ensure integration of behavioral and physical health needs of Members.

#### **8.1.17.9 Mental Health Parity**

The MCO must comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act of 2008.

#### **8.1.18 Dental Services and Dental Network**

The MCO must provide the delivery of all dental Medically Necessary Covered Services as described in the **TMPPM**. Dental services include, without limitation, periodontics, orthodontics, endodontics, pediatric dentistry, and other services included in the **TMPPM**. Dental services must comply with the Texas Health Steps Dental Policy and Procedures and American Academy of Pediatric Dentistry (AAPD) recommendations, and the Texas Medicaid Bulletins. The MCO must ensure the STAR Health population receives a Texas Health Steps dental exam within 60 days of enrollment for Members six months of age and older. Members under 6 months of age at the time of enrollment must receive their initial Texas Health Steps dental checkup within 30 days of becoming 6 months of age. The MCO must recruit and maintain an adequate dental Provider Network, including dentists for First Dental Home for children 6 months through 35 months and MSHCN. Dental services include, without limitation, periodontics, orthodontics, endodontics, pediatric dentistry, and other services included in the **TMPPM**.

The MCO must enroll, train, and support a statewide Network of dental Providers who understand and are responsive to the STAR Health population’s special health and dental care needs. The MCO must undertake an aggressive dentist recruitment strategy in collaboration with the Texas Dental Association (TDA), the Texas Academy of Pediatric Dentists (TAPD), Texas Academy of General Dentistry, the Gulf State Dental Association, the Hispanic Dental Association, and any other interested dental provider organization to the extent these organizations are willing to commit to assistance in the dental provider outreach and recruiting effort.

Section  
8.1.17.9  
added by  
Version 2.1

Dentists providing emergency dental services outside the State of Texas are required to be located in the United States and licensed in the state that the Member received the Emergency Services.

#### **8.1.18.1 First Dental Home**

The MCO must implement a “First Dental Home Initiative” that will enhance dental Providers’ ability to assist Members, Medical Consenters, and Caregivers in obtaining optimum oral healthcare. The First Dental Home visit can be initiated as early as six months of age and must include the following:

1. Comprehensive oral examination;
2. oral hygiene instruction with Caregiver or Medical Conserter;
3. dental prophylaxis, if appropriate;
4. topical fluoride varnish application when teeth are present;
5. caries risk assessment; and
6. dental anticipatory guidance.

Members from 6 through 35 months of age may be seen for dental checkups by a certified First Dental Home Initiative Provider as frequently as every three months if Medically Necessary.

To become a First Dental Home Initiative Provider, the dentist must complete either the online module or an in-person training and submit registration information. The Texas Health Steps online First Dental Home Module is available at <http://www.txhealthsteps.com/catalog/coursedetails.asp?crd=1772> or accessed through [www.txhealthsteps.com](http://www.txhealthsteps.com).

#### **8.1.18.2 Main Dental Home**

Establishment of a client’s Main Dental Home must begin no later than at 6 months of age and includes referrals to dental specialists when appropriate. A Main Dental Home must support an ongoing relationship with the Member that includes all aspects of oral healthcare delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Provider types that can serve as Main Dental Home Providers are FQHCs, RHCs, and individuals who are general dentists or pediatric dentists.

The MCO must require Main Dental Home Providers to provide Members with diagnostic and preventive services in accordance with the AAPD recommendations. The MCO must make best efforts to ensure that Main Dental Home Providers follow these periodicity dental requirements for children. Best efforts must include Provider education, Provider profiling, monitoring, and feedback activities.

#### **8.1.19 Vision Services and Vision Network**

The MCO must provide the delivery of all Medically Necessary Covered Services for vision as described in the **TMPPM**. The MCO must recruit and maintain an adequate vision network, including optometrists for MSHCN.

Section  
8.1.18.2  
modified by  
Version 2.3

The MCO must enroll, train, and support a statewide Network of vision Providers who understand and are responsive to the STAR Health population's special health and vision care needs. The MCO must undertake an aggressive recruitment strategy.

Vision providers providing emergency vision services outside the State of Texas are required to be located in the United States and licensed in the state that the Member received the Emergency Services.

### **8.1.20 Pharmacy Services**

The MCO must provide pharmacy-dispensed prescriptions as a Covered Service.

The MCO must submit pharmacy clinical guidelines and PA policies and 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 and must encourage Network pharmacies to also become Medicaid-enrolled DME providers.

The MCO is responsible for negotiating reasonable pharmacy Provider reimbursement rates, including individual MCO MAC rates, as described in **Section 8.1.20.11**, "Maximum Allowable Cost Requirements." The MCO must ensure that, as an aggregate, rates comply with 42 C.F.R. Part 50, Subpart E, regarding upper payment limits.

#### **8.1.20.1 Formulary and Preferred Drug List (PDL)**

Section  
8.1.20.1  
modified by  
Versions  
2.1 and 2.2

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.

#### **8.1.20.2 Prior Authorization (PA) for Prescription Drugs and 72-Hour Emergency Supplies**

Section  
8.1.20.2  
modified by  
Versions  
2.1 and 2.2

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, [www.txvendordrug.com](http://www.txvendordrug.com) 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 3.29. The MCO may choose to implement additional Clinical PAs once the criteria are approved by the Drug Utilization Review (DUR) Board or by HHSC.

The MCO must submit new Clinical PA proposals to HHSC for DUR Board review and approval. The MCO may also submit any proposed revisions to existing Clinical PAs to HHSC for DUR Board review and approval. The MCO must submit all Clinical PA proposals in compliance with the required information outlined in **UMCM Chapter 3.29**. HHSC will conduct preliminary review of these edit proposals and respond to the MCO before the next DUR Board meeting. If the MCO has clinical PAs that are identical to HHSC VDP's Clinical PAs, the MCO can reference VDP's Texas Medicaid formulary on Epocrates.

HHSC's Medicaid PDL PA, Clinical PA, and other drug policies for the VDP are available on HHSC's VDP website. HHSC's website also includes exception criteria for each drug class included on HHSC's Medicaid PDL. These exception criteria describe the circumstances under which a non-preferred drug may be dispensed without a PDL PA. If HHSC modifies the policies described above on the VDP website, HHSC will notify MCOs.

The MCO may require a prescriber's office to request a PA as a condition of coverage or pharmacy payment if the PA request is approved or denied within 24 hours of receipt. If a prescription cannot be filled when presented to the pharmacist due to a PA requirement and the prescriber's office cannot be reached, then the MCO must instruct the pharmacy to dispense a 72-hour emergency supply of the prescription. The pharmacy is not required to dispense a 72-hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the Member's health or safety, and he or she has made good faith efforts to contact the prescriber. The pharmacy may fill consecutive 72-hour supplies if the prescriber's office remains unavailable. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.

For second generation antiviral drugs used to treat Hepatitis C, a 72-hour emergency rule should not be utilized. These medications require strict prior authorization procedure, however, the immediate dispensing is not required prior to confirming with the prescriber that the specific clinical criteria is met.

The MCO must provide access to a toll-free call center for prescribers to call to request a PDL PA for non-preferred drugs that are subject to Clinical PAs. If the prescriber's office calls the MCO's PA call center, the MCO must provide a PA approval or denial immediately. For all other PA requests, the MCO must notify the prescriber's office of a PA denial or approval no later than 24 hours after receipt. If the MCO cannot make a timely PA determination, the MCO must allow the Member to receive a sufficient supply (e.g., a 72-hour supply) of the medication pending resolution of the PA request.

The MCO must have an automated process that may be used to assess a Medicaid recipient's medical and drug claim history to determine whether the recipient's medical condition satisfies the applicable criteria for dispensing a drug without an additional PA request. (See Texas Government Code § 531.073(h).) This process must automatically evaluate whether a submitted pharmacy claim meets PA criteria for both PDL and Clinical PAs. (See **UMCM, Chapter 2.2.**, Section V for the definition of an Automated PA Request.) The MCO's PA system must accept PA requests from prescribers that are sent electronically, by phone, fax, or mail. The MCO may not charge pharmacies for PA transaction, software, or related costs for processing PA requests.

If the MCO or its PBM operates a separate call center for PA requests, the PA call center must meet the Provider Hotline performance standards set forth in **Section 8.1.4.8**, "Provider Hotline." The MCO must train all PA, Provider Hotline, and pharmacy call center staff on the requirements for dispensing 72-hour emergency supplies of medication.

The MCO may not require a PA for any drug exempted from PA requirements by federal law. For drug products purchased by a pharmacy through the Health Resources Services Administration (HRSA) 340B discount drug program, the MCO may only impose Clinical PA requirements. These drugs must be exempted from all PDL PA requirements.

A Provider may appeal PA denials on a Member's behalf, in accordance with **Section 8.1.33**, "Member Complaint and Appeal System."

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.

Texas Health and Safety Code, Section 483.047 allows a pharmacist to dispense a refill medication without prescriber authorization during a Governor-declared disaster if certain legal requirements are met. The MCO or its PBM may not use circumstances described in Section 483.047(b-1) as a justification for rejecting a claim provided the pharmacy or pharmacist met the requirements set out in that section.

### **8.1.20.3 Coverage Exclusions**

In accordance with 42 U.S.C. § 1396r-8, the MCO must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate

program. The MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product. A list of participating drug companies can be found on the CMS webpage under "Contact Information" (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program.html>).

#### **8.1.20.4 This Section Intentionally Left Blank**

#### **8.1.20.5 Pharmacy Rebate Program**

Under the provisions 42 U.S.C. § 1396r-8, drug companies that wish to have their products covered through the Texas Medicaid Program must sign an agreement with the federal government to provide the pharmacy claims information that is necessary to return federal rebates to the state.

Under Texas Government Code § 533.005 (a)(23)(D)(i), the MCO may not negotiate rebates with drug companies for pharmaceutical products. HHSC or its designee will negotiate rebate agreements. If the MCO or its PBM has an existing rebate agreement with a manufacturer, all outpatient drug claims, including Provider-administered drugs, must be exempt from such rebate agreements. The MCO must include rebatable National Drug Codes (NDCs) on all encounters for outpatient drugs and biological products, including physician-administered drugs.

The MCO must implement a process to timely support HHSC's Medicaid rebate dispute resolution processes.

- a. The MCO must allow HHSC or its designee to contact Network pharmacy Providers to verify information submitted on claims, and upon HHSC's request, assist with this process.
- b. The MCO must establish a single point of contact where the HHSC's designee can send information or request clarification.
- c. HHSC will notify the MCO of claims submitted with incorrect information. The MCO must correct this information on the next scheduled pharmacy encounter data transmission and respond in writing to the original request with the outcome of the correction.

#### **8.1.20.6 Drug Utilization Review (DUR) Program**

The MCO must have a process in place to conduct prospective and retrospective Utilization Review of prescriptions. Prospective review should take place at the dispensing pharmacy's point-of-sale (POS). The prospective review at the POS must include screening to identify potential drug therapy problems such as drug-disease contraindication, therapeutic duplication, adverse drug-drug interaction, incorrect drug dosage, incorrect duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. The MCO's retrospective review must monitor prescriber and contracted pharmacies for outlier activities. Retrospective reviews should also determine whether services were delivered as prescribed and consistent with the MCO's payment policies and procedures.

Section  
8.1.20.6  
modified by  
Version 2.2

### **8.1.20.7 Pharmacy Benefit Manager (PBM)**

Section  
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modified by  
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The MCO must use a PBM to process prescription claims.

The MCO must identify the proposed PBM and the ownership of the proposed PBM. If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store or pharmaceutical manufacturer, the MCO will submit a written description of the assurances and procedures that must be put in place under the proposed PBM Subcontract, such as an independent audit, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The MCO must provide a plan documenting how it will monitor such Subcontractors. These assurances and procedures must be submitted for HHSC’s review during Readiness Review (see **Section 7**, “Transition Phase Requirements”) then prior to initiating any PBM Subcontract after the Operational Start Date.

The MCO must ensure its subcontracted PBM follows all pharmacy-related Contract, UMCM, state, and federal law requirements related to the provision of pharmacy services.

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 6.1**, “Cost Principles for Expenses.”

The MCO must ensure its subcontracted PBM does not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of or component or mechanism related to the claim adjudication process, including the development or management of a claim processing or adjudication network, or participation in a claim processing or adjudication network.

### **8.1.20.8 Financial Disclosures for Pharmacy Services**

The MCO must disclose all financial terms and arrangements for remuneration of any kind that apply between the MCO or the MCO’s PBM and any provider of outpatient drugs, any prescription drug manufacturer or labeler, including formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees. **Attachment A, Article 9**, “Audit and Financial Compliance,” provides HHSC with the right to audit such information at any time. HHSC agrees to maintain the confidentiality of information disclosed by the MCO pursuant to this section, to the extent that such information is confidential under state or federal law.

### **8.1.20.9 Limitations Regarding Registered Sex Offenders**

HHSC’s Medicaid formulary does not include sexual performance enhancing medications. If these medications are added to the Medicaid formulary, then MCO must comply with the requirements of Texas Government Code § 531.089 prohibiting the provision of sexual performance enhancing medication to persons required to register as sex offenders under Chapter 62, Texas Code of Criminal Procedure.

### **8.1.20.10 Specialty Drugs**

The MCO must develop policies and procedures for reclassifying prescription drugs from retail to specialty drugs for purposes of entering into selective contracting arrangements for specialty drugs. The MCO's policies and procedures must comply with 1 Tex. Admin. Code § 353.905 and § 354.1853 and include processes for notifying Network pharmacy Providers.

### **8.1.20.11 Maximum Allowable Cost (MAC) Requirements**

The MCO must develop MAC prices and lists that comply with state and federal laws, including Texas Government Code § 533.005(a)(23)(K). To place an outpatient drug on a MAC list, the MCO must ensure that:

1. the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's *Approved Drug Products with Therapeutic Equivalence Evaluations*, also known as the *Orange Book*, has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and
2. the drug is generally available for purchase by pharmacies in Texas from national or regional wholesalers and is not obsolete.

In formulating the MAC price for a "market basket" of drugs (a group of therapeutically related drugs that will be assigned the same price), MCOs and PBMs must use only the prices of the drugs listed as therapeutically equivalent in the most recent version of the *Orange Book*. Drugs listed as therapeutically equivalent are A-rated drugs. Therefore, MCOs and PBMs can only use A-rated drugs to set MAC prices. B-rated drugs cannot be used in MAC pricing calculation. MCOs and PBMs can include B-rated drugs in 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.

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 have a process for allowing Network pharmacies to challenge a MAC price, including Network pharmacies that are contracted with a Pharmacy Services Administrative Organization (PSAO). The MCO must submit the process for HHSC's review and approval prior to implementation and modification. The MCO must respond to a challenge by the 15th day after it is made. If the challenge is successful, the MCO must adjust the drug price, effective on the date the challenge is resolved, and apply the new price to all similarly situated Network pharmacies, as appropriate and determined by the MCO. If the challenge is denied, the MCO must provide the pharmacy the reasons for the denial. The MCO must provide a quarterly report regarding MAC price challenges in the manner and format specified in the UCM.

The MCO or PBM, as applicable, must provide a process for each of its Network pharmacy providers to readily access the MAC list specific to that provider directly from the MCO or PBM, even if the pharmacy is contracted with a PSAO. At a minimum, the MCO and PBM must allow a network pharmacy to download a searchable file of the MAC list specific to that pharmacy from the MCO or PBM website. Alternatively, the MCO or PBM may allow a network pharmacy to view and search the MAC list specific to that pharmacy on the website. The list provided on the website must be searchable by drug name. The MCO must implement a process that allows a Network pharmacy to readily access the pharmacy's MAC price through a website. The MCO must submit the process for HHSC's review and approval prior to implementation and modification. As described in Texas Government Code § 533.005(a-2), a MAC price list that is specific to a Network pharmacy is confidential for all other purposes.

The MCO must inform HHSC no later than 21 days after implementing a MAC price list for drugs dispensed at retail pharmacies but not by mail.

#### **8.1.20.12 Mail-Order and Delivery**

The MCO may include mail-order pharmacies in its pharmacy Network, but cannot require Members to use a mail-order pharmacy. MCOs and their PBMs cannot reject claims for any drugs in a retail pharmacy for the purpose of (1) redirecting prescriptions to a plan's a mail order pharmacy or selectively contracted specialty pharmacy, and (2) informing a member about receiving a drug filled by a mail order pharmacy or the plan's selectively contracted specialty pharmacy.

The MCO cannot charge a Member who opts to use a mail order pharmacy any fees for using this service, including postage or handling for standard or expedited deliveries. The MCO must implement a process to ensure that Members receive free outpatient pharmaceutical deliveries from community retail pharmacies, or through other methods approved by HHSC. Mail order delivery is not an appropriate substitute for delivery from a qualified community retail pharmacy unless requested by the Member. The MCO's process must be approved by HHSC, submitted using HHSC's template, and include all qualified community retail pharmacies identified by HHSC.

The MCO must implement a process to ensure that Medicaid and CHIP Members receive free outpatient pharmaceutical deliveries from community retail pharmacies in their Service Areas, or through other methods approved by HHSC. Mail order delivery is not an appropriate substitute for delivery from a qualified community retail pharmacy unless requested by the Member. The MCO's process must be approved by HHSC, submitted using HHSC's template, and include all qualified community retail pharmacies identified by HHSC.

#### **8.1.20.13 Health Resources and Services Administration 340B Discount Drug Program**

The MCO must use a shared-savings approach for reimbursing Network Providers that participate in the federal Health Resources and Services Administration's (HRSA's) 340B discount drug program. The MCO 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 2.2**, "Pharmacy Claims Manual." In addition, the MCO

cannot impose PA requirements based on non-preferred status (“PDL PAs”) for these drugs and products.

#### **8.1.20.14 Pharmacy Claims and File Processing**

The MCO must process claims in accordance with **UMCM Chapter 2.2**, “Pharmacy Claims Manual,” and Texas Insurance Code § 843.339. This law requires the MCO to pay Clean Claims that are submitted electronically no later than 18 days after adjudication, and no later than 21 days after adjudication if the claim is not submitted electronically. In addition, the MCO must comply with **Section 8.1.27**, “Continuity of Care and Out-of-Network (OON) Providers,” regarding payment of OON pharmacy claims.

HHSC will provide the MCO or its designee with pharmacy interface files, including formulary, PDL, third party liability, master provider, and drug exception files. Due to the POS 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 within two business days of the files becoming available through HHSC’s file transfer process, unless clarification is needed or data/file exceptions are identified. If clarification is needed, the MCO must notify HHSC within the same two business days. Additionally, the MCO must be able to perform off-cycle formulary and PDL updates at HHSC’s request.

The MCO must ensure that all daily enrollment and eligibility files in the JIP are loaded into the pharmacy claims adjudication system within two calendar days of receipt.

#### **8.1.20.15 Pharmacy Audits**

The MCO and its PBM are prohibited from using extrapolation in pharmacy audits.

#### **8.1.20.16 E-Prescribing**

The MCO must provide the appropriate data to the national e-prescribing network, which at a minimum will support: eligibility confirmation, PDL benefit confirmation, identification of preferred drugs that can be used in place of non-preferred drugs (“alternative drugs”), medication history, and prescription routing.

#### **8.1.20.17 This Section Intentionally Left Blank**

#### **8.1.21 Cancellation of Product Orders**

If a Network Provider offers delivery services for covered products, such as DME, home health supplies, or outpatient drugs or biological products, then the MCO’s Network 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 Agreement must require the Provider to confirm with the Member that a refill, or new prescription received directly from

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the physician, should be delivered. Further, the MCO must ensure that the Provider completes a drug regimen review on all prescriptions filled as a result of the auto-refill program in accordance with 22 Tex. Admin. Code § 291.34. The Member or Member's Medical Consenter or Caregiver must have the option to withdraw from an automated refill delivery program at any time.

#### **8.1.22 Financial Requirements for Covered Services**

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

A Member may receive collateral health benefits under a different type of insurance such as workers compensation or personal injury protection under an automobile policy. If a Member is entitled to coverage for specific services payable under another insurance plan, and the MCO paid for such Covered Services, the MCO may obtain reimbursement from the responsible insurance entity not to exceed 100 percent of the value of Covered Services paid to Providers. See **Section 8.1.34**, "Third Party Liability and Recovery," for additional information regarding coordination of benefits and recoveries from third parties.

#### **8.1.23 Accounting and Financial Reporting Requirements**

The MCO's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations ("FAR"), Generally Accepted Accounting Principles (GAAP), **Attachment A, Article 9**, "Audit and Financial Compliance," and the cost principles contained in the Cost Principles Document in **UMCM Chapter 6.1**, "Cost Principles for Expenses." HHSC will not recognize or pay services that cannot be properly substantiated by the MCO and verified by HHSC.

The MCO must maintain:

1. accounting records separate and apart from other corporate accounting records;
2. records for all claims payments, refunds and adjustment payments to Network Providers and OON providers, and capitation payments;
3. records on interest income and payments for administrative services or functions;
4. separate records for medical and administrative fees, charges, and payments; and
5. an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts.

The MCO agrees to pay for all reasonable costs incurred by HHSC to perform an examination, review or audit of the MCO's records pertaining to the Contract.

#### **8.1.23.1 Financial Reporting Requirements**

HHSC will require the MCO to provide financial reports to support Contract monitoring as well as state and federal reporting requirements. All financial information and reports submitted by the MCO become the property of HHSC. HHSC may, at its discretion, release such information and reports to the public at any time and without notice to the MCO. In accordance with state

and federal laws regarding Member confidentiality, HHSC will not release any Member-identifying information contained in such reports.

Any data submitted with respect to the required financial reports or filings that are in Portable Document Format (PDF), or similar file format such as Tagged Image File Format (TIF), must be generated in a text-searchable format.

Due dates, content, and formats for the following deliverables and reports may be referenced herein or in **UMCM Chapter 5.0**, “Consolidated Deliverables Matrix.”

- (a) **Audited Financial Statements**—The MCO must provide the annual audited financial statement, for each year covered under the Contract, no later than June 30. The MCO must provide the most recent annual financial statements, as required by the TDI for each year covered under the Contract, no later than March 1.
- (b) **Affiliate Report**—The MCO must submit an Affiliate Report to HHSC if the information changes from the submission of the MCO’s proposal or the last report submission. The report must contain:
  - 1. a list of all Affiliates; and
  - 2. for HHSC’s prior review and approval, a schedule of all transactions with Affiliates that, under the provisions of the Contract, will be Allowable Expenses in the FSR for services provided to the MCO by the Affiliate. The schedule should include financial terms (such as pricing), a detailed description of the services to be provided, and an estimated aggregate amount that will be incurred by the MCO for each Affiliate’s services during each Rate Period of the Contract.
- (c) **Employee Bonus or Incentive Payment Plan**—If an MCO intends to include employee bonus or incentive payments as allowable administrative expenses, the MCO must furnish a written Employee Bonus or Incentive Payments Plan to HHSC so it may determine whether such payments are allowable administrative expenses in accordance with **UMCM Chapter 6.1**, “Cost Principles for Expenses.” The written plan must include a description of the MCO’s criteria for establishing bonus and incentive payments, the methodology to calculate bonus and incentive payments, and the timing of bonus and incentive payments. The Employee Bonus or Incentive Payment Plan and description must be submitted to HHSC for approval no later than 30 days after the Effective Date of the Contract and any Contract renewal. If the MCO substantively revises the Employee Bonus or Incentive Payment Plan, the MCO must submit the revised plan to HHSC for prior review and approval.
- (d) **Claims Lag Report**—The MCO must submit a Claims Lag Report as a Contract year-to-date report. The report must be submitted quarterly by the last day of the month following the reporting period. The report must be submitted to HHSC in a format specified by HHSC, or in a format approved by HHSC. The report format is contained in the **UMCM Chapter 5.6.2**, “Claims Lag Reports.” The report must at a minimum disclose the amount of incurred claims each month and the amount paid each month.
- (e) **MCO Disclosure Statement**—The MCO must file:
  - 1. an updated MCO Disclosure Statement by September 1 of each Contract Year; and

2. a “change notification” abbreviated version of the report, no later than 30 days after any of the following events:
  - a. entering into, renewing, modifying, or terminating a relationship with an affiliated party;
  - b. a change in control, ownership, or affiliations; or
  - c. a material change in, or need for addition to, the information previously disclosed.

The MCO Disclosure Statement will include, at a minimum, a listing of the MCO’s control, ownership, and any affiliations, and information regarding Affiliate transactions. Minor quarterly adjustments in stock holdings for publicly-traded corporations are excluded from the reporting requirements. The reporting format is included in the **UMCM Chapter 5.3.2**, “MCO Disclosure Statement.”

- (f) **Financial Statistical Reports**—The MCO must file quarterly and SFY FSRs in the format, timeframe and per the instructions specified in the HHSC **UMCM Chapter 5.3.1**, “FSR and Instructions.” The MCO must incorporate financial and statistical data of delegated Networks (e.g., IPAs, Limited Provider Networks), if any, in its FSRs. Administrative expenses reported in the FSRs must be reported in accordance with **UMCM Chapter 6.1**, “Cost Principles for Expenses.” Quarterly FSRs are due no later than 30 days after the end of the quarter and must provide information for the current quarter and year-to-date information through the current quarter. The first annual FSR must reflect expenses incurred through the 90<sup>th</sup> day after the end of the fiscal year. The first annual report must be filed on or before the 120<sup>th</sup> day after the end of each fiscal year. Subsequent annual reports must reflect data completed through the 334<sup>th</sup> day after the end of each fiscal year and must be filed on or before the 365<sup>th</sup> day following the end of each fiscal year.

HHSC will post all FSRs on the HHSC website.

- (g) **Historically Underutilized Business (HUB) Reports**—Upon contract award, the MCO must attend a post-award meeting in Austin, Texas, at a time specified by HHSC, to discuss the development and submission of a Client Services Historically Underutilized Business (HUB) Subcontracting Plan for inclusion, and the MCO’s good faith efforts to notify HUBs of subcontracting opportunities. The MCO must maintain its HUB Subcontracting Plan and submit monthly reports documenting the MCO’s HUB program efforts and accomplishments to the HHSC HUB Office. The report must include a narrative description of the MCO’s HUB program efforts and a financial report reflecting payments made to HUBs. MCOs must use the formats included in HHSC’s **UMCM Chapter 5.4.4**, “HUB Reports,” for the HUB monthly reports. The MCO must comply with HHSC’s standard Client Services HUB Subcontracting Plan requirements for all Subcontractors.
- (h) **Out-of-Network (OON) Utilization Reports**—The MCO must file quarterly OON Utilization Reports in the format and timeframe specified in the **UMCM Chapter 5.3.8**, “OON Utilization Reports.” Quarterly reports are due 30 days after the end of each quarter.
- (i) **TDI Examination Report**—As applicable, the MCO must furnish a copy of any TDI Examination Report, including the financial, market conduct, target exam, quality of care components, and corrective action plans and responses, no later than 10 calendar days after receipt of the final report from TDI.

- (j) **TDI Filings**—The MCO must furnish a copy of any TDI filings, including, without limitation, annual figures for controlled risk-based capital, and quarterly financial statements, both as applicable and required by TDI.
- (k) **Registration Statement (also known as the “Form B”)**—If the MCO is a part of an insurance holding company system, the MCO must submit to HHSC a complete Form B, and all amendments to this form, and any other information filed by such insurer with the insurance regulatory authority of its domiciliary jurisdiction.
- (l) **Third Party Recovery (TPR) Reports**—The MCO must file TPR Reports in accordance with the format developed by HHSC in the **UMCM Chapter 5.3.4**, “Third Party Recovery (TPR) Report.” HHSC will require the MCO to submit TPR reports no more often than quarterly. TPR reports must include total dollars recovered from third party payors for services to the MCO’s Members, and the total dollars recovered through subrogation, and worker’s compensation.
- (m) **Report of Legal and Other Proceedings and Related Events**—The MCO must comply with the **UMCM Chapter 5.8**, “Report of Legal and Other Proceedings,” regarding the disclosure of certain matters involving the MCO, its Affiliates, or its Material Subcontractors. Reports are due both on an as-occurs basis and annually each August 31. The as-occurs report is due no later than 30 days after the event that triggered the notification requirement.
- (n) **Filings with other entities, and other existing financial reports** – The MCO must submit an electronic copy of the following reports or filings pertaining to the MCO, or its parent, or its parent’s parent:
- (1) *SEC Form 10-K*. For publicly-traded (stock-exchange-listed) for-profit corporations, submit the most-recent annual SEC Form 10K filing.
  - (2) *IRS Form 990*. For nonprofit entities, submit the most recent annual IRS Form 990 filing, complete with any and all attachments or schedules. If a nonprofit entity is exempt from the IRS 990 filing requirement, demonstrate this and explain the nature of the exemption.
  - (3) If the MCO is a nonprofit entity that is a component or subsidiary of a County Hospital District, or otherwise an entity of a government, then submit the annual financial statements as prepared under the relevant rules or statutes governing annual financial reporting and disclosure for the MCO and/or its parent, including all attachments, schedules, and supplements.
  - (4) *Annual Report*. The MCO must submit this report if it is different than or supplementary to the audited financial statements or Form 10-K required herein, and if it is distributed to either shareholders, customers, employees, owner(s), parent, bank or creditor(s), donors, the community, or to any regulatory body or constituents, or is otherwise externally distributed or posted.
  - (5) *Bond or debt rating analysis*. If the MCO or its ultimate parent has been the subject of any bond rating analysis, ratings affirmation, write-up, or related report, such as by AM Best, Fitch Ratings, Moody’s, Standard & Poor, etc., submit the most recent complete detailed report from each rating entity that has produced such a report.

All of the above such reports or filings are due to HHSC no later than 30 calendar days after such report is filed or otherwise initially distributed. Each report should include all exhibits, attachments, notes, supplemental data, management letters, auditor letters, etc., and any updates, revisions, clarifications, or supplemental filings. If the reporting entity has a regular required due date for any of the above reports, and receives an extension on the filing deadline, then the MCO should notify HHSC of any such extension and the estimated revised filing date.

#### **8.1.24 Management Information System (MIS) Requirements**

The MCO must maintain an MIS that supports all functions of the MCO's processes and procedures for the flow and use of MCO data. If the MCO subcontracts a MIS function, the Subcontractor's MIS must comply with the requirements of this section. The MCO must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS subsystems for the following operational and administrative areas:

1. Enrollment/eligibility subsystem;
2. Provider subsystem;
3. Encounter/claims processing subsystem;
4. financial subsystem;
5. Utilization/Quality Improvement subsystem;
6. reporting subsystem;
7. interface subsystem;
8. TPR subsystem;
9. Health Passport subsystem and
10. Information Management Protecting Adults and Children in Texas (IMPACT) subsystem, the DFPS system that will transmit to and receive data from the MCO).

The MIS must enable the MCO to meet the Contract requirements, including all applicable state and federal laws, rules, and regulations. The MIS must have the capacity and capability to capture and utilize various data elements required for MCO administration.

The MCO must have a system that can be adapted to changes in business practices or policies within the timeframes negotiated by the Parties. The MCO is expected to cover the cost of such systems modifications over the life of the Contract.

The MCO is required to participate in the HHSC Systems Work Group.

The MCO must provide HHSC prior written notice, generally at least 180 days, of Major Systems Changes and implementations, including any changes relating to Material Subcontractors, in accordance with the requirements of this Contract. Refer to **Attachment A, Article 12**, "Remedies and Disputes," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix," for additional information regarding remedies and damages. Refer to **Section 7.3.7**, "Operations Readiness," and **Section 8.1.1.1**, "Additional Readiness Reviews and Monitoring Efforts," for additional information regarding MCO Readiness Reviews. Refer to **Attachment A, Section 4.09(c)**, "Subcontractors and Agreements with Third Parties," for information regarding Readiness Reviews of the MCO's Material Subcontractors.

The MCO must notify HHSC of Major Systems Changes in writing. The notification must detail the following.

- The aspects of the system that will be changed and date of implementation
- How these changes will affect the Provider and Member community, if applicable
- The communication channels that will be used to notify these communities, if applicable
- A contingency plan in the event of downtime of system(s)

Major Systems Changes are subject to HHSC desk review and onsite review of the MCO's facilities as necessary to test readiness and functionality prior to implementation. Prior to HHSC approval of the Major Systems Change, the MCO may not implement any changes to its operating systems. Failure to comply will result in contractual remedies, including damages. HHSC retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

If HHSC determines that it is necessary to conduct an onsite review, the MCO is responsible for all reasonable travel costs associated with such onsite reviews. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. This provision does not limit HHSC's ability to collect other costs as damages in accordance with **Attachment A, Section 12.02(e)**, "Damages." The MCO must provide HHSC any updates to the MCO's organizational chart relating to MIS and the description of MIS responsibilities at least 30 days prior to the effective date of the change. The MCO must provide HHSC with the names of official points of contact for MIS issues on an ongoing basis.

If for any reason an MCO does not fully meet the MIS requirements, then the MCO must, upon request by HHSC, either correct such deficiency or submit to HHSC a Corrective Action Plan and risk mitigation plan to address such deficiency as requested by HHSC. Immediately upon identifying a deficiency, HHSC may impose remedies according to the severity of the deficiency including liquidated damages. The MCO's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan. Refer to **Attachment A**, "STAR Health Contract Terms," for additional information.

#### **8.1.24.1 Encounter Data**

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The MCO must provide complete and accurate Encounter Data for all Covered Services, including Value-added Services. Encounter Data must follow the format and data elements as described in the most current version of HIPAA-compliant 837 Companion Guides, NCPDP format (pharmacy), and Encounters Submission Guidelines. HHSC will specify the method of transmission, and the submission schedule, in the **UMCM Chapter 5.0**, "Consolidated Deliverables Matrix." Minimally, the MCO must submit monthly Encounter Data transmissions, and include all Encounter Data and Encounter Data adjustments processed by the MCO within the preceding month. In addition, pharmacy Encounter Data must be submitted no later than 25 calendar 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 30<sup>th</sup> calendar day after the last day of

the month in which the claim was adjudicated. The MCO must make original records available for inspection by HHSC and its agents for validation purposes. The MCO must correct and return Encounter Data that do not meet quality standards within a time period specified by HHSC.

For reporting Encounters and Fee-for-Service claims to HHSC, the MCO must use the procedure codes, diagnosis codes, and other codes as directed by HHSC. Any exceptions will be considered on a code-by-code basis after HHSC receives written notice from the MCO requesting an exception. The MCO must also use the Provider numbers as directed by HHSC for both Encounter Data and Fee-for-Service claims submissions, as applicable.

The MCO must report Texas Health Steps medical and dental checkups data in a manner required for the reports to courts of law, including the number and percent of Members who receive all of their Texas Health Steps medical and dental checkups when due.

HHSC will use the Encounter Data to run the Quarterly Encounter Reconciliation Report, which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Vision 21 Data Warehouse. This report is based on querying the Vision 21 Data Warehouse 60 calendar days after the last day of the quarter. The MCO may be subject to liquidated damages as specified in **Attachment B-3**.

The MCO's Provider Contracts must require Network Providers to comply with the requirements of Texas Government Code § 531.024161, regarding reimbursement of claims based on orders or referrals by supervising Providers.

#### **8.1.24.2 MCO Deliverables related to MIS Requirements**

At the beginning of each SFY, 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 Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.

Additionally, at the beginning of each SFY, 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 in the **UMCM Chapter 5.2**, "MIS Deliverables/Formats." Additionally, if a Systems Readiness Review is triggered by one of the events described in **Section 8.1.24**, "Management Information Systems (MIS) Requirements," the MCO must submit all of the plans identified in this section in accordance with an HHSC-approved timeline.

The MCO must follow all applicable JIPs and all required file submissions for HHSC's Administrative Services Contractor, EQRO and HHSC Medicaid Claims Administrator. The JIPs can be accessed through the **UMCM Chapter 7.1**, "Joint Interface Plans (JIP)."

#### **8.1.24.3 System-wide Functions**

The MCO's MIS system must include key business processing functions and features, which must apply across all subsystems as follows:

1. Process electronic data transmission or media to add, delete or modify membership records with accurate begin and end dates;
2. track Covered Services received by Members through the system, and accurately and fully maintain those Covered Services as HIPAA-compliant Encounter Data transactions;
3. transmit or transfer Encounter Data transactions on electronic media in the HIPAA format to the contractor designated by HHSC to receive the Encounter Data;
4. maintain a history of changes and adjustments and audit trails for current and retroactive data;
5. maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure;
6. employ industry standard medical billing taxonomies (procedure codes, diagnosis codes) to describe services delivered and Encounter Data transactions produced;
7. accommodate the coordination of benefits;
8. produce standard Explanation of Benefits (EOBs);
9. pay financial transactions to providers in compliance with federal and state laws, rules and regulations;
10. ensure that all financial transactions are auditable according to GAAP guidelines;
11. relate and extract data elements to produce report formats provided within the **UMCM Chapter 5**, "Deliverables, Report Formats, Due Dates," or otherwise required by HHSC;
12. ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS; and
13. maintain and cross-reference all Member-related information with the most current Medicaid Provider number.

#### **8.1.24.4 Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH Act) Compliance**

The MCO's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA or the HITECH Act as amended or modified. The MCO must comply with HIPAA EDI requirements. MCO's enrollment files must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 format and all claims and remittance transactions in the 837/835 format, with the exception of pharmacy services. Pharmacies may submit eligibility inquiries in the NCPDP E1 HIPAA-compliant format. Claim transactions for pharmacy services must be in the NCPDP B1/B2 HIPAA-compliant formats; all others must be in the 837/835 HIPAA-compliant format.

The MCO must follow the rules for 5010 Compliancy and ICD-10 Compliancy listed at the following website:

[www.cms.hhs.gov/TransactionCodeSetsStands/02\\_TransactionsandCodeSetsRegulations.asp](http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp).

The MCO must provide its Members or their Medical Consenters with a privacy notice as required by HIPAA or the HITECH Act, including 45 C.F.R. § 164.520. The MCO must provide HHSC with a copy of its privacy notice during Readiness Review and any changes to the notice prior to distribution.

#### **8.1.24.5 Claims Processing Requirements**

The MCO must process all provider claims and must pay all claims for Medically Necessary healthcare Covered Services that are filed within the timeframe specified by this section, and pharmacy claims that are filed in accordance with the timeframes specified in **UMCM Chapter 2.2**, “Pharmacy Claims Manual.” The MCO must administer an effective, accurate, and efficient claims payment process in compliance with state and federal laws, rules and regulations, and the Contract, including the claims processing procedures contained in the **UMCM Chapters 2.0**, “Claims Manual,” and **2.2**, “Pharmacy Claims Manual.” The MCO and its Subcontractors cannot directly or indirectly charge or hold a Member or provider responsible for claims adjudication or transaction fees.

The MCO must maintain an automated claims processing system that registers the date a claim is received by the MCO, the detail of each claim transaction (or action) at the time the transaction occurs, and that has the capability to report each claim transaction by date and type to include interest payments. This information must be at claim and line detail level, maintained on line and in archived files, as appropriate, per contractual record retention requirements. All claims data must be easily sorted and produced in formats upon request by HHSC. All provider claims must be processed within 30 days from the date of claim receipt by the MCO. All provider claims that are Clean Claims must be adjudicated within 30 days from the date of claim receipt.

The MCO must offer its Providers the option of submitting and receiving claims information through electronic data interchange (EDI) that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats.

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. A provider portal brings information together from diverse sources in a uniform way. The provider portal functionality must include the following.

1. Client eligibility verification;
2. submission of electronic claims;
3. PA requests;
4. claims appeals and reconsiderations; and
5. exchange of clinical data and other documentation necessary for PA and claim processing

To the extent possible, the provider portal should support both online and batch processing as applicable to the information being exchanged. Batch Processing is a billing technique that uses a single program loading to process many individual jobs, tasks, or requests for service. Specifically in managed care, batch billing is a technique that allows Providers to send billing information all at once in a “batch” rather than in separate individual transactions. To facilitate the exchange of clinical data and other relevant documentation, the provider portal must provide a secure exchange of information between the Provider and MCO, including, as applicable, a Subcontractor of the MCO.

The MCO is subject to remedies, including liquidated damages, if the MCO does not pay providers interest at an 18 percent annual rate, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 30-day claims processing deadline. The MCO may negotiate Provider Contract terms that indicate that duplicate claims filed prior to the expiration of 31 days would not be subject to the 18 percent interest payment if not processed within 30 days. The MCO is subject to contractual remedies, including liquidated damages and interest, if the MCO does not process and adjudicate pharmacy claims in accordance with the procedures and the timeframes listed in **UMCM Chapter 2.2**, “Pharmacy Claims Manual.”

The MCO may deny a claim submitted by a provider for failure to file in a timely manner as provided for in **UMCM Chapters 2.0**, “Claims Manual,” and **2.2**, “Pharmacy Claims Manual.”

The MCO must withhold all or part of payment for any claim submitted by a provider who is:

1. excluded or suspended from the Medicare, Medicaid, or CHIP programs for Fraud, Abuse, or Waste;
2. on payment hold under the authority of HHSC or its authorized agent(s);
3. with debts, settlements, or pending payments due to HHSC, or the state or federal government;
4. for neonatal services provided on or after September 1, 2017, if submitted by a Hospital that does not have a neonatal level of care designation from HHSC; or
5. for maternal services provided on or after September 1, 2019, if submitted by a Hospital that does not have a maternal level of care designation from HHSC.

In accordance with Texas Health and Safety Code § 241.186, the restrictions on payment identified in items 4–5 above do not apply to emergency services that must be provided or reimbursed under state or federal law.

With the following exceptions, the MCO must complete all audits of a provider claim no later than two years after receipt of a clean claim, regardless of whether the provider participates in the MCO’s Network. This limitation does not apply in cases of provider Fraud, Waste, or Abuse that the MCO did not discover within the two-year period following receipt of a claim. In addition, the two-year limitation does not apply when the officials or entities identified in **Attachment A, Section 9.02(c)**, “Access to records, books and documents,” conclude an examination, audit, or

inspection of a provider more than two years after the MCO received the claim. Finally, the two-year limitation does not apply when HHSC has recovered a capitation from the MCO based on a Member's ineligibility. If an exception to the two-year limitation applies, then the MCO may recoup related payments from providers.

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

The MCO's Provider Contract must specify that program violations arising out of performance of the contract are subject to administrative enforcement by the HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

The MCO is subject to remedies, including liquidated damages, if within 30 days of receipt, the MCO does not adjudicate to a paid or denied status 98 percent of all Clean Claims. The MCO is subject to remedies, including liquidated damages, if within 90 days of receipt, the MCO does not adjudicate to a paid or denied status 99 percent of all Clean Claims. Claims paid or denied deficient for additional information must be adjudicated paid or denied by the 30<sup>th</sup> day following the date the claim is pended or denied deficient, if reasonably requested information is not received prior to the expiration of 30 days.

The MCO must adjudicate all Appealed claims to a paid or denied status within 30 days of receipt of the appealed claim. The MCO is subject to remedies, including liquidated damages, if 98 percent of Appealed claims are not adjudicated to a paid or denied status within 30 days of receipt of the Appealed claim.

The MCO may deny a claim for failure to file timely if a provider does not submit the claim to the MCO within 95 days of the date of service or a pharmacy claim. If a provider files with the wrong health plan, or with the HHSC Administrative Services Contractor, and produces documentation verifying the initial timely claims filing within 95 days of the date of service, the MCO must process the provider's claim without denying for failure to timely file.

The MCO must send a remittance and status report or other remittance written communication that includes detailed information for each adjudicated, denied deficient and pended deficient claim to allow the Provider to easily identify the claim number, date of service, type of service, claim codes, Member's name, and Member ID number.

The MCO must finalize all claims, including Appealed claims, within 24 months of the date of service.

The MCO is subject to the requirements related to coordination of benefits for secondary payors in the Texas Insurance Code § 843.349(e) and (f).

The MCO must notify HHSC of major claim system changes in writing no later than 180 days prior to implementation. The MCO must provide an implementation plan and schedule of proposed changes. HHSC reserves the right to require a desk or on-site readiness review of the changes.

The MCO must inform all Network Providers about the information required to submit a claim at least 30 days prior to the Operational Start Date and as a provision within the Provider Contract. The MCO must make any policies affecting claims adjudication and claims coding and processing guidelines available to Providers for the applicable provider type. Providers must receive 90 days' notice prior to the MCO's implementation of changes to these claims policies and guidelines, unless HHSC requires a different notice period.

#### **8.1.24.6 National Correct Coding Initiative**

The MCO must comply with the requirements of Section 6507 of PPACA (P.L. 11-148), regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

#### **8.1.25 Fraud, Waste, and Abuse**

The MCO is subject to all state and federal laws, rules, and regulations relating to Fraud, Waste, and Abuse in healthcare and the Medicaid programs. The MCO must cooperate and assist the HHSC Office of Inspector General (OIG) and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected Fraud Waste, and Abuse.

1. The MCO is subject to and must meet all requirements in [Texas Government Code § 531.113](#), [Texas Government Code § 533.012](#), 1 Tex. Admin. Code §§ 353.501-353.505, and 1 Tex. Admin. Code §§ 370.501-370.505 as well as all laws specified in the Contract.
2. The MCO must require all employees who process Medicaid claims, including Subcontractors, to attend annual training as provided by HHSC per Texas Government Code § 531.105.
3. The MCO must perform pre-payment review for identified providers as directed by 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 OIG.

Failure to comply with any requirement of Sections 8.1.25 and 8.1.26.2(c) and (f) may subject the MCO to liquidated damages and/or administrative enforcement pursuant to 1 Tex. Admin. Code Chapter 371 Subchapter G, in addition to any other legal remedy.

Section  
8.1.25  
modified by  
Versions  
2.1 and 2.3

### **8.1.25.1 Special Investigative Units**

In order to facilitate cooperation with OIG, the MCO must establish and maintain a special investigative unit (SIU), either in-house or by contract with another entity, to investigate possible acts of fraud, waste, or abuse for all services provided under the Contract, including those that the MCO subcontracts to outside entities.

1. The MCO's SIU does not have to be physically located in Texas but must be adequately staffed to handle Texas volume. The SIU must have adequate staff and resources located in Texas and apportioned at the levels and experience sufficient to effectively work Texas cases based on objective criteria considering, but not necessarily limited to, the MCO's total member population, claims processes, risk exposure, current caseload, and other duties as described in [1 Tex. Admin. Code §§ 353.501-353.505](#), and [1 Tex. Admin. Code §§ 370.501-370.505](#).
2. The MCO must submit a written Fraud, Waste, and Abuse compliance plan to OIG for approval each year. 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.) If an MCO has not made any changes to its plan from the previous year, it may notify OIG that: (1) no changes have been made to the previously-approved plan and (2) the plan will remain in place for the upcoming State Fiscal Year. The notification must be signed and certified by an officer or director of the MCO that is responsible for carrying out the Fraud, Waste, and Abuse compliance plan. Upon receipt of a written request from OIG, the MCO must submit the complete Fraud, Waste, and Abuse compliance plan.

### **8.1.25.2 General requests for and access to data, records, and other information**

Section  
8.1.25.2  
modified by  
Version 2.3

The MCO and its subcontractors must allow access to all premises and provide originals or copies of all records and information requested free of charge to the HHSC OIG, HHSC or its authorized agent(s), the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, the Office of the Attorney General, the Texas Department of Insurance (TDI), or other units of state government. The MCO must provide all copies of records free of charge.

1. The MCO must designate one primary and one secondary contact person for all HHSC OIG records requests. HHSC OIG records requests will 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 OIG requestor no less than two Business Days prior to the due date.
3. The MCO's response must include data for all data fields, as available. The data must be provided in the order and format requested. If any data field is left blank, an explanation must accompany the response. The MCO must not add or delete any additional data fields in its response. All requested information must be

accompanied by a notarized Business Records Affidavit unless indicated otherwise in HHSC OIG's record request.

The most common requests include, but are not limited to:

1. 1099 data and other financial information – 3 Business Days;
2. claims data for sampling and recipient investigations – 10 Business Days;
3. urgent claims data requests – 3 Business Days (with OIG manager's approval);
4. Provider education information – 10 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 OIG; and
8. other time-sensitive requests – as needed.

#### **8.1.25.3 Monthly Claims Data Submission Requirements**

1. The MCO and its subcontractors shall submit processed claims data on a monthly basis that meets established OIG data quality standards and requirements. These standards are defined by OIG to ensure receipt of complete and accurate data for investigative purposes. OIG will revise and amend these standards and requirements as necessary to ensure continuous quality improvement. The MCO and its subcontractors shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with OIG data quality standards and requirements as originally defined or subsequently amended.
2. The MCO and its subcontractors shall comply with industry-accepted clean claim standards for all data submissions to OIG, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of all paid and denied claims. In the event that the MCO or its subcontractors denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the MCO and its subcontractors are required to submit all available claims data, for such denied claims, to OIG without alteration or omission.
3. The MCO and its subcontractors shall submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by OIG, in order to support comprehensive financial reporting, utilization analysis and investigative efforts.
4. The MCO and its subcontractors shall submit processed claims data according to standards and formats as defined by 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.
5. 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 OIG.

6. The MCO and its subcontractors shall supply Electronic Funds Transfer (EFT) account numbers on a monthly basis in a format defined by OIG for all Medicaid providers who have elected to receive payments via EFT and who are participating in their plans.
7. Failure by the MCO or its subcontractor to submit data as described in this section may result in administrative enforcement by HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G or liquidated damages as specified in Attachment B-3.

#### **8.1.25.4 Payment Holds and Settlements**

1. 42 C.F.R. § 455.23 requires the State Medicaid agency to suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or suspend payment only in part. In Texas, HHSC OIG is responsible for evaluating allegations of fraud and imposing payment suspensions when appropriate. 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 1 business day. When notice of a payment hold or a payment hold lift is received, the MCO must respond to the notice within 3 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**, "Fraud Deliverable/Report Format" and provide this information to 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: Sanctions Division, 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 8.1.25** and all state and federal laws and regulations relating to Fraud, Waste, and Abuse in healthcare and the Medicaid program is subject to administrative enforcement by HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

#### **8.1.25.5 Additional Requirements**

In accordance with Section 1902(a)(68) of the Social Security Act, Medicaid MCOs and their Subcontractors that receive or make annual Medicaid payments of at least \$5 million must:

1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the MCO or Subcontractor, which provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
2. Include as part of such written policies, detailed provisions regarding the MCO's or Subcontractor's policies and procedures for detecting and preventing fraud, waste, and abuse.
3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the MCO's or Subcontractor's policies and procedures for detecting and preventing fraud, waste, and abuse.

#### **8.1.25.6 Lock-in Actions**

HHSC OIG LP restricts, or locks in, a Medicaid Member to a designated provider or pharmacy if it finds that the Member used Medicaid services, including drugs, at a frequency or amount that is duplicative, excessive, contraindicated, or conflicting; or that the Member's actions indicate abuse, misuse, or fraud. The MCO is required to maintain, and provide to OIG upon request, written policies for all employees, managers, officers, contractors, subcontractors, and agents of the MCO or Subcontractor. The policies must provide detailed information related to the "HHSC OIG Lock-in Program MCO Policies and Procedures" about overutilization of prescription medications.

The MCO must not pay any claim submitted by a provider excluded or suspended from the Medicare, Medicaid, or CHIP programs for Fraud, Abuse, or Waste. Furthermore, the MCO must not pay any claim submitted by a provider pending an investigation of a credible allegation of fraud unless an HHSC OIG determination that there is good cause not to suspend such payments.

### 8.1.26 Reporting Requirements

The MCO must provide and must require its Subcontractors to provide at no cost to the Texas HHSC:

1. All information required under the Contract, including but not limited to, the reporting requirements or other information related to the performance of its responsibilities thereunder as reasonably requested by the HHSC.
2. Any information in its possession sufficient to permit HHSC to comply with the Federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats and instructions as specified by HHSC. Where practicable, HHSC may consult with the MCO to establish timeframe and formats reasonably acceptable to both parties.
3. The MCO's Chief Executive and Chief Financial Officers, or persons in equivalent positions, must certify that financial data, Encounter Data and other measurement data have been reviewed by the MCO and are true and accurate to the best of their knowledge after reasonable inquiry.

#### 8.1.26.1 Performance Measurement

Section  
8.1.26.1  
modified by  
Versions  
2.1 and 2.2

The MCO must provide to HHSC or its designee all information necessary to analyze the MCO's provision of quality care to Members using measures to be determined by HHSC in consultation with the MCO.

#### 8.1.26.2 Reports

Section  
8.1.26.2  
modified by  
Version 2.3

The MCO must provide the following reports, in addition to the Financial Reports described in **Section 8.1.23.1**, "Financial Reports," and those reporting requirements listed elsewhere in the Contract. The **UMCM Chapter 5**, "Deliverables, Report Formats, Due Dates," will include a list of all required reports, and a description of the format, content, file layout and submission deadlines for each report. HHSC also retains the option to require additional reports or to change the reporting frequency for any report(s).

- (a) **Claims Summary Report**—The MCO must submit a quarterly Claims Summary Report to HHSC by claim type by the 30th day following the quarter unless otherwise specified. Claim Types include facility or professional services for Acute Care, BH, Vision, Dental, and Pharmacy. Within each claim type, claims data must be reported separately on the UB and CMS 1500 claim forms. Reporting specifications are found in **UMCM Chapter 5.6.1**, "Claims Summary Report."
- (b) **Quality Assurance and Performance Improvement (QAPI) Program Annual Summary Report**—The MCO must submit a QAPI Program Annual Summary in a format and timeframe as specified in the **UMCM Chapter 5.7.1**, "QIP-QAPI Summary Format."
- (c) **Fraudulent Practices Report**—Utilizing the OIG fraud referral form, the HHSC's assigned officer or director must report and refer all possible acts of Fraud or Abuse to the HHSC-OIG within 30 Business Days of receiving the reports of possible acts of Fraud or Abuse from the HHSC's Special Investigative Unit (SIU). The report and referral must include: an

investigative report identifying the allegation, statutes/regulations violated or considered, and the results of the investigation; copies of Program rules and regulations violated for the time period in question; copies of any MCO contractual provisions, policies, published MCO program bulletins, policy notification letters, or Provider policy or procedure manuals that apply to the alleged conduct for the time period in question; the estimated overpayment identified; a summary of the interviews conducted; the Encounter Data submitted by the Provider for the time period in question; and all supporting documentation obtained as the result of the investigation. This requirement applies to all reports of possible acts of Fraud, Waste, and Abuse.

Additional reports required by the OIG relating to Fraud, Waste, and Abuse are listed in the **UMCM Chapter 5.5**, "Fraud Deliverable/Report Format."

- (d) **Provider Complaints, Member Complaints, and Member Appeals**—The MCO must submit quarterly Complaints and Appeals reports. The MCO must include in its reports 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. The MCO Member Appeal report must include counts of expedited and standard appeals received and resolved during the reporting quarter in addition to pending appeals. The MCO must submit its Complaints and Appeals reports 45 days following the end of the State Fiscal Quarter, using the Provider Complaints, Member Complaints, and Member Appeals reports in UMCM Chapter 5.4.2 Complaints and Appeals Report. The MCO must not submit its complaint and/or appeals reports prior to the due date if it has pending complaints or appeals.
- (e) **Provider Terminations Report**—The MCO must submit a quarterly report that identifies all Network Providers (both primary care and specialty) who cease to participate in the MCO's Provider Network, either voluntarily or involuntarily. The report must be submitted using the Provider Termination Report under UMCM 5.4.1 Provider Network Reports, no later than 30 days after the end of the reporting period.
- (f) **Hotline Reports**—The MCO must submit quarterly status reports for the Member Services Hotline, the Behavioral Health Services Hotline, the Nurse Hotline and the Provider Hotline to measure the MCO's compliance in accordance with the performance standards set out in **Sections 8.1.4.8** Provider Hotline, **8.1.5.6** Nurse and Member Hotline Requirements," and **8.1.17.3** Behavioral Health Hotline and Emergency Services using the report templates located in UMCM Chapter 5.4.3 Hotline Reports.

If the MCO is not meeting a hotline performance standard, HHSC may require the MCO to submit monthly hotline performance reports and implement corrective actions until the hotline performance standards are met. If the MCO has a single hotline serving multiple hotline functions (i.e. Member, Provider, Behavioral Health Services, Nurse Hotlines), HHSC may request that the MCO submit certain hotline response information by hotline function and/or Program on an annual basis. HHSC may also request additional hotline information if the MCO is not meeting a hotline performance standard.

- (g) **Medicaid Managed Care Texas Health Steps Medical Checkups Reports**—The MCO must submit reports identifying the number of New Members and Existing Members receiving Texas Health Steps medical checkups. The MCO must also document and report those Members refusing to obtain the medical checkups. For HHSC purposes only, the documentation must include the reason the Member refused the checkup or the reason the checkup was not received.

The definitions, timeframe, format, and details of the reports are contained and described in the **UMCM Chapters 12.4**, “MMC THSteps Report Instructions,” and **12.9**, “MMC THSteps Annual Report Template (STAR Health).” The MCO may utilize **UMCM Chapter 12.6**, “Annual Report Refusal Tracking Log,” for refusal reporting.

- (h) **Other**—The MCO must follow all applicable JIPs and all required file submissions for Medicaid’s Administrative Services Contractor, EQRO, Quality Vendor, and Medicaid Claims Administrator. The JIPs can be accessed through the **UMCM Chapter 7.1**, “Joint Interface Plans (JIP).”

- (i) **Audit Reports**—The MCO must comply with the requirements in **UMCM Chapter 5.3.11**, “Audit Reports,” regarding notification and submission of audit reports.

- (j) **Frew Quarterly Monitoring Report**—Each calendar year quarter, HHSC prepares a report for the court that addresses the status of the Consent Decree paragraphs of the *Frew v. Smith* lawsuit. The MCO must prepare responses to questions posed by HHSC on the Frew Quarterly Monitoring Report template. The timeframe, format, and details of the report are set forth in the **UMCM Chapter 12**, “Frew.”

- (k) **PCP Enrollment in Texas Health Steps Report**—The MCO must submit a quarterly PCP Enrollment in Texas Health Steps Report. The MCO must include in its reports the number of PCPs enrolled in Network, and the number and percent of Network PCPs that are enrolled as Texas Health Steps providers. All data should be reported as of the first day in the SFQ. The MCO must submit the PCP Enrollment in Texas Health Steps reports electronically on or before 30 days following the end of the SFQ, using the format specified in the **UMCM Chapter 5.4.1.3**, “STAR Health PCP THSteps Enrollment Report.”

HHSC retains the option to request a listing of Network PCPs enrolled as Texas Health Steps providers at the time of report submission when the need for further review is identified.

- (l) **Network Summary Report**—The MCO must submit a quarterly Network Summary Report. The MCO must include in its reports the number of enrollees residing in each county in the State, and the number of contracted and unduplicated Providers, by type, who are currently practicing in each county in the State. Provider types to be included in the report as well as the format to be used are specified in the **UMCM Chapter 5.4.1.4**, “STAR Health Network Summary Report.” The MCO must submit the Network Summary reports electronically on or before 30 days following the end of the SFQ.

- (m) **Liaison Summary Report**—The MCO must submit a quarterly Liaison Summary Report. The MCO must include in its reports the number of issues or requests, by type, that are

received from the DFPS Well-Being Specialists in each of seven regions of the State and worked by the MCO Liaisons, and any pertinent detail that describes the nature of such issues or requests. The MCO must submit the Liaison Summary reports electronically on or before 30 days following the end of the SFQ, using the format specified in the **UMCM Chapter 5.9.1, "STAR Health Liaison Summary Report."**

- (n) **Psychotropic Medication Utilization Review (PMUR) Report**—The MCO must submit a quarterly PMUR Report. The MCO must include in its reports the number of PMUR screenings triggered by each of the sources approved by HHSC and specified in the **UMCM Chapter 5.9.2, "STAR Health PMUR Report,"** the number of PMUR screenings completed, and the number that fall into each of the outcomes approved by HHSC and specified in the **UMCM**, as well as the percentages of each source and outcome appearing in the format specified in the **UMCM**. The MCO must submit the PMUR Reports electronically on or before 30 days following the end of the SFQ.
- (o) **Service Management Summary Report**—The MCO must submit a quarterly Service Management Summary Report. The MCO must include in its reports the total number of telephonic screenings to be completed for new Members enrolled within the reporting quarter, the total number that were successfully completed in the reporting quarter, and the number that resulted in the development of an HCSP. The MCO must also include in its reports the number of telephonic screenings and HCSPs that could not be completed due to a wrong contact number listed in the eligibility or enrollment file, a non-responsive Caregiver or Medical Consenter, refusal by the Medical Consenter to assist in completion of an HCSP, or hospitalization of the Member. The MCO must also include in its reports the number of telephonic screenings and HCSPs that were not completed within contractually required timeframes. The MCO must submit the Service Management Summary Reports electronically on or before 45 days following the end of the SFQ, using the format specified in the **UMCM Chapter 5.9.3, "STAR Health Service Management Summary Report."**
- (p) **Drug Utilization Review (DUR) Reports**—MCO must submit the DUR reports in accordance with the requirements of **UMCM Chapter 5.13, "Pharmacy Reports."**
- (q) **Perinatal Risk Reports**—The MCO must submit a quarterly perinatal risk report as described in **UMCM Chapter 5.16, "Perinatal Risk Report"**. Quarterly reports are due 30 days after the end of each quarter.
- (r) **Enrollment/Credentialing Denial Report**—The MCO must submit a quarterly report in accordance with the **UMCM Chapter 5.4.1.9, "Provider Enrollment/Credentialing Denial Report"** identifying Providers who were denied enrollment in the MCO's network. The report must be submitted in the format specified by HHSC in the UMCM, no later than 30 days after the end of the reporting period.
- (s) **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 5.13.4, "MCO Quarterly Pharmacy Report Template"**. Reports must be submitted for each MCO and cannot be grouped by the Pharmacy Benefit Manager (PBM).

- (t) **Critical Incidents and Abuse, Neglect, and Exploitation Report**—Medicaid MCOs must submit a quarterly report that includes the number of Critical Incidents and ANE reports received from the Department of Family and Protective Services (DFPS) Adult Protective Services (APS) for Members receiving LTSS.
- (u) **24-7 PCP Access Report**—STAR and STAR+PLUS MCOs must complete and submit an annual report as described in the UMCM Chapter 5.4.1.13 to assess compliance with ensuring access to providers 24 hours a day and 7 days a week (24-7). MCO Annual reports are due the 2<sup>nd</sup> Friday in December.

### **8.1.27 Continuity of Care and Out-of-Network (OON) Providers**

The MCO must ensure that the care of newly enrolled Members and Members who disenroll from the MCO is not disrupted or interrupted. The MCO must take special care to provide continuity of care to newly enrolled Members and Members who disenroll from the MCO whose health or BH condition has been treated by specialty care providers or whose health could be placed in jeopardy if Medically Necessary Covered Services are 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 PA from either another MCO or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

1. 90 calendar 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.

The MCO must make every effort to outreach to and recruit providers providing services to Members, including individual BH providers providing services in RTCs.

The MCO must allow pregnant Members with 12 weeks or less remaining before the expected delivery date past the 24th week of pregnancy to remain under the care of the Member's current OB/GYN through the Member's delivery, immediate postpartum care, and the follow-up postpartum checkup, even if the provider is OON. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

The MCO must pay a Member's existing OON providers for Medically Necessary Covered Services until the Member's records, clinical information and care can be transferred to a Network Provider. Payment to OON providers must be made within the time period required for Network Providers. The MCO must comply with OON provider reimbursement rules as adopted by HHSC and found in 1 Tex. Admin. Code § 353.4.

With the exception of pregnant Members who are past the 24th week of pregnancy, this section does not extend the obligation of the MCO to reimburse the Member's existing OON providers for ongoing care for more than 90 days after a Member enrolls in the MCO, or for more than nine months in the case of a Member who, at the time of enrollment in the MCO, has been

diagnosed with and is receiving treatment for a terminal illness and remains enrolled in the MCO.

The MCO's obligation to reimburse the Member's existing OON provider for services provided to a pregnant Member past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

The MCO must provide or pay OON providers who provide Medically Necessary Covered Services to Members who move out of the state through the end of the period for which capitation has been paid for the Member.

The MCO must provide Members with timely and adequate access to OON Covered Services for as long as those services are necessary and are not available within the Network, in accordance with 42 C.F.R. § 438.206(b)(4). The MCO will not be obligated to provide a Member with access to OON services if such Covered Services become available from a Network Provider.

The MCO must ensure that each Member, DFPS Staff, Caregiver or Medical Consenter has access to a second opinion regarding the use of any Medically Necessary Covered Service. A Member, DFPS Staff, Caregiver or Medical Consenter must be allowed access to a second opinion from a Network Provider or OON provider if a Network Provider is not available, at no cost to the Member, in accordance with 42 C.F.R. § 438.206(b)(3).

#### **8.1.27.1 For MDCP Members**

The MCO must ensure that the healthcare of MDCP Members enrolled November 1, 2016, is not disrupted, compromised, or interrupted. The MCO must take special care to provide continuity in the care of enrolled Members who are Medically Fragile and those whose physical or behavioral health could be placed in jeopardy if Medically Necessary Covered Services are disrupted, compromised, or interrupted.

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 either another MCO or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following: (1) 180 calendar days after the transition to a new MCO, (2) until the end of the current prior authorization, or (3) until the MCO has appropriately evaluated and administered the STAR Health MDCP Screening and Assessment Process and issued or denied a new authorization. MCOs must allow Members to continue seeing their existing providers, including Out of Network Providers, for the 180 day period.

#### **8.1.28 Provisions Related to Covered Services for Members**

##### **8.1.28.1 Emergency and Post-Stabilization Services**

MCO Emergency Services and Post-Stabilization Care Services policies and procedures, Covered Services, claims adjudication methodology, and reimbursement performance must comply with all applicable state and federal laws, rules, and regulations including 42 C.F.R. §

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438.114 and Title 1, Texas Administrative Code, Chapter 353, Medicaid Managed Care. These requirements apply whether the provider is Network or Out-of-Network.

The MCO must pay for the professional, facility, and ancillary services that are related to the provision of Emergency Services needed to evaluate or stabilize an Emergency Medical Condition, and Emergency BH Condition, and Post-Stabilization Care Services 24 hours a day, seven days a week, rendered by either the MCO's Network or Out-of-Network providers.

The MCO cannot require a PA as a condition for payment for Emergency Services. The MCO cannot limit what constitutes an Emergency Medical Condition or an Emergency BH Condition on the basis of lists of diagnoses or symptoms. The MCO cannot refuse to cover Emergency Services based on the emergency room provider, Hospital, or fiscal agent not notifying the Member's PCP or the MCO of the Member's screening and treatment within ten calendar days of presentation for Emergency Services. The MCO may not hold the Member who has an Emergency Medical Condition or an Emergency BH Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. The MCO must accept the attending emergency physician's or the treating provider's determination of when the Member is sufficiently stabilized for transfer or discharge.

Emergency Services must be provided in a Hospital-based emergency department that meets the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 C.F.R. §§ 489.20, 489.24, and 438.114(b)&(c)). The MCO must pay for the emergency medical screening examination, as required by 42 U.S.C. § 1395dd. The MCO must reimburse for both the physician's services and the Hospital's Emergency Services, including the emergency room and its ancillary services.

When the medical screening examination determines that an Emergency Medical Condition or an Emergency BH Condition exists, the MCO must pay for Emergency Services performed to stabilize the Member (Post-Stabilization Care Services). The emergency physician must document these services in the Member's medical record. The MCO must reimburse for both the physician's and Hospital's emergency stabilization services including the emergency room and its ancillary services.

The MCO must cover and pay for Post-Stabilization Care Services in the amount, duration, and scope required by 42 C.F.R. § 438.114(b)&(e) and 42 C.F.R. § 422.113(c).

#### **8.1.28.2 Family Planning—Specific Requirements**

The MCO must require, through Provider Contract provisions, that Members requesting contraceptive services or family planning services are also provided counseling and education about the family planning and family planning services available to Members. The MCO must develop outreach programs to increase community support for family planning and encourage Members to use available family planning services.

The MCO must ensure that Members and their Medical Consenters have the right to choose any Medicaid participating family planning provider, whether the provider chosen by the Member and their Medical Conserter is in or outside the Provider Network. The MCO must provide

Members and their Medical Consenters access to information about available providers of family planning services and the Member and their Medical Consenter's right to choose any Medicaid family planning provider. The MCO must provide access to confidential family planning services.

The MCO must provide at a minimum, the full scope of services available under the Texas Medicaid program for family planning services. The MCO will reimburse family planning agencies the Medicaid Fee-for Service amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies and will reimburse OON family planning providers in accordance with HHSC's administrative rules. The MCO cannot require a PA for family planning services whether rendered by a Network or Out-of-Network provider.

The MCO must provide medically approved methods of contraception to Members, provided that the methods of contraception are Covered Services. Contraceptive methods must be accompanied by verbal and written instructions on their correct use. The MCO must establish mechanisms to ensure all medically approved methods of contraception are made available to the Member, either directly or by referral to a Subcontractor.

The MCO must develop, implement, monitor, and maintain standards, policies and procedures for providing information regarding family planning to Providers, Members, Caregivers, and Medical Consenters, specifically regarding state and federal laws governing Member confidentiality (including minors). Providers and family planning agencies cannot require parental consent for minors to receive family planning services. The MCO must require, through contractual provisions, that Subcontractors have mechanisms in place to ensure Member's (including minor's) confidentiality for family planning services.

### **8.1.28.3 Texas Health Steps (EPSDT) Medical and Dental**

#### **8.1.28.3.1 Medical Checkups**

The MCO must develop effective methods to ensure that Members receive Texas Health Steps medical checkup services according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the **TMPPM**, which includes checkups from birth through age 20. Medical services must be provided within-30 days of enrollment for all Members. Texas Health Steps dental services must be provided to Members 6 months of age through the month of their 21st birthday. Members 6 months of age and older must receive Texas Health Steps dental services within 60 days of enrollment, when due and according to the AAPD recommendations. Members under 6 months of age at the time of enrollment must receive their initial Texas Health Steps dental checkup within 30 days of becoming 6 months of age.

The MCO must arrange for Texas Health Steps medical checkup services for all eligible Members except when a Member's Caregiver or Medical Consenter knowingly and voluntarily declines or refuses services after receiving sufficient information to make an informed decision. A refusal to obtain a Texas Health Steps checkup for the Member must be authorized by the DFPS Caseworker.

A checkup for an Existing Member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date based on the Member's birth date. A Texas Health Steps medical checkup for an Existing Member age three years and older is due annually beginning on the child's birthday and is considered timely if it occurs no later than 364 calendar days after the child's birthday. For New Members birth through age 20, overdue or upcoming Texas Health Steps medical checkups should be offered as soon as practicable, but in no case later than 30 days of enrollment for all Members. For purposes of this requirement, the terms "New Member" and "Existing Member" are defined in **UMCM Chapter 12.4**, "MMC THSteps Report Instructions."

For the purposes of this contract section only, enrollment means the effective date received on the Daily Eligibility file.

In addition, in compliance with Tex. Fam. Code § 264.1075(b), the MCO must arrange for an assessment of each Member in conservatorship to determine if the Member has an intellectual or developmental disability. The MCO may use the Texas Health Steps visits and other relevant screenings or assessments performed by the PCP to comply with this provision of the Family Code.

#### **8.1.28.3.2 Oral Evaluation and Fluoride Varnish**

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The MCO must educate Providers on the availability of the Oral Evaluation and Fluoride Varnish (OEFV) Medicaid benefit that can be rendered and billed by certified Texas Health Steps providers when performed on the same day as the Texas Health Steps medical checkup. The MCO must educate Providers about the importance of OEFV documentation for inclusion in the Member's medical record, and the necessity of documentation to support a qualification for reimbursement for appropriate provision of OEFV to eligible Members. The Provider education must include information about how to assist a Member with referral to a dentist to establish a dental home.

#### **8.1.28.3.3 Lab**

The MCO must require Providers to send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.

All laboratory specimens collected as a required component of a Texas Health Steps checkup (see **TMPPM** for age-specific requirements), must be submitted to the DSHS Laboratory Services Section or to a laboratory approved by the department under Texas Health & Safety Code Section 33.016 for analysis unless the **TMPPM**, Children's Services Handbook provides otherwise. The MCO must educate Providers about Texas Health Steps Program requirements for submitting laboratory tests to the DSHS Laboratory Services Section.

#### **8.1.28.3.4 Education/Outreach**

The MCO must ensure that Members, Caregivers, and Medical Consenters are provided information and educational materials about the services available through the Texas Health Steps Program, and how and when they may obtain the services. The information should tell the Member, Caregiver and Medical Consenter how they can obtain medical and dental benefits, transportation services through HHSC's NEMT Program, and advocacy assistance from the MCO. The **UMCM Chapter 3.24**, "MMC Texas Health Steps Outreach Materials," includes required language for Texas Health Steps services, including medical, dental, and case management services. Any additions to or deviations from the required language must be reviewed and approved by HHSC prior to publication and distribution to Members.

The MCO will contact Members, Caregivers, and Medical Consenters in the manner designated by HHSC to inform them to obtain Texas Health Steps services as soon as possible and of outreach opportunities. Each month, the MCO must retrieve from the HHSC Administrative Services Contractor Bulletin Board System a list of Members who are due and overdue Texas Health Steps services. Using these lists and its own internally generated list, the MCO will contact such Members, Caregivers and Medical Consenters to obtain the service as soon as possible. The MCO outreach staff must ensure that Members, Caregivers and Medical Consenters have access to the HHSC NEMT Program. The MCO outreach staff must coordinate with the Texas Health Steps call center, agencies or staff for any other Texas Health Steps coordination needs.

The MCO must make an effort to coordinate and cooperate with existing community and school-based health and education programs that offer services to school-aged children in a location that is both familiar and convenient to the Members.

#### **8.1.28.3.5 Training**

The MCO must provide appropriate training to all Network Providers and Provider staff in the Provider's area of practice regarding the scope of benefits available and the Texas Health Steps Program. Training must include:

1. Texas Health Steps benefits and training on how to use the mandatory Texas Health Steps forms;
2. the periodicity schedule for Texas Health Steps medical and dental checkups and immunizations;
3. required components of Texas Health Steps medical and dental checkups, the importance of documenting all required components of the checkup in the medical record, and the necessity of documentation to support a complete checkup qualifying for reimbursement is provided;
4. providing or arranging for all required lab screening tests (including lead screening), the importance of lab screening (including lead screening) documentation completed for Texas Health Steps medical checkups;
5. Comprehensive Care Program (CCP) services available under the Texas Health Steps program to Members;
6. Services available through the NEMT Program such as rides to healthcare service by bus, taxi, van, airfare, etc.; gas money, mileage reimbursement, meals and lodging when away from home;

7. Services available through Case Management for CPW and how to make referrals;
8. importance of updating contact information to ensure accurate Provider directories and the Medicaid Online Provider Lookup;
9. missed appointment referrals and assistance provided by the THSteps Outreach and Informing Unit;
10. administrative issues such as claims filing (including the processes regarding claims appeals and recoupments) and services available to Members;
11. 72-hour emergency supply prescription policy and procedures;
12. outpatient prescription drug PA process;
13. how to access the Medicaid formulary and PDL on HHSC's website;
14. how to use HHSC's free subscription service for accessing the Medicaid formulary and PDL through the internet or hand-held devices;
15. scope of DME and other items commonly found in a pharmacy that are available for class Members; and
16. Providers' obligation to identify and report a Critical Event or Incident such as Abuse or Neglect (CPS) to the state.

The MCO must include specific information in training materials (such as in the MCO's Provider Manual) pertaining to Attention Deficit Hyperactivity Disorder (ADHD) Covered Services for children including reimbursement for ADHD and availability of follow-up care for children who have been prescribed ADHD medications. Providers should be educated and trained to treat each Texas Health Steps visit as an opportunity for a comprehensive assessment of the Member.

The MCO will encourage Medicaid-enrolled pharmacies to also become Medicaid-enrolled DME Providers.

At least seventy-five percent (75%) of the MCO's network of PCPs must be enrolled as Texas Health Steps providers at all times. The MCO will implement an HHSC approved process by which it will systematically outreach contracted PCPs for enrollment and participation in the Texas Health Steps program. The MCO must require PCPs who are not enrolled Texas Health Steps providers to refer Members to Texas Health Steps providers for Texas Health Steps screenings. The MCO must also require non-PCP Texas Health Steps providers to notify the Members' PCP of the results of the Texas Health Steps exams, and refer Members to the PCP for follow-up services recommended as a result of the Texas Health Steps screening. HHSC will monitor the MCO's compliance with these requirements on a quarterly basis by comparing the MCO's PCP Provider list with Texas Health Steps listing of enrolled providers, in accordance with Performance Indicator Dashboard.

The MCO must educate Providers about blood lead level reporting under Texas Health & Safety Code Chapter 88 and 25 Tex. Admin. Code Chapter 37, Subchapter Q; coordination with the Texas Childhood Lead Poisoning Prevention Program at DSHS; and appropriate follow-up testing and care, including the Centers for Disease Control and Prevention guidelines located at [http://www.dshs.state.tx.us/lead/pdf\\_files/pb\\_109\\_physician\\_reference.pdf](http://www.dshs.state.tx.us/lead/pdf_files/pb_109_physician_reference.pdf). The MCO must educate Providers about Medicaid coverage for lead screening, follow-up testing, and environmental lead investigations, whether as Non-capitated services or Covered Services.

### **8.1.28.3.6 Data Validation**

An MCO must require all Texas Health Steps Providers to submit claims for services paid on the NSF 837 claim form or CMS 1500 claim form and use the HIPAA compliant code set required by HHSC.

HHSC or its designee will validate Encounter Data by comparing chart review data and Encounter Data for a random sample of Members. HHSC or its designee will conduct chart reviews to validate that all components of the Texas Health Steps checkups are performed when due and as reported, and that reported data are accurate and timely. Substantial deviation between reported and charted Encounter Data could result in the MCO or Network Providers being investigated for potential Fraud, Waste, and Abuse infractions without notice to the MCO or the Provider.

### **8.1.28.4 Perinatal Services**

The MCO's perinatal Healthcare Services must ensure appropriate care is provided to Members and infant Members from the preconception period through the infant's first year of life. The MCO's perinatal healthcare system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M.

The MCO must have a perinatal healthcare system in place that, at a minimum, provides the following services:

1. Pregnancy planning and perinatal health promotion and education for reproductive- age women and adolescents;
2. perinatal risk assessment of non-pregnant women, pregnant and postpartum women, and infants up to one year of age;
3. access to appropriate levels of care based on risk assessment, including emergency care;
4. transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
5. availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems;
6. availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems; and
7. education and care coordination for Members who are at high-risk for preterm labor, including education on the availability of medication regimens to prevent preterm birth, such as hydroxyprogesterone caproate. The MCO should also educate Providers on the PA processes for these benefits and services.

On a monthly basis, HHSC will supply the MCO with a file containing birth record data. The MCO must use this file to identify reproductive-age Members with a previous preterm birth. The MCO must provide outreach to, education to, and care coordination for identified Members as described in this section to prevent preterm births. Care coordination may include Service Management under **Section 8.1.13.2**, "Access to Care and Service Management" and Member referrals to Providers to assess the need for the use of hydroxyprogesterone caproate. The

MCO must report on use of the data file as specified **Section 8.1.20.2**, “Reports” and in **UMCM Chapter 5.16** "Perinatal Risk Report".

The MCO must have a process to expedite scheduling a prenatal appointment for an obstetrical exam for a pregnant Member no later than two weeks after the MCO learns of her pregnancy.

The MCO must have procedures in place to contact and assist DFPS Staff, the Medical Consenter or the pregnant/delivering Member in selecting a PCP for her baby as soon as the baby is born.

The MCO must provide Medically Necessary Covered Services relating to the labor and delivery for its pregnant/delivering Members, including inpatient care and professional services for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated Caesarian delivery. The MCO must provide all Medically Necessary neonatal care to the Newborn Member, and may not place limits on the duration of such care.

The MCO must adjudicate provider claims for services provided to a newborn Member in accordance with HHSC’s claims processing requirements using the proxy ID number or state-issued Medicaid ID number. The MCO cannot deny claims based on a provider’s non-use of state-issued Medicaid ID number for a newborn Member. The MCO must accept provider claims for newborn services based on mother’s name or Medicaid ID number with accommodations for multiple births, as specified by the MCO.

The MCO must notify providers involved in the care of pregnant/delivering women and newborns (including OON providers and Hospitals) of the MCO’s PA requirements. The MCO cannot require a PA for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the emergency condition arises.

#### **8.1.28.5 Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)**

The MCO must provide STD services that include STD/HIV prevention, screening, counseling, diagnosis, and treatment. The MCO is responsible for implementing procedures to ensure that Members have prompt access to appropriate services for STDs, including HIV. The MCO must allow Members access to STD services and HIV diagnosis services without a PA or referral by a PCP.

The MCO must comply with Texas Family Code § 32.003, relating to consent to treatment by a child. The MCO must provide all Covered Services required to form the basis for a diagnosis by the Provider as well as the STD/HIV treatment plan.

The MCO must make education available to Providers, Members, Caregivers and Medical Consenters, on the prevention, detection and effective treatment of STDs, including HIV.

The MCO must require Providers to report all confirmed cases of STDs, including HIV, to the local or regional health authority according to 25 Tex. Admin. Code §§ 97.131–97.134, using the required forms and procedures for reporting STDs. The MCO must require the Providers to coordinate with the HHSC regional health authority to ensure that Members with confirmed

cases of syphilis, chancroid, gonorrhea, chlamydia and HIV receive risk reduction and partner elicitation/notification counseling, as appropriate.

The MCO must have established procedures to make Member records available to public health agencies with authority to conduct disease investigation, receive confidential Member information, and provide follow up activities.

The MCO must require that Providers have procedures in place to protect the confidentiality of Members provided STD/HIV services. These procedures must include, but are not limited to, the manner in which medical records are to be safeguarded, how employees are to protect medical information, and under what conditions information can be shared. The MCO must inform and require its Providers who provide STD/HIV services to comply with all state laws relating to communicable disease reporting requirements. The MCO must implement policies and procedures to monitor Provider compliance with confidentiality requirements.

The MCO must have policies and procedures in place regarding obtaining informed consent and counseling Members provided STD/HIV services. See also the **Procurement Library** for the DFPS policy related to acquired immune deficiency syndrome (AIDS) and AIDS prevention.

#### **8.1.28.6 Tuberculosis (TB)**

The MCO must provide Members, Caregivers, Medical Consenters, and Providers with education on the prevention, detection and effective treatment of tuberculosis (TB). The MCO must develop policies and procedures to ensure that all Members are screened for TB. The MCO must establish mechanisms to ensure all procedures required to screen Members for TB, and to form the basis for a diagnosis and proper prophylaxis and management of TB, are available to all Members, Caregivers and Medical Consenters, except services referenced in **Section 8.1.28.8**, "Medicaid Non-capitated Services." The MCO must consult with the local TB control program to ensure that all services and treatments are in compliance with the guidelines recommended by the American Thoracic Society (ATS), the CDC, and DSHS policies and standards.

The MCO must implement policies and procedures requiring Providers to report all confirmed or suspected cases of TB to the local TB control program within one Business Day of identification, using the most recent DSHS forms and procedures for reporting TB. The MCO must provide access to Member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases upon request.

The MCO must coordinate with the local TB control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). The MCO must require, through contract provisions, that Providers report to DSHS or the local TB control program any Member who is non-compliant, drug resistant, or who is or may be posing a public health threat. The MCO must cooperate with the local TB control program in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Texas Health and Safety Code.

The MCO must have a mechanism for coordinating a post-discharge plan for follow-up DOT with the local TB program. The MCO must coordinate with the DSHS South Texas Healthcare

System and Texas Center for Infectious Disease for voluntary and court-ordered admission, discharge plans, treatment objectives and projected length of stay for Members with multi-drug resistant TB.

### **8.1.28.7 Objection to Provide Certain Services**

In accordance with 42 C.F.R. § 438.102, the MCO may file an objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a Covered Service based on moral or religious grounds. The MCO must work with HHSC to develop a work plan to complete the necessary tasks and determine an appropriate date for implementation of the requested changes to the requirements related to Covered Services. The work plan will include timeframes for completing the necessary Contract and waiver amendments, adjustments to Capitation Rates, identification of the MCO and enrollment materials needing revision, and notifications to Members.

In order to meet the requirements of this section, the MCO must notify HHSC of grounds for and provide detail concerning its moral or religious objections and the specific services covered under the objection, no less than 120 days prior to the proposed effective date of the policy change.

### **8.1.28.8 Medicaid Non-capitated Services**

The following Texas Medicaid programs, services, or benefits have been excluded from MCO Covered Services. Medicaid Members are eligible to receive these Non-capitated services on another basis, such as a Fee-for-Service basis, and FFCC Members may be eligible for some of these services. MCOs should refer to relevant chapters in the TMPPM for more information.

1. Texas Health Steps environmental lead investigation (ELI);
2. ECI Case Management;
3. ECI Specialized Skills Training;
4. Case Management for CPW;
5. Texas School Health and Related Services (SHARS);
6. DARS Blind Children's Vocational Discovery and Development Program;
7. Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation);
8. HHSC NEMT Program;
9. DADS hospice services;
10. Court-Ordered Commitments to inpatient BH facilities as a condition of probation; and-
11. Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members.

### **8.1.28.9 Referrals for Non-capitated Services**

Although the MCO is not responsible for paying or reimbursing Non-capitated Services, the MCO is responsible for educating Members, Caregivers, Medical Consenters, and DFPS Staff about the availability of Non-capitated Services, and for providing appropriate referrals for Members, Caregivers, and Medical Consenters to obtain or access these services. The MCO is responsible for informing Providers that bills for all Non-capitated Services must be submitted to HHSC's Claims Administrator for reimbursement.

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### **8.1.28.10 Immunizations**

Section  
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The MCO must educate Providers on the Immunization Standard Requirements set forth in Texas Health & Safety Code Chapter 161; the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule; and the ACIP Immunization Schedule for Medicaid Members. The MCO must educate Providers that Medicaid Members birth through age 20 must be immunized during the Texas Health Steps checkup according to the ACIP routine immunization schedule. The MCO must also educate Providers that the screening Provider is responsible for administration of the immunization and should not refer children to Local Health Departments 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 Texas Health & Safety Code Chapter 161 relating to the Texas Immunization Registry (ImmTrac), to include Medical Consenter consent on the Vaccine Information Statement.

The MCO must notify Providers that they may enroll, as applicable, as Texas Vaccines for Children Providers. In addition, the MCO must work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac Registry.

### **8.1.29 Medicaid Significant Traditional Providers (STPs)**

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The MCO must seek participation in its Network from all STPs listed in the **Procurement Library**. The MCO must also seek participation in its Network from healthcare providers on contract or subcontract with DFPS. The **Procurement Library** contains a list of DFPS residential providers. DFPS residential providers often have healthcare providers on contract to provide Medicaid services to the Target Population. These healthcare providers on contract with DFPS residential providers are considered STPs.

HHSC defines STPs as any Provider currently serving STAR Health Members.

The MCO must provide all types of STPs above the opportunity to participate in its Network on an ongoing basis. Upon the request of a Member or their Caregiver to contract with a particular healthcare provider, the MCO must make best efforts to recruit that provider into the Network. However, the STP provider must:

1. Agree to accept the MCO's Provider reimbursement rate for the provider type
2. Meet the standard credentialing requirements of the MCO, provided that lack of board certification or accreditation by The Joint Commission (TJC) is not the sole grounds for exclusion from the Provider Network.

The MCO is not obligated to retain STPs in the Provider Network that the MCO has determined to be non-compliant with requirements in the Provider Contract. The MCO may terminate a Network Provider Contract with an STP after demonstrating, to the satisfaction of HHSC, good

cause for the termination. Good cause may include evidence of provider fraud, waste, or abuse. The MCO must provide documentation on Providers terminated due to non-compliant, upon HHSC's request.

Medicaid STP requirements apply statewide for Community First Choice (CFC) through February 28, 2018, for Providers with a valid certification or license (as applicable) and who are:

- a) Home and community support services agencies licensed under Texas Health and Safety Code Chapter 142 that are contracted with DADS to provide services under the Community Living Assistance and Support Services (CLASS) or Deaf Blind Multiple Disabilities (DBMD) waiver programs; or
- b) Providers exempted from licensing under Texas Health and Safety Code § 142.003(a)(19) and are contracted with DADS to provide services under the Home and Community-based Services (HCS) or Texas Home Living (TxHmL) waiver programs.

Medicaid STP requirements apply statewide for providers of MDCP services through October 31, 2019. MDCP provider requirements are stated in **Section 8.2** "Additional Requirements Regarding the Medically Dependent Children Program (MDCP)".

### **8.1.30 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)**

The MCO must make reasonable efforts to include FQHCs and RHCs (freestanding and Hospital-based) in its Provider Network. The MCO must reimburse FQHCs, RHCs, and municipal health departments' public clinics for Healthcare Services provided outside of regular business hours, (defined under 1 Tex. Admin. Code § 353.2(51), as time before 8:00 a.m. and after 5:00 p.m. Monday through Friday, weekends, and federal holidays,) at a rate that is equal to the allowable rate for those services as determined under Texas Human Resources Code § 32.028, if the Member does not have a referral from his or her PCP.

The MCO must pay full encounter rates to FQHCs and RHCs for Medically Necessary Covered Services provided to Medicaid and CHIP Members 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.

### **8.1.31 Provider Complaints and Appeals**

#### **8.1.31.1 Provider Complaints**

The MCO must develop, implement, and maintain a system for tracking and resolving all Provider Complaints. Within this process, the MCO must fully and completely respond to each Complaint and establish a tracking mechanism to document the status and final disposition of each Provider Complaint.

The MCO must resolve Provider Complaints within 30 days from the date the Complaint is received. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Provider Complaints are not resolved within 30 days of receipt of the Complaint by the MCO.

The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Provider Complaints are not resolved within 30 days of receipt of the Complaint by the MCO (See **Attachment A**, “STAR Health Contract Terms,” and **Attachment B-3**, “Deliverables/Liquidated Damages Matrix.”)

MCO must also resolve Provider Complaints received by HHSC no later than the due date indicated on HHSC’s notification form. HHSC will generally provide MCO 10 Business Days to resolve such Complaints. If MCO cannot resolve a Complaint by the due date indicated on the notification form, it may submit a request to extend the deadline. HHSC may, in its reasonable discretion, grant a written extension if the MCO demonstrates good cause.

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

#### **8.1.31.2 Appeal of Provider Claims**

The MCO must develop, implement, and maintain a system for tracking and resolving all Provider Appeals related to claims payment, as required by Texas Government Code § 533.005(a)(15). Within this process, the MCO must respond fully and completely to each provider’s claims payment Appeal and establish a tracking mechanism to document the status and final disposition of each provider’s claims payment Appeal.

In addition, the MCO’s process must comply with Texas Government Code § 533.005(a)(19).

The MCO is subject to liquidated damages if at least 98 percent of Provider Appeals are not resolved within 30 days of the MCO’s receipt.

The MCO must contract with non-network physicians to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a Provider Appeal. The physician resolving the dispute must not be an employee of the MCO’s Medicaid or CHIP business but may be an employee in the MCO’s Medicare or commercial lines of business. The determination of the physician resolving the dispute must be binding on the MCO and a Network Provider. The physician resolving the dispute must be licensed in the State of Texas and hold the same specialty or a related specialty as the appealing Provider. HHSC reserves the right to amend this process to include an independent review process established by HHSC for final determination on these disputes.

#### **8.1.32 Member Rights and Responsibilities**

In accordance with 42 C.F.R. § 438.100, the MCO must maintain written policies and procedures for informing Members, DFPS Staff, and Medical Consenters of their rights and responsibilities, and the right to a Medicaid Fair Hearing separate from the Appeals process for all Members.

The MCO must notify Members, DFPS Staff, and Medical Consenters of their right to request a copy of these rights and responsibilities. The Member handbook must include notification of Member, DFPS Staff, and Medical Consenter rights and responsibilities.

### **8.1.33 Member Complaint and Appeal System**

The MCO must develop, implement, and maintain a Member Complaint and Appeal system that complies with the requirements in applicable federal and state laws, rules and regulations, including 42 C.F.R. § 431.200, 42 C.F.R. Part 438, Subpart F, "Grievance System," and the provisions of 1 Tex. Admin. Code Chapter 357 relating to Medicaid MCOs.

The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC's Fair Hearing System. The procedures must be the same for all Members, DFPS Staff, and Medical Consenters, and must be reviewed and approved in writing by HHSC or its designee. Providers and Caregivers who are not Medical Consenters may file a Complaint or an Appeal on behalf of a Member if authorized by the Medical Consenter. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC's approval at least 30 days prior to the implementation.

#### **8.1.33.1 Member Complaint Process**

The MCO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members, DFPS Staff, or Medical Consenters.

The MCO must resolve Complaints within 30 days from the date the Complaint is received. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 days of receipt of the Complaint by the MCO (See **Attachment A**, "STAR Health Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix."

MCO also must resolve Member Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will provide MCO up to 10 Business Days to resolve these Complaints, depending on the severity or urgency of the Complaint. HHSC may, in its reasonable discretion, grant a written extension if the MCO demonstrates good cause. Unless the HHSC has granted a written extension as described above, the MCO is subject to remedies, including damages if Member Complaints are not resolved by the timeframes indicated in this section.

The Complaint procedure must be the same for all Members, DFPS Staff, and Medical Consenters. Member, DFPS Staff, or Medical Consenter may file a Complaint either orally or in writing. The MCO must also inform Members, DFPS Staff, and Medical Consenters how to file a Complaint directly with HHSC, once the Member, DFPS Staff, or Medical Consenter has exhausted the MCO's Complaint process.

The MCO must designate an officer of the MCO who has primary responsibility for ensuring that Complaints are resolved in compliance with written policy and within the required timeframe. For purposes of this section, an "officer" of the MCO means a president, vice president, secretary,

treasurer, or chairperson of the board for a corporation, the sole proprietor, the managing general partner of a partnership, or a person having similar executive authority in the organization.

The MCO must have a routine process to detect patterns of Complaints. Management, supervisory, and Quality Improvement staff must be involved in developing policies and procedures to address Complaints.

The MCO's Complaint procedures must be provided to Members, DFPS Staff, and Medical Consenters in writing and through oral interpretive services. A written description of the MCO's Complaint procedures must be available in Spanish and other prevalent non-English languages for Major Population Groups identified by HHSC, at no more than a 6th-grade reading level. The MCO must include a written description of the Complaint process in the Member handbook. The MCO must maintain and publish in the Member handbook, at least one toll-free telephone number with TeleTypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities for making Complaints. The MCO must provide such oral interpretive service to callers free of charge.

The MCO's process must require that every Complaint received in person, by telephone, or in writing be acknowledged and recorded in a written record and logged with the following details:

1. Date;
2. identification of the individual filing the Complaint;
3. identification of the individual recording the Complaint;
4. nature of the Complaint;
5. disposition of the Complaint (i.e., how the MCO resolved the Complaint);
6. corrective action required; and
7. date resolved.

For Complaints that are received in person or by telephone, the MCO must provide Members, DFPS Staff, and Medical Consenters with written notice of resolution if the Complaint cannot be resolved within one working day of receipt.

The MCO is prohibited from discriminating or taking punitive action against a Member, DFPS Staff, or Medical Consenter for making a Complaint or filing an Appeal.

The MCO will cooperate with HHSC or its designee to resolve all Member, DFPS Staff, or Medical Consenter Complaints. Such cooperation may include, but is not limited to, providing information or assistance to HHSC Complaint team members.

The MCO must provide designated Member Advocates to assist Members, DFPS Staff, and Medical Consenters in understanding and using the MCO's Complaint system as described in **Section 8.1.33**, "Member Complaint and Appeal System." The MCO's Member Advocates must assist Members, DFPS Staff, and Medical Consenters in writing or filing a Complaint and monitoring the Complaint through the MCO's Complaint process until the issue is resolved.

### **8.1.33.2 Member Pre-Appeal Process**

The MCO must develop, implement and maintain a Pre-Appeals process for Members for tracking, resolving, and reporting disputes regarding the potential 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. The purpose of this process is to facilitate and expedite the resolution of disputes that may escalate and delay or impair the Member's receipt of services. The MCO should make consistent good-faith efforts to reach compromise and resolution, with the goal of resolving the majority of disagreements regarding potential denials or limited authorization of services before they become formal Member Appeals.

The Pre-Appeal Process agreed upon by HHSC, DFPS, and the MCO takes place when upon the review of an authorization request for Member services, Medical Management staff concludes there is either a) insufficient clinical or other information for a Covered Service to be authorized, or b) the available information does not meet the Medical Necessity criteria for the Covered Service. In this case, the MCO's Medical Management staff will contact the requesting Provider's office to determine if additional information is available. If additional information is available and, upon review of such information, the MCO determines that the Covered Service meets Medical Necessity criteria, it will approve the Covered Service within three Business Days of receipt of the service authorization request. If additional information is not available, the request for services is transferred to the Medical Director, or his/her designee, for review.

The Medical Director, or his/her designee, will make at least two attempts to schedule a peer-to-peer review to obtain additional clinical information or coordinate to provide acceptable alternative care options. The second attempt to contact the Provider will be made no sooner than four business hours after the first attempt. The Medical Director, or his/her designee, will consider any new information presented. In cases where all information relevant to the decision is available and the Covered Service meets Medical Necessity criteria, the requested services will be approved within 15 days from the date the additional information was requested. If, after all new information is reviewed, the Covered Service still does not meet Medical Necessity criteria, the Medical Management staff will request to obtain all available and necessary information relevant to the Pre-Appeal, by contacting the Member, or the Member's Medical Consenter, Caregiver, or DFPS staff.

If any additional information is obtained and if the requested Covered Service meets Medical Necessity criteria, the MCO's Medical Management staff must approve the services requested within 15 days from the date it requested the additional information. If the resolution of the Pre-Appeal is to approve the request for a Covered Service, the MCO will give the affected healthcare Provider(s) written notice of the Pre-Appeal resolution on the same day it gives notice to the Member or the Member's Medical Consenter. If no additional information is available or if the information provided does not meet Medical Necessity criteria for the Covered Service, the MCO must refer this information back to its Medical Director, or his/her designee, who must issue a final resolution to the Pre-Appeal within 48 hours of receiving the file from the Medical Management staff. The Medical Director, or his/her designee, may reverse a proposed denial, or deny the requested Covered Service with guidance for the provision of acceptable alternative care options. If the resolution of the Pre-Appeal approves the request for the Covered Service, the Medical Management staff must communicate the resolution verbally and in writing to the Member or the Medical Consenter. The MCO must give the affected healthcare

Provider(s) written notice of the Pre-Appeal resolution on the same day it gives notice to the Member or the Member's Medical Consenter.

### **8.1.33.3 Standard Member Appeal Process**

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The MCO must develop, implement and maintain an Appeal process by which a Member or his or her representative, Medical Consenter or DFPS Staff can request a review of the MCO's Action. This procedure must comply with the state and federal laws, rules and regulations, including 42 C.F.R. § 431.200 and 42 C.F.R. Part 438, Subpart F, "Grievance System." The Appeal procedure must be the same for all Members, DFPS Staff, and Medical Consenters. When a Member, DFPS Staff, or Medical Consenter expresses orally or in writing any dissatisfaction or disagreement with an Action, the MCO must regard the expression of dissatisfaction as a request to Appeal an Action.

A Member, DFPS Staff, or Medical Consenter must file a request for an Appeal with the MCO within 30 days from receipt of the notice of the Action. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Appeals are not resolved within 30 days of receipt of the Appeal by the MCO (See **Attachment A**, "STAR Health Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix." To ensure continuation of currently authorized services, however, the Member must file the Appeal on or before the later of 10 days following the MCO's mailing of the notice of the Action, or the intended effective date of the proposed Action. The MCO must designate an officer who has primary responsibility for ensuring that Appeals are resolved in compliance with written policy and within the 30-day time limit.

The provisions of Texas Insurance Code Chapter 4201, relating to a Member's right to Appeal an Adverse Determination made by the MCO or a UR agent to an independent review organization, do not apply to a Medicaid recipient. These provisions are pre-empted by Federal Fair Hearings requirements.

The MCO must have policies and procedures in place outlining the Medical Director's role in an Appeal of an Action. The Medical Director must have a significant role in monitoring, investigating and hearing Appeals. In accordance with 42 C.F.R. § 438.406, the MCO's policies and procedures must require that individuals who make decisions on Appeals are not involved in any previous level of review or decision-making, and are healthcare professionals who have the appropriate clinical expertise in treating the Member's condition or disease.

The MCO must provide designated Member Advocates, as described in **Section 8.1.33.10**, "Member Advocates," to assist Members, DFPS Staff, and Medical Consenters in understanding and using the Appeal process. The MCO's Member Advocates must assist Members, DFPS Staff, and Medical Consenters in writing or filing an Appeal and monitoring the Appeal through the MCO's Appeal process until the issue is resolved.

Requirements regarding the MCO's obligation to respond to each Member Appeal, and the timeframes associated with those responses, are identical to the requirements regarding Member Complaints in **Section 8.1.33.1**, "Member Complaint Process."

During the Appeal process, the MCO must provide the Member, DFPS Staff, and Medical Consenter a reasonable opportunity to present evidence and any allegations of fact or law in person as well as in writing. The MCO must inform the Member, DFPS Staff, and Medical Consenter of the time available for providing this information and that, in the case of an expedited resolution, limited time will be available.

The MCO must provide the Member, DFPS Staff, and Medical Consenter an opportunity, before and during the Appeal process, to examine the Member's case file, including medical records and any other documents considered during the Appeal process. The MCO must include, as parties to the Appeal, the Member, DFPS Staff, and Medical Consenter, or the legal representative of a deceased Member's estate. The MCO must also seek information and participation from the Caregiver when appropriate.

In accordance with 42 C.F.R. § 438.420, the MCO must continue the Member's benefits currently being received by the Member, including the benefit that is the subject of the Appeal, if all of the following criteria are met:

1. The Member, DFPS Staff, or Medical Consenter files the Appeal timely as defined in this Contract;
2. the Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. the services were ordered by an authorized Provider;
4. the original period covered by the original authorization has not expired; and
5. the Member, DFPS Staff, or Medical Consenter requests an extension of the benefits.

If, at the Member's, DFPS Staff, or Medical Consenter's request, the MCO continues or reinstates the Member's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:

1. The Member, DFPS Staff, or Medical Consenter withdraws the Appeal;
2. ten days pass after the MCO mails the notice resolving the Appeal against the Member, unless the Member, DFPS Staff, or Medical Consenter has requested a Fair Hearing with continuation of benefits until a Fair Hearing decision can be reached; or
3. a state Fair Hearing officer issues a hearing decision adverse to the Member or the time period or service limits of a previously authorized service have been met.

By execution of the Contract, the MCO agrees to waive its right under 42 C.F.R. § 438.420(d), to recover costs from Members, HHSC, DFPS Staff, and Medical Consenters if the final resolution of the Appeal is adverse to the Member and upholds the MCO's Action.

If the MCO or state Fair Hearing Officer reverses a decision to deny authorization of services and the Member received the disputed services while the Appeal was pending, the MCO is responsible for the payment of services.

If the MCO or state Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.

If a state Fair Hearing Officer reverses an MCO's denial of a prior authorization for a DME service/equipment after the Member has enrolled with a second MCO, the original MCO must pay for the DME service/equipment from the date it denied the authorization until the date the Member enrolled with the second MCO. In the case of custom DME, the original MCO must pay for the custom DME if the denial is reversed.

#### **8.1.33.4 Expedited MCO Appeals**

In accordance with 42 C.F.R. § 438.410, the MCO must establish and maintain an expedited review process for Appeals, when the MCO determines (for a request from a Member, DFPS Staff, or Medical Consenter) or the Provider indicates (in making the request on the Member's behalf or supporting the Member's, DFPS Staff, or Medical Consenter's request) that taking the time for a standard resolution could seriously jeopardize the Member's life or health. The MCO must follow all Appeal requirements for standard Member Appeals as set forth in **Section 8.1.33.2**, "Member Pre-Appeal Process," and **Section 8.1.33.3**, "Standard Member Appeal Process," except where differences are specifically noted. The MCO must accept oral or written requests for Expedited Appeals.

Members, DFPS Staff, and Medical Consenters must exhaust the MCO's Expedited Appeal process before making a request for an expedited Fair Hearing. After the MCO receives the request for an Expedited Appeal, it must hear an approved request for a Member, DFPS Staff, or Medical Consenter to have an Expedited Appeal, and notify the Member, DFPS Staff, or Medical Consenter of the outcome of the Expedited Appeal within three Business Days, except that the MCO must complete investigation and resolution of an Appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one Business Day after receiving the Member's, DFPS Staff, or Medical Consenter's request for Expedited Appeal.

Except for an Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member, DFPS Staff, and Medical Consenter of the outcome of the Expedited Appeal may be extended up to 14 calendar days if the Member, DFPS Staff, or Medical Consenter requests an extension or the MCO shows (to the satisfaction of HHSC, upon HHSC's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the MCO must give the Member, DFPS Staff, and Medical Consenter written notice of the reason for delay if the Member, DFPS Staff, or Medical Consenter did not request the delay.

If the decision is adverse to the Member, the MCO must follow the procedures relating to the notice in **Section 8.1.33.6**, "Notices of Action and Disposition of Appeals for Members." The MCO is responsible for notifying the Member, DFPS Staff, and Medical Consenter of the Member's right to access an expedited Fair Hearing from HHSC. The MCO will be responsible for providing documentation to HHSC and to the Member, DFPS Staff, and Medical Consenter, indicating how the decision was made, prior to HHSC's expedited Fair Hearing.

The MCO is prohibited from discriminating or taking punitive action against a Member, DFPS Staff, or Medical Consenter for requesting an Expedited Appeal. The MCO must ensure that

punitive action is neither taken against a Provider who requests an expedited resolution or supports a Member's, DFPS Staff's, or Medical Consenter's request.

If the MCO denies a request for expedited resolution of an Appeal, it must:

1. transfer the Appeal to the timeframe for standard resolution; and
2. make a reasonable effort to give the Member, DFPS Staff, or Medical Consenter prompt oral notice of the denial, and follow up within two calendar days with a written notice.

#### **8.1.33.5 Access to Fair Hearing for Members**

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The MCO must inform Members, DFPS Staff, and Medical Consenters that they have the right to access the Fair Hearing process at any time during the Appeals process provided by the MCO. In the case of an expedited Fair Hearing process, the MCO must inform the Member, DFPS Staff, or Medical Consenter that he or she must first exhaust the MCO's internal Expedited Appeal process prior to filing an Expedited Fair Hearing. The MCO must notify Members, and Medical Consenters that they may be represented by an authorized representative such as DFPS Staff, or a Medical Consenter in the Fair Hearing process.

If a Member requests a Fair Hearing, the MCO will complete the request for Fair Hearing, and submit the form via facsimile to the appropriate Fair Hearings office, within five calendar days of the Member's request for a Fair Hearing.

Within five calendar days of notification that the Fair Hearing is set, the MCO will prepare an evidence packet for submission to the HHSC Fair Hearings staff and send a copy of the packet to the Member. The evidence packet must comply with HHSC's Fair Hearings requirements.

The MCO must ensure that the appropriate staff members who have firsthand knowledge of the Member's appeal in order to be able to speak and provide relevant information on the case attend all Fair Hearings as scheduled.

#### **8.1.33.6 Notices of Action and Disposition of Appeals for Members**

The MCO must notify the Member, DFPS Staff, and Medical Consenter, in accordance with 1 Tex. Admin. Code Chapter 357, whenever the MCO takes an Action. The notice must, at a minimum, include any information required by 1 Tex. Admin. Code Chapter 357 that relates to an MCO's notice of Action and any information required by 42 C.F.R. § 438.404, including:

1. The dates, types, and amount of service requested;
2. the Action the MCO has taken or intends to take;
3. the reasons for the Action (If the Action taken is based upon a determination that the requested service is not medically necessary, the MCO must provide an explanation of the medical basis for the decision, application of policy or accepted standards of medical practice to the individuals medical circumstances, in its notice to the Member.);
4. the Member's, DFPS Staff, and Medical Consenter's right to access the MCO's Appeal process;
5. the procedures by which the Member, DFPS Staff, and Medical Consenter may Appeal the MCO's Action;

6. the circumstances under which expedited resolution is available and how to request it.
7. the circumstances under which a Member may continue to receive benefits pending resolution of the Appeal and how to request that benefits be continued;
8. the date the Action will be taken;
9. a reference to the MCO policies and procedures supporting the MCO's Action;
10. an address where written requests may be sent and a toll-free number that the Member, DFPS Staff, and Medical Consenter can call to request the assistance of a Member representative, file an Appeal, or request a Fair Hearing;
11. an explanation that Members, DFPS Staff, and Medical Consenters may represent themselves, or be represented by a provider, legal counsel;
12. a statement that if the Member, DFPS Staff, and Medical Consenter wants a Fair Hearing on the Action, the Member, DFPS Staff, or Medical Consenter must make the request for a Fair Hearing within 90 days of the date on the notice or the right to request a hearing is waived;
13. a statement explaining that the MCO must make its decision within 30 days from the date the Appeal is received by the MCO, or three Business Days in the case of an Expedited Appeal; and
14. a statement explaining that the hearing officer must make a final decision within 90 days from the date a Fair Hearing is requested.

#### **8.1.33.7 Timeframe for Notice of Action**

In accordance with 42 C.F.R. § 438.404(c), the MCO must mail a notice of Action within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid Covered Services, within the timeframes specified in 42 C.F.R. §§ 431.211, 431.213, and 431.214;
2. for denial of payment, at the time of any Action affecting the claim; and
3. for standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R. § 438.210(d)(1).

If the MCO extends the timeframe in accordance with 42 C.F.R. § 438.210(d)(1), it must:

1. Give the Member, DFPS Staff, and Medical Consenter written notice of the reason for the decision to extend the timeframe and inform the Member, DFPS Staff, and Medical Consenter of the right to file an Appeal if he or she disagrees with that decision;
2. issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires;
3. for service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an adverse Action), on the date that the timeframes expire; and for expedited service authorization decisions, within the timeframes specified in 42 C.F.R. § 438.210(d).

### **8.1.33.8 Notice of Disposition of Appeal**

In accordance with 42 C.F.R. § 438.408(e), the MCO must provide written notice of disposition of all Appeals including Expedited Appeals. The written resolution notice must include the results and date of the Appeal resolution. For decisions not wholly in the Member's favor, the notice must contain all of the following:

1. The right to request a Fair Hearing;
2. how to request a Fair Hearing;
3. the circumstances under which the Member may continue to receive benefits pending a Fair Hearing;
4. how to request the continuation of benefits; and
5. any other information required by 1 Tex. Admin. Code Chapter 357 that relates to an MCO's notice of disposition of an Appeal.

### **8.1.33.9 Timeframe for Notice of Resolution of Appeals**

In accordance with 42 C.F.R. § 438.408, the MCO must provide written notice of resolution of Appeals, including Expedited Appeals, as expeditiously as the Member's health condition requires, but the notice must not exceed the timelines as provided in this section for Standard or Expedited Appeals.

For expedited resolution of Appeals, the MCO must make reasonable efforts to give the Member, DFPS Staff, and Medical Consenter prompt oral notice of resolution of the Appeal, and follow up with a written notice within the timeframes set forth in this section for Expedited Appeals.

If the MCO denies a request for expedited resolution of an Appeal, the MCO must transfer the Appeal to the timeframe for standard resolution as provided in this section, and make reasonable efforts to give the Member, DFPS Staff, or Medical Consenter prompt oral notice of the denial, and follow up within two calendar days with a written notice.

### **8.1.33.10 Member Advocates**

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

1. Their rights and responsibilities;
2. the Complaint process;
3. the Appeal process;
4. Covered Services available to them, including preventive services; and
5. availability of and access to Non-capitated Services.

Member Advocates must assist Members, DFPS Staff, and Medical Consenters in writing Complaints and are responsible for monitoring the Complaint through the MCO's Complaint process.

Member Advocates are responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered. Member Advocates are also responsible for identifying and referring Members, DFPS Staff, and Medical Consenters to community resources available to meet Members' needs that are not available from the MCO as Covered Services.

### **8.1.34 Third-Party Liability and Recovery**

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The MCO is responsible for establishing a plan and process for avoiding and recovering costs for services that should have been paid through a third party in accordance with state and federal law and regulations, including Section 1902(a)(25)(E) and (F) of the Social Security Act, which require MCOs to pay and later seek recovery from liable third parties: (1) for prenatal and preventive pediatric care, and (2) in the context of a state child support enforcement action. To recognize this requirement, Capitation Payments to the MCO are reduced by the projected amount of TPR that the MCO is expected to recover. In the STAR Health program only, Medicaid coverage is primary when coordinating benefits with all other insurance coverage. Third-Party Recovery in the STAR Health program should be sought in the following instances only:

1. In cases of tort, the MCO will pay the claim and follow the established process for Third Party Recovery.
2. In cases where healthcare coverage was required of a biological parent by an order of the court, the MCO will cost avoid and deny the claim for other insurance or, if the claim is already paid, pursue Third Party Recovery.

The MCO must provide required reports as stated in **Section 8.1.23.1**, "Financial Reporting Requirements."

After 120 days from the date of adjudication on any claim, encounter, or other Medicaid related payment by the MCO subject to Third Party Recovery, HHSC may attempt recovery independent of any MCO action. HHSC will retain, in full, all funds received as a result of the state initiated recovery or subrogation action.

The MCO shall provide a Member quarterly file, that contains the following information if available to the MCO: the Member name, address, claim submission address, group number, employer's mailing address, social security number, and date of birth for each subscriber or policyholder and each dependent of the subscriber or policyholder covered by the insurer. The file shall be used for the purpose of matching the HHSC Texas Medicaid eligibility file against the MCO Member file to identify Members for whom third party resources may be available and for whom information about potential third party resources may not have been known by the Medicaid Program.

#### **8.1.34.1 Advance Directives**

Federal and state law require MCOs and providers to maintain written policies and procedures for informing all Members 18 years of age and older about their rights to refuse, withhold or withdraw medical treatment and BH treatment through advance directives (see Social Security Act § 1902(a)(57) and § 1903(m)(1)(A)). Also see the **Procurement Library**, DFPS Policy on

Withdrawal of Life Support. The MCO's policies and procedures must include written notification to Members 18 years of age and older and comply with provisions contained in 42 C.F.R. § 489, Subpart I, relating to advance directives for all Hospitals, critical access Hospitals, skilled nursing facilities, home health agencies, Providers of home healthcare, Providers of personal care services and hospices, as well as the following state laws, rules and regulations:

1. A Member's right to self-determination in making healthcare decisions;
2. the Advance Directives Act, Texas Health & Safety Code Chapter 166, which includes:
  - a) a Member's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition;
  - b) a Member's right to make written and non-written out-of-Hospital do-not-resuscitate (DNR) orders; and
  - c) a Member's right to execute a Medical Power of Attorney to appoint an agent to make healthcare decisions on the Member's behalf if the Member becomes incompetent; and
3. the Declaration for Mental Health Treatment, Tex. Civ. Prac. and Rem. Code Chapter 137, which includes: a Member's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding BH treatment.

The MCO must maintain written policies for Providers to follow regarding receiving and documenting consent from the DFPS individual authorized to provide medical consent prior to implementing a Member's advance directive. Those policies must include a clear and precise statement of limitation if the Provider cannot or will not implement a Member's advance directive.

The MCO cannot require a Member to execute or issue an advance directive as a condition of receiving Healthcare Services. The MCO cannot discriminate against a Member based on whether or not the Member has executed or issued an advance directive.

The MCO's policies and procedures must require the MCO and Subcontractors to comply with the requirements of state and federal law and DPFS policies relating to advance directives. The MCO must provide education and training to employees and Members, Caregivers and Medical Consenters on issues concerning advance directives.

All materials provided to Members regarding advance directives must be written at a 7th–8th grade reading comprehension level, except where a provision is required by state or federal law and the provision cannot be reduced or modified to a 7th–8th grade reading level because it is a reference to the law or is required to be included "as written" in the state or federal law.

The MCO must notify Members, Medical Consenters, DFPS staff, and Caregivers of any changes in state or federal laws relating to advance directives within 90 days from the effective date of the change, unless the law or regulation contains a specific time requirement for notification.

### **8.1.35 Minimum Wage Requirements for Attendants**

The MCO must ensure that facilities and agencies that provide the following services pay attendants at or above \$8.00 per hour for dates of service on or after September 1, 2015:

1. Personal Care Services (PCS);
2. CFC services (including PCS-CFC and acquisition, maintenance, and enhancement of skills); and
3. MDCP services (including Respite, Supported Employment and Employment Assistance).

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### **8.1.36 Preadmission Screening and Resident Review (PASRR) Referring Entity Requirements**

The MCO must follow any PASRR requirements when acting as a referring entity for Members as required by 40 Tex. Admin. Code §§ 17.101, 17.102(25), and 17.301.

### **8.1.37 Electronic Visit Verification (EVV)**

HHSC requires the MCO contract with EVV Vendors who use a system to verify attendant care services, private duty nursing, and other services identified **UMCM Chapter 8.7**.

The MCO must contract with EVV Vendors for the provision of EVV services in a manner consistent with the **UMCM Chapter 8.7**, "Electronic Visit Verification." The MCO may not pass EVV transaction costs to Providers.

### **8.1.38 Community First Choice (CFC) Services**

Community First Choice (CFC) provides community-based LTSS to eligible Members with physical or cognitive disabilities, SPMI, or SED as an alternative to living in an institution. The MCO must make the array of services allowable under CFC available to Members who meet eligibility requirements.

The administration of CFC in managed care is governed by 1 Tex. Admin. Code, §§354.1360 *et seq.*

Members with physical disabilities must meet the MN/LOC requirements for nursing facility care to be eligible for CFC services. The MCO must complete the MN/LOC Assessment Instrument, as amended or modified, and submit the form to HHSC's Administrative Services Contractor (ASC). The MCO must also complete the assessment documentation, and prepare a service plan identifying the needed CFC services and include it in the Member's HCSP. The MCO must complete these activities within 45 days of the identified need for or request for services, or within an alternate timeframe as determined solely by HHSC. The Member must be reassessed annually or if the child experiences a change in condition. A re-assessment must be completed and electronically submitted via the ASC's portal in the specified format no later than 45 days prior to the annual service plan expiration date.

Members with cognitive disabilities must meet the institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF-IID) to be

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eligible for CFC services. The MCO must review and consider the assessment and service plan completed by the Local IDD Authority when determining eligibility and finalizing the service plan. The MCO must also include the CFC service plan in the Member's HCSP. The MCO must complete these activities within 45 days of the identified need for or request for services, or within an alternate timeframe as determined solely by HHSC.

Members with SPMI or SED must meet an IMD level of care, which is determined by receiving a CANS or ANSA with a level of care 4.

The MCO must coordinate with a provider of Mental Health Rehabilitative Services and Mental Health Targeted Case Management to determine whether the Member meets an IMD level of care. The MCO is also responsible for preparing a service plan identifying the needed CFC services, and include it in the Member's HCSP. The MCO must complete these activities within 45 days of the identified need for or request for services, or within an alternate timeframe as determined solely by HHSC.

The MCO must notify Members and their Medical Consenters of their eligibility determination. If the Member is eligible for CFC services, the MCO will notify the Member of the effective date of eligibility. If the Member is not eligible for CFC services, the MCO will provide the Member information on the right to appeal the determination, including access to HHSC's Fair Hearing process. The MCO is responsible for preparing any requested documentation regarding its assessments and service plans and attending the Fair Hearing.

As part of any assessment, the MCO must inform the Member and their Medical Consenter about service delivery options such as Consumer Directed Services (CDS).

The MCO must contract with Providers of CFC services to ensure access to these services for all qualified Members. At a minimum, these Providers must meet all of the following state licensure and certification requirements for providing the services. CFC Providers, with the exception of Emergency Response Services Providers must be licensed by DADS as a Home and Community Support Services Agency (HCSSA) or certified as a Home and Community-based Services or Texas Home Living agency. The level of licensure required depends on the type of service delivered. Emergency Response Service Providers must be licensed by the Public Security Bureau of the Texas Department of Public Safety as an alarm systems company or by DSHS as a personal emergency response system provider.

### **8.1.39 Covered Community-Based Services**

The MCO must ensure that Members needing Community-Based Services are identified and that services are referred and authorized in a timely manner. Community-Based Services include Home and Community-Based LTSS for MDCP Members and home health Covered Services, including PCS and CFC, for all Members. The MCO must ensure that Providers of Community-Based Services are appropriately licensed to deliver the service they provide.

Community-Based Services may be necessary for preventative reasons to avoid more expensive hospitalizations, emergency room visits, or institutionalization. Community-Based Services must also be made available to Members to assure maintenance of the highest level of functioning possible in the least restrictive setting. A Member's need for Community-Based Services to assist with activities of daily living and instrumental activities of daily living must be considered as important as needs related to a medical condition.

Section 8.1.40 deleted in its entirety by Version 2.2 and moved to Section 8.1.5.10.1 and added by Version 2.3

### **8.1.40 Service Delivery Options**

There are three options available to Members desiring to self-direct the delivery of PCS, PCS or acquisition, maintenance and enhancement of skills in CFC, and for MDCP in-home or out-of-home Respite, Supported Employment, and Employment Assistance. The three options are:

1. Consumer –Directed Services Option;
2. Service-Related Option; and
3. Agency Option

The MCO must provide information, including the risks and benefits about the three options to all eligible Members and their Caregiver and Medical Consenter. The MCO must also provide orientation in the option selected to the Member, Caregiver, and Medical Consenter. The MCO must provide information regarding all available options:

1. at initial assessment;
2. at annual reassessment or placement change;
3. at any time when a Member requests the information; and
4. in the Member Handbook.

#### **8.1.40.1 Consumer Directed Services (CDS) Model**

Section 8.1.40.1 added by Version 2.3

Consumer Directed Services (CDS) is a service delivery option in which a Member or their Medical Consenter employs and retains service providers and directs the delivery of PCS, PCS or acquisition, maintenance and enhancement of skills in CFC, and for MDCP in-home or out-of-home Respite, Supported Employment, and Employment Assistance services.

In the CDS Model, the Member or their Medical Consenter is the employer of record and retains control over the hiring, management, and termination of an individual providing these services.

The Member or their Medical Consenter is responsible for assuring that the employee meets the qualifications and requirements for these services. The Member or their Medical Consenter is required to select a Financial Management Services Agency (FMSA) to handle functions such as processing payroll, withholding taxes, and filing tax-related reports to the Internal Revenue Service and the Texas Workforce Commission for these services.

The FMSA is also responsible for providing training to the Member or their Medical Consenter on being an employer, verifying provider qualifications (including criminal history and registry checks), and approving the budget. The FMSA must be qualified to perform these services, by having completed the mandatory FMSA enrollment training, holding a DADS FMSA contract, or becoming part of the MCO's network.

#### **8.1.40.2 Service Related Option Model**

Section 8.1.40.2 added by Version 2.3

In the Service Related Option (SRO) Model, the Member or their Medical Consenter is actively involved in choosing his/her personal attendant or Respite provider but is not the employer of record. The Home and Community Support Services Agency (HCSSA) in the MCO's Provider Network is the employer of record for the personal attendant employee and Respite provider.

In this model, the Member or their Medical Consenter selects the personal attendant or Respite provider from the HCSSA's personal assistance employees. The personal attendant/Respite provider's schedule is set up based on the Member's or Medical Consenter's input, and the

Member or their Medical Consenter manages the PCS, PCS or acquisition, maintenance and enhancement of skills in CFC, and MDCP in-home or out-of-home Respite, Supported Employment, and Employment Assistance services. The Member or their Medical Consenter retains the right to supervise and train the personal attendant. The Member or their Medical Consenter may request a different personal attendant, and the HCSSA would be expected to honor the request as long as the new attendant is a Network Provider.

The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of these services. The MCO contracts with HCSSAs that are the employer or contractor of record for the attendant or nurse. In this model, the Member or their Medical Consenter selects the attendant or nurse from the MCO's Provider Network. The attendant or nurse schedule is set up based on the Member's or their Medical Consenter's input, and the Member or their Medical Consenter manages the attendant services or Nursing Services.

The Member or Medical Consenter retains the right to supervise and train the attendant or nurse. The Member or Medical Consenter may request a different attendant or nurse, and the MCO must honor the request as long as the attendant or nurse is a Network Provider. The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of attendant services or Nursing Services.

### **8.1.40.3 Agency Model**

Section  
8.1.40.3  
added by  
Version 2.3

In the Agency Model, the MCO contracts with a HCSSA or a certified Home and Community-based Services or Texas Home Living Agency for the delivery of services. The HCSSA is the employer of record for the personal attendant, Respite provider, or nurse. The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports for the service provider.

### **8.1.41 Facility Based Care**

Section  
8.1.41  
added by  
Version 2.3

A STAR Health Member who enters a community-based ICF/IID will remain a STAR Health Member.

The MCO will not be responsible for the cost of care provided in an ICF/IID. The MCO will not maintain ICFs/IID in its Provider Network and will not reimburse ICFs/IID for Covered Services.

The MCO must provide Service Coordination and any Covered Services that occur outside of the ICF/IID when a STAR Health Member is in an ICF/IID. Throughout the duration of the ICF/IID stay, the STAR Health MCO must coordinate with the Member and their Medical Consenter, and DFPS Staff to identify Community-Based Services and LTSS programs that may help the Member return to a placement in the community.

### **8.1.42 Prescribed Pediatric Extended Care**

Section  
8.1.42  
added by  
Version 2.3

Prescribed Pediatric Extended Care services must be prescribed by a physician and are considered an alternative to private duty nursing (PDN). However, PPECC services must not supplant a child's right to receive PDN per Texas Health and Safety Code § 248A.151. Service

hours in a PPECC are intended to be a one-to-one replacement of PDN service hours, unless additional hours are medically necessary, in accordance with Texas Health and Safety Code §248A.158. A Member who is eligible may receive both private duty nursing and PPECC services. These services may be billed on the same day but cannot be received at or billed for at the same time in that day.

MCOs must ensure that Network PPECCs adhere to licensing requirements contained in 40 Tex. Admin. Code, Part 1, Chapter 15, "Licensing Standards for Prescribed Pediatric Extended Care Centers" and Texas Health and Safety Code, Chapter 248A - Prescribed Pediatric Extended Care Centers. MCOs and Network PPECCs must also adhere to Medicaid program rules contained in 1 Tex. Admin. Code, , §§ 363.201 - 363.217, which are effective November 1, 2016.

Pursuant to Texas Health and Safety Code § 248A.151, admission to a PPECC must be voluntary and based on the preference of the Member or their Medical Consenter. The MCO must ensure continuity of PPECC services in accordance with the authorization timeframes established in **Section 8.1.27**, "Continuity of Care and Out-of-Network (OON) Providers." The MCO must also coordinate care and authorizations between PPECCs and the Member's other providers, including home health agencies, to ensure that the Member's PPECC plan of care does not include an overlap or duplication of Medically Necessary Covered Services, including, but not limited to, PDN, PCS, Home Health Skilled Nursing, Home Health Aide services, and therapies. Members eligible for PPECC services will be classified as MSHCN as described in **Section 8.1.13**. The MCO must offer Service Management and develop an HCSP, as appropriate.

The cost of service must not be a factor in determining the most appropriate setting for an eligible Member to receive skilled nursing services. PPECC services are limited to no more than 12 hours a day, and may not be rendered overnight. Therapy services (occupational, speech, physical, and respiratory) rendered in a PPECC may be provided by (1) therapists employed by or contracted with the PPECC or (2) by credentialed Network therapists not employed by or contracted with the PPECC. Therapy services must be authorized and billed separately from PPECC services, and the MCO's claims systems must accommodate PPECCs as a place of service for therapy services.

#### **8.1.42.1 Prior Authorization for PPECC Services**

All PPECC services must be prior authorized. All prior authorization requests must contain documentation of medical necessity including a physician order and PPECC plan of care. MCOs may choose to utilize prior authorization forms used in fee-for-service Medicaid, such as the plan of care and Nursing Addendum, which includes a 24-hour daily care flow sheet, or similar plan-developed forms, as supplements to the standardized TDI prior authorization form.

An initial authorization for PPECC services may last for a maximum period of 90 days, at which point a PPECC Provider must seek a new authorization of services, up to a maximum of 180 days. Additionally, if there is a change in the Member's status before expiration of the authorization period, the PPECC Provider must modify the plan of care and seek a new authorization or a change in authorization.

### 8.1.43 Medicaid Wrap-Around Services

Section  
8.1.43  
added by  
Version 2.3

The MCO may be required to supplement Medicare coverage for Dual Eligible Members by providing services, supplies, and outpatient drugs and biologicals that are available under the Texas Medicaid program. There are 3 categories of Medicaid wrap-around services:

1. Medicaid Only Services (i.e., services that do not have a corresponding Medicare service);
2. Medicare Services that become a Medicaid expense due to a benefit limitation on the Medicare side being met; and
3. Medicare Services that become a Medicaid expense due to coinsurance (True Cross-over Claims).

The MCOs will provide Medicaid wrap-around services for outpatient drugs, biological products, certain limited home health supplies (LHHS), and vitamins and minerals as identified on the HHSC drug exception file to Dual Eligible Members under a non-risk, cost settlement basis, as described in **Attachment A, Section 10.16**, “Supplemental Payments for Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products.” Refer to HHSC’s UMCM, Chapter 2.2, “Pharmacy Claims Manual,” for additional information regarding the claims processing requirements for these Medicaid wrap-around services.

### 8.1.44 Carve-in Readiness

Section  
8.1.44  
added by  
Version 2.3

MCOs must participate in Readiness Review dictated by HHSC for the expansion of Medicaid managed care to populations currently served by the fee-for-service system.

## 8.2 Additional Requirements Regarding the Medically Dependent Children Program (MDCP)

Section 8.2  
added by  
Version 2.3

The purpose of MDCP is to prevent unnecessary placement of an individual in a long-term care facility and to support de-institutionalization of individuals by providing them with support services in the community. The programmatic goals for MDCP are to:

1. enable children and young adults who are medically dependent to remain safely in a home-like setting;
2. offer cost-effective alternatives to placement in nursing facilities and hospitals; and support Caregivers and Medical Consenters in providing a stable placement in a home-like setting for children and young adults who are medically dependent.

### 8.2.1 Program Eligibility and Assessment

Section  
8.2.1 added  
by Version  
2.3

MDCP provides Community-based LTSS for individuals under the age of 21 with complex medical needs as a cost-effective alternative to living in a Nursing Facility (NF). Total enrollment in MDCP is limited to the number of individuals and the amount of state funding approved by the Texas Legislature except as otherwise provided in 40 Tex. Admin. Code § 51.211(b)–(c). Individuals will be considered for program entry through an interest list process or following an institutional stay.

To be eligible for MDCP services, an individual must meet disability and medical necessity criteria, as well as other program requirements determined by HHSC or its designee. A determination of medical necessity must be based on information collected as part of the SAI and MDCP module. A medical necessity determination must be authorized through HHSC or its designee.

If a Member is considered by HHSC for MDCP entry, the MCO must schedule and complete the required elements of the Screening and Assessment Instrument (SAI) within 30 days of notice from HHSC. Once the SAI and MDCP module are complete, the MCO must submit the results of the assessment to the HHSC Administrative Services Contractor (ASC) within 72 hours. The MCO must submit the ISP no later than 60 calendar days following the initial notice from HHSC.

The MCO must ensure medical necessity is reviewed for each Member receiving MDCP services on an annual basis. Annual assessments for MDCP eligibility must occur at the same time as annual reassessment with the SAI. For reassessments, the MCO may not submit an SAI earlier than 90 days prior to the expiration of the Member's ISP. The MCO must work to prevent a lapse in MDCP eligibility by performing the Member's annual reassessment for MDCP eligibility and submitting the medical necessity determination to HHSC in time to prevent coverage gaps. The MCO must ensure reassessments occur prior to the expiration of the Member's medical necessity determination. The reassessment must be submitted to the HHSC ASC no later than 30 days prior to the expiration of the Member's ISP to ensure that the HHSC ASC has sufficient time to process the Member's medical necessity determination so that the Member does not experience a lapse in MDCP program eligibility.

If a placement change occurs that is related to a change in condition, the MCO must complete a re-assessment using the required elements of the SAI. If a placement change occurs that is not related to a change in condition, the MCO must review the budget plan for MDCP services with the Member, Caregiver and Medical Consenter within 14 days of receipt of placement change information on the DNF. All re-assessments related to a change in condition must be completed within 30 days of notification from the Member or Medical Consenter or receipt of placement change information on the DNF.

The MCO must complete an electronic ISP for each Member receiving MDCP services. The ISP is established for a one-year period. After the initial ISP is established, the ISP must be completed on an annual basis and the end date or expiration date does not change. The required elements of the ISP, as directed by HHSC, must be completed and submitted to the TMHP portal within 14 days of completion and submission of the SAI. The MCO must initiate all applicable MDCP services on the effective date of the ISP. A medical necessity determination will expire 120 days after it is approved by the HHSC ASC if MDCP services have not begun.

The MCO must coordinate with the Member and their Medical Consenter to update the Member's HCSP with the MDCP plan of care.

Prior to November 1, 2016, HHSC will provide the MCO with a file on each MDCP Member, including when each Member is due for their next annual reassessment. The MCO must prioritize MDCP reassessments to ensure they occur on schedule. The MCO must continue to provide all services included in the Member's existing MDCP plan of care and may not reduce or replace services until the Member has been re-assessed using the required elements of the SAI, the Member's initial ISP has been submitted, and the HCSP is complete. If an MDCP Member is disenrolled from STAR Health and enrolls in the STAR Kids program prior to annual

reassessment, the MCO must provide the STAR Kids MCO with the results from the previous SAI assessment.

### **8.2.2 Service Management Requirements for MDCP Members**

Section  
8.2.2 added  
by Version  
2.3

A registered nurse (RN), advance practice nurse (APRN), physician assistant (PA) social worker (MSW, LCSW, or LBSW), or LVN (with a minimum of one year previous experience with case management with pediatric clients) must administer the SAI Core Module and PCAM, if needed, and these modules may not be administered by any contracted entity providing direct services to the Member. An RN or APRN must administer the SAI NCAM and MDCP module, if needed.

Any MCO staff, or MCO-contracted staff, administering the SK SAI must take the SK SAI training module required by HHSC before administering the SAI. All MCO staff, or MCO-contracted staff administering the MDCP portion of the SKSAI must not only have completed the HHSC-approved SKSAI training, but also must be certified through the state-approved RUG training found at <http://www.txstate.edu/continuinged/CE-Online/RUG-Training.html>.

The SAI MDCP Module will establish an annual cost limit for each Member receiving MDCP services, which will be based on the anticipated cost if the Member received services in a Nursing Facility. The MCO must develop an MDCP plan of care that does not exceed the Member's cost limit and include it in the Member's HCSP. If the MCO does not properly establish this plan of care and the Member's cost exceeds the individual limit, the MCO must continue to provide MDCP services to the Member at the MCO's expense. The MCO may not terminate MDCP enrollment if a Member exceeds their cost limit. The MCO must also develop a process to track each Member's MDCP-related expenditures on a monthly basis and provide an update on the progress to the Member and their Medical Consenter no less than once per month. The MCO must provide information about each MDCP Member's individual budget to HHSC in a prescribed format and on an annual basis.

Service authorizations for MDCP must include the amount, frequency, and duration of each service to be provided, and the schedule for when services will be rendered. The MCO must ensure the MDCP Member does not experience gaps in authorizations and that authorizations are consistent with information in the Member's HCSP.

For all MDCP Members, the MCO must consult with the Member and their Medical Consenter to determine if the Member needs Minor Home Modifications and Adaptive Aids as part of the annual assessment process, or if the Member experiences a change in condition or requests assistance. The MDCP Member's HCSP must include the components of a person-centered service plan described in 42 C.F.R. § 441.301(c)(2).

### **8.2.3 MDCP Provider Requirements**

Section  
8.2.3 added  
by Version  
2.3

The MCO must provide MDCP Covered Services (see **Attachment B-2**, "Covered Services") to eligible Members. The MCO must contract with Providers with the following qualifications, consistent with requirements in the MDCP HCBS Waiver.

**Respite:** Attendants providing Respite Care must be at least 18 years of age. The attendant must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the required services as needed by the individual. Registered nurses

and licensed vocational nurses must have current licenses under Texas Occupations Code Chapter 301. Child Day Care Facilities must be licensed under 40 Tex. Admin. Code Chapter 745.

Children with special healthcare needs must receive the care recommended by a healthcare professional or qualified professional affiliated with the local school district or ECI program.

Specific licensure requirements apply based on the place of service for Respite Care:

For in-home Respite delivered by a Home and Community Support Services Agency (HCCSA) licensed by DADS under 40 Tex. Admin. Code Chapter 97, skilled care must be performed by a registered nurse (RN) or licensed vocational nurse (LVN) or delegated by a RN. Non-licensed individuals providing delegated skilled tasks must be supervised by a RN. Any delegated skilled care must meet the requirements of the Texas Nursing Practice Act. The HCCSA must employ a Respite attendant who meets the following requirements:

1. Is at least 18 years of age;
2. has a high school diploma, certificate of high school equivalency (General Educational Development (GED) credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks;
3. is trained in CPR and first-aid;
4. can pass criminal history checks;
5. is not on the Employee Misconduct Registry or Nurse Aide Registry list;
6. is familiar with the individual's specific tasks;
7. is not on the state and federal lists of excluded individuals and entities; and
8. is not the individual's spouse, Caregiver, or Medical Consenter.

For out-of-home Respite delivered by a host family licensed as a foster home by DFPS or verified as a foster home by a child-placing agency that is licensed by DFPS (40 Tex. Admin. Code Chapters 745, 749, 750), the Provider of the Respite service component must be at least 18 years of age and have a high school diploma or certificate of high school equivalency (GED credentials). The host family must not provide services in its residence to more than four persons unrelated to the individual at one time. The host family may not be the foster family that is receiving payment from DFPS for the residential care of the child. The host family must ensure that the individual participates in age-appropriate community activities; and the host family home environment is healthy and safe for the individual. The host family must provide services in a residence that the host family owns or leases. The residence must be a typical residence in the neighborhood and must meet the needs of the individual.

For out-of-home Respite delivered by a Child Day Care Facility licensed by DFPS under 40 Tex. Admin. Code Chapter 745, the Provider of the Respite service component must be at least 18 years of age. The Provider must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the required services as needed by the individual. RNs and LVNs must have current licenses under Texas Occupations Code Chapter 301.

For out-of-home Respite delivered by Special Care Facilities licensed by DSHS under 25 Tex. Admin. Code Chapter 125, the Provider of the Respite service component must be at least 18 years of age. The Provider must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and

competence to perform job tasks, including ability to provide the required services as needed by the individual. RNs and LVNs must have current licenses under Texas Occupations Code, Chapter 301.

For out-of-home Respite delivered by a Hospital licensed by DSHS under 25 Tex. Admin. Code Chapter 133 and participating in Medicare under 42 C.F.R. Part 482, the Provider of the Respite service component must be at least 18 years of age. The Provider must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the required services as needed by the individual. RNs and LVNs must have current licenses under Texas Occupations Code Chapter 301.

For out-of-home Respite delivered by a Nursing Facility licensed by DADS under 40 Tex. Admin. Code Chapter 19, the nursing facility respite provider must employ staff who meet items 1-7 in the respite attendant requirements list above.

For out-of-home Respite delivered by a Camp licensed by DSHS under 25 Tex. Admin. Code Chapter 265, Subchapter B, the Provider of the Respite service component must be at least 18 years of age. The Provider must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the required services as needed by the individual. RNs and LVNs must have current licenses under Texas Occupations Code Chapter 301. These camps must be accredited by the American Camping Association.

**Supported Employment and Employment Assistance:** HCCSAs providing Supported Employment or Employment Assistance are licensed by DADS under 40 Tex. Admin. Code Chapter 97. The Provider of supported employment services must meet all of the criteria in one of three options:

Option 1:

- a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- six months of documented experience providing services to people with disabilities in a professional or personal setting.

Option 2:

- an associate's degree in rehabilitation, business, marketing, or a related human services field; and
- one year of documented experience providing services to people with disabilities in a professional or personal setting.

Option 3:

- a high school diploma or GED; and
- two years of documented experience providing services to people with disabilities in a professional or personal setting.

**Financial Management Services:** Private entities furnish Financial Management Services. These entities, called Financial Management Services Agencies (FMSAs), are procured through an open enrollment process and are required to hold a Medicaid provider agreement with the

State. Through a delegation arrangement, DADS executes a contract with the required elements of a Medicaid provider agreement on behalf of HHSC.

An FMSA must comply with the requirements for delivery of Financial Management Services, including attending a DADS mandatory 3-day training session. Topics covered in the training session include: contracting requirements and procedures; FMSA responsibilities; consumer/employer responsibilities; DADS case manager/service coordinators responsibilities; enrollment, transfer, suspension and termination of the CDS option; employer budgets; reporting abuse, neglect and exploitation allegations; oversight of CDS; contract compliance and financial monitoring. The required training materials include the definition and responsibilities of a vendor fiscal/employer agent in accordance with IRS Revenue Procedure 70-6, 1970-1 C.B. 420 and an explanation of fiscal employer agent based on Section 3504 of the IRS code and state tax (unemployment) requirements as a Vendor Fiscal/Employer Agent. The training also covers IRS Forms SS-4 and 2678. The rules for the CDS option, located at 40 Tex. Admin. Code Chapter 41, require FMSAs to act as vendor fiscal/employer agents along with describing responsibilities such as the revocation of IRS Form 2678 if the individual terminates the CDS option or transfers to another FMSA.

The FMSA must not be the individual's spouse, Caregiver, Medical Consenter, legal guardian, or the spouse of the individual's legal guardian.

**Adaptive Aids:** The Provider of Adaptive Aids must be a DME supplier or be a manufacturer of items not supplied through DME suppliers.

**Flexible Family Support Services:** HCSSAs providing Flexible Family Support Services are licensed by DADS under 40 Tex. Admin. Code Chapter 97. Skilled care must be performed by a RN or LVN or delegated by a RN. Non-licensed individuals providing delegated skilled tasks must be supervised by a RN. Any delegated skilled care must meet the requirements of the Texas Nursing Practice Act. The HCSSA must employ a Respite attendant who meet items 1-8 in the respite attendant requirements list above.

**Minor Home Modifications:** A Minor Home Modification Provider must comply with city building codes and American with Disabilities Act standards. A minor home modification program provider must have:

1. five years of experience as a building contractor;
2. three references from previous contractor clients; and
3. current General Comprehensive Liability coverage for Errors & Omissions.

**Transition Assistance Services:** The Transition Assistance Services Provider must comply with the requirements for delivery of Transition Assistance Services, which include requirements regarding allowable purchases, costs limits, and timeframes for delivery. Transition Assistance Services Providers must demonstrate knowledge of, and history in, successfully serving individuals who require HCBS.

The MCO must offer the CDS option for Respite, Flexible Family Supports Services, Supported Employment, and Employment Assistance.

## DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	2.0	July 1, 2015	Initial version of Attachment B-1, RFP Section 9, "Turnover Requirements" that includes all modifications negotiated by the Parties.
Revision	2.1	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	2.2	March 1, 2016	Section 9.4 is modified to clarify the requirements.
Revision	2.3	September 1, 2016	Contract amendment did not revise Attachment B-1, RFP Section 9, and "Turnover Requirements".
<sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions <sup>2</sup> 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. <sup>3</sup> Brief description of the changes to the document made in the revision.			

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## 9 TURNOVER REQUIREMENTS

### 9.1 Introduction

Turnover is defined as the activities that the MCO is required to perform prior to or upon termination of the Contract, in situations where the MCO will transition data and documentation to HHSC or a subsequent contractor.

### 9.2 Turnover Plan

Section 9.2  
modified by  
Version 2.1

Twelve months after the start of the Contract, the MCO must provide a Turnover Plan covering the turnover of the records and information maintained to either HHSC or a subsequent contractor. The Turnover Plan will be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan should also include information about third-party software used by the MCO in the performance of duties under the contract, including the manner in which the software is used and terms of the software license agreement, so that HHSC can determine if this software is needed to transition operations under Section 9.3 of the Contract. HHSC must approve the Turnover Plan.

### 9.3 Transfer of Data and Information

Section 9.3  
modified by  
Version 2.1

The MCO must transfer to HHSC or a subsequent contractor all data and information necessary to transition operations, including:

1. data and reference tables;
2. data entry software;
3. license agreements for third-party software and modifications if required by HHSC;
4. documentation relating to software and interfaces;
5. functional business process flows; and
6. operational information, including
  - a. correspondence,
  - b. documentation of ongoing or outstanding issues,
  - c. operations support documentation, and
  - d. operational information regarding Subcontractors.

For purposes of this provision, “documentation” means all operations, technical, and user manuals used in conjunction with the software, Services and Deliverables, in whole or in part, that HHSC determines are necessary to view and extract application data in a proper format. The MCO must provide the documentation in the formats in which any documentation exists at the expiration or termination of the Contract.

In addition, the MCO must provide the following to HHSC.

1. The MCO must provide data, information, and services necessary and sufficient to enable HHSC to map all Program data from the MCO’s system(s) to the replacement system(s) of HHSC or a successor contractor, including a comprehensive data dictionary as defined by HHSC.
2. The MCO must provide all necessary data, information, and services in the format defined by HHSC and must be HIPAA-compliant.
3. The MCO must provide all of the data, information, and services mentioned in this section using its best efforts to ensure the efficient administration of the contract. The

data and information must be supplied in media and format specified by HHSC and according to the schedule approved by HHSC in the Turnover Plan. The data, information, and services provided as detailed in this section must be provided at no additional cost to HHSC.

HHSC or the subsequent contractor must receive and verify all relevant data and information must be received and verified. If HHSC determines that data or information are not accurate, complete, or HIPAA-compliant, HHSC reserves the right to hire an independent contractor to assist HHSC in obtaining and transferring all the required data and information and to ensure that all the data are HIPAA-compliant. The MCO is responsible for the reasonable cost of providing these services.

#### **9.4 Turnover Services**

Section 9.4  
modified by  
Versions 2.1  
and 2.2

Twelve (12) months prior to the end of the Contract Period, including any extensions, the MCO must update its Turnover Plan and submit it to HHSC. If HHSC terminates the Contract prior to the expiration of the Contract Period, then HHSC may require the MCO to submit an updated Turnover Plan sooner than twelve (12) months prior to the termination date. In these cases, HHSC's notice of termination will include the date the Turnover Plan is due.

The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the Turnover tasks. The Turnover Plan describes MCO's policies and procedures that guarantees:

1. the least disruption in the delivery of Healthcare Services to those Members who are enrolled with the MCO during the transition to a subsequent contractor or provider;
2. cooperation with HHSC and the subsequent contractor or provider in notifying Members of the transition, as requested and in the form required or approved by HHSC; and
3. cooperation with HHSC and the subsequent contractor or provider in transferring information to the subsequent contractor or provider, as requested and in the form required or approved by HHSC.

HHSC must approve the Turnover Plan, which must include the following at a minimum:

1. The MCO's approach and schedule for the transfer of data, information, and services, as described in this Section;
2. the quality assurance process that the MCO will use to monitor Turnover activities; and
3. the MCO's approach to training HHSC or a subsequent contractor's staff in the operation of its business processes.

HHSC is not limited or restricted in the ability to require additional information from the MCO or modify the Turnover schedule as necessary.

#### **9.5 Post-Turnover Services**

Thirty days following Turnover of operations, the MCO must provide HHSC with a Turnover Results Report documenting the completion and results of each step of the Turnover Plan. HHSC will not consider Turnover completed until HHSC approves the Turnover Plan.

If the MCO does not provide the required data, information, or services necessary for HHSC or the subsequent contractor to assume the operational activities successfully, the MCO agrees to reimburse HHSC for all reasonable costs and expenses, including: transportation, lodging, and subsistence to carry out inspection, audit, review, analysis, reproduction, and transfer functions

at the location(s) of any necessary records; and attorneys' fees and costs. This section does not limit HHSC's ability to impose remedies or damages as set forth in the Contract.

**DOCUMENT HISTORY LOG**

<b>STATUS<sup>1</sup></b>	<b>DOCUMENT REVISION<sup>2</sup></b>	<b>EFFECTIVE DATE</b>	<b>DESCRIPTION<sup>3</sup></b>
Baseline	2.0	July 1, 2015	Initial version of Attachment B-2, "STAR Health Covered Services" that includes all modifications negotiated by the Parties.
Revision	2.1	September 1, 2015	"Covered Services include the following" is modified to add "Emergency and non-emergency" to Ambulance services, Mental Health Rehabilitative Services, Community First Choice services, and Mental Health Targeted Case Management and to remove the asterisk and related language for Behavioral Health Services.
Revision	2.2	March 1, 2016	Contract amendment did not revise Attachment B-2, "STAR Health Covered Services."
Revision	2.3	September 1, 2016	"Covered Services include the following:" is modified to add Prescribed Pediatric Extended Care Centers (PPECC). "Services included under the MCO capitation payment for MDCP" is added.
<p><sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions</p> <p><sup>2</sup> 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.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			

## COVERED SERVICES

The following is a non-exhaustive, high-level listing of Services included under the STAR Health Medicaid managed care program.

The MCO is responsible for providing a benefit package to Members that includes all Medically Necessary services covered under the traditional, fee-for-service Medicaid program except for Non-capitated Services listed in **Section 8.1.28.8**. The MCO must coordinate care for Members for these Non-capitated Services so that Members have access to a full range of Medically Necessary Medicaid services. The MCO may elect to offer additional Value-added Services.

The MCO should refer to the current **Texas Medicaid Provider Procedures Manual** for a more inclusive listing of limitations and exclusions that apply to each Medicaid benefit category. These document can be accessed online at: <http://www.tmhp.com>.

The services listed in this Attachment are subject to modification based on federal and state laws and regulations and HHSC policy updates.

### **Covered Services include the following.**

- Emergency and non-emergency ambulance services
- Audiology services, including hearing aids, for adults and children
- Behavioral Health Services, including:
  - Inpatient and outpatient mental health services, including mental health rehabilitative services and mental health targeted case management
  - Psychiatry services
  - Mental Health Rehabilitative Services
  - Residential and outpatient substance abuse disorder treatment services, including:
    - Assessment
    - Detoxification services
    - Counseling treatment
    - Medication assisted therapy
- Birthing services provided by a physician and certified nurse midwife (CNM) in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Community First Choice services, including:
  - Personal Assistance Services
  - Habilitation
  - Emergency Response Services
  - Support Consultation
- Dental services, including:
  - Diagnostic and preventive, including support of the First Dental Home strategic initiative for Texas Health Steps children 6 through 35 months of age
  - Therapeutic
  - Restorative
  - Endodontic

Covered Services include: modified by Versions 2.1 and 2.3

- Periodontal
- Prosthodontic (removable and fixed)
- Implant and oral and maxillofacial surgery
- Orthodontic
- Adjunctive general
- Dialysis
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency Services
- Family planning services
- Home healthcare services
- Hospital services, including inpatient and outpatient
  - The MCO may provide inpatient services for acute psychiatric conditions in a freestanding psychiatric hospital in lieu of an acute care inpatient hospital setting.
  - The MCO may provide substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting.
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
  - inpatient services; outpatient services provided at an outpatient hospital and ambulatory healthcare center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    - all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
    - surgery and reconstruction on the other breast to produce symmetrical appearance;
    - treatment of physical complications from the mastectomy and treatment of lymphedemas; and
    - prophylactic mastectomy to prevent the development of breast cancer.
    - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
- Medical checkups and Comprehensive Care Program (CCP) Services (for children birth through age 20) through the Texas Health Steps Program (EPSDT)
  - Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
- Mental Health Targeted Case Management
- Optometry, glasses, and contact lenses
- Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Drugs and biologicals provided in an inpatient setting
- Podiatry
- Personal Care Services
- Prenatal care
- Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center
- Prescribed Pediatric Extended Care Centers (PPECC)
- Primary care services
- Private Duty Nursing (for adult and child Members)

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-2 – HHSC STAR Health MCO RFP, STAR Health Covered Services**

Version 2.3

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- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies: physical, occupational, and speech
- Transplantation of organs and tissues

**Services included under the MCO capitation payment for MDCP:**

The following is a list of Covered Services for Members who qualify for MDCP services. The MCO must provide Medically and Functionally Necessary services to Members who meet the functional eligibility for MDCP.

1. Respite Care;
2. Supported Employment;
3. Financial Management Services;
4. Adaptive Aids;
5. Employment Assistance;
6. Flexible Family Support Services;
7. Minor home modifications; and
8. Transition Assistance Services.

Services included under the MCO capitation payment for MDCP: added by Version 2.3

## DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	2.0	July 1, 2015	Initial version of Attachment B-3, "Deliverables/Liquidated Damages Matrix" that includes all modifications negotiated by the Parties.
Revision	2.1	September 1, 2015	<p>Item 9 is modified to increase the LD from \$250 to \$1,000 per calendar day of noncompliance.</p> <p>Item 17 is modified to allow the MCO to reference the VDP formulary on Epocrates when the MCO's clinical edits are the same as or less stringent than VDP's.</p> <p>Item 17.1 is added.</p> <p>Item 18 is modified to conform to other contracts</p> <p>Item 25 is modified to the change the requirement from 30 days to 10 days</p> <p>Item 32 is modified to separate certain Pharmacy requirements from non-pharmacy requirements.</p> <p>Item 34 is modified to add pharmacy requirements.</p> <p>Item 35 is modified to increase the LD from \$250 to \$1,000 per calendar day of noncompliance.</p> <p>Item 35.1 is added.</p> <p>Item 35.2 is added.</p> <p>Item 35.3 is added.</p> <p>Item 36 is modified to increase the LD from \$250 to \$1,000 per calendar day of noncompliance.</p> <p>Item 39 is modified</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			Item 41 is modified. Item 44 is modified to change from six months to twelve months.
Revision	2.2	March 1, 2016	Item 3.1 is added. Item 3.2 is added. Item 3.3 is added. Item 14 is modified. Item 14.1 is added. Item 17 is modified. Item 42.1 is added.
Revision	2.3	September 1, 2016	Item 35.4 is added. Item 39 subsections (c) (d) and (e) are deleted. Item 42.2 is added.
<sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions <sup>2</sup> 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. <sup>3</sup> Brief description of the changes to the document made in the revision.			

### Deliverables/Liquidated Damages Matrix

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
1.	General Requirement: Failure to Perform an Administrative Service  STAR Health Contract Terms, RFP §§ 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.	Ongoing	Each incident of non-compliance	HHSC may assess up to \$5,000.00 per calendar day for each incident of non-compliance.
2.	General Requirement: Failure to Provide a Covered Service  STAR Health Contract Terms, RFP §§ 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 calendar day of non-compliance	HHSC may assess up to \$7,500.00 per day for each incident of non-compliance.

<sup>1</sup> Derived from the Contract or HHSC's Uniform Managed Care Manual.

<sup>2</sup> Standard specified in 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.

<sup>3</sup> Period during which HHSC will evaluate service for purposes of tailored remedies.

<sup>4</sup> Measure against which HHSC will apply remedies.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – HHSC STAR Health MCO RFP, Deliverables/Liquidated Damages Matrix**

Version 2.3

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
2.1	Contract Attachment B-1, RFP §§ 3, 4, and 5 Uniform Managed Care Manual (UMCM)	All reports as specified in Sections 3, 4, and 5 of Attachment B-1 must be submitted according to the requirements stated in the Contract (including all attachments) and the UMCM.	Transition Period, Quarterly during Operations Period	Per incident of noncompliance.	HHSC may assess up to \$2000 if the report is not submitted in the format/template required by HHSC.
3.	STAR Health Contract Terms, Section 4.09 Subcontractors and Agreements with Third Parties	The MCO must notify HHSC in writing:  (i) three Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Subcontract;  (ii) 180 calendar days prior to the termination date of a Material Subcontract for MIS systems operation or reporting;  (iii) 90 calendar days prior to the termination date of a Material Subcontract for non-MIS MCO Administrative Services; and  (iv) 30 calendar days prior to the termination date of any other Material Subcontract.	Transition Period, Quarterly during the Operations Period	Each calendar day, or portion thereof, of non-compliance	HHSC may assess up to \$5,000 per calendar day, or portion thereof, of non-compliance.
3.1	Contract Attachment A, "Uniform Managed Care Contract Terms and Conditions", Section 7.07 HIPAA and Article 11	The MCO must meet all privacy and security standards under applicable state or federal law, rule, regulation and HHSC contract requirement.	Transition Period, Quarterly during Operations Period	Per violation	Privacy: HHSC may assess up to \$5,000 per reporting period for each privacy violation of applicable federal or state law or the HHSC privacy standards in the contract.  Security: HHSC may assess up to

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – HHSC STAR Health MCO RFP, Deliverables/Liquidated Damages Matrix**

Version 2.3

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
	Item 3.1 added by Version 2.2				\$1,000 per reporting period for each security violation of security requirements under federal or state law or the HHSC security standard in the contract.
3.2	Contract Attachment A, "Uniform Managed Care Contract Terms and Conditions", Section 7.07 HIPAA and Article 11	The MCO must meet all confidentiality standards, under applicable state or federal law, rule, regulation and HHSC contract requirement.	Transition Period, Quarterly during Operations Period	Per privacy/security incident	HHSC may assess up to \$5,000 per reporting for each breach by MCO scenario as required by HHSC.
	Item 3.2 added by Version 2.2				
3.3	Contract Attachment A, "Uniform Managed Care Contract Terms and Conditions", Section 7.07 HIPAA and Article 11	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 Period, Quarterly during Operations Period	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.
	Item 3.3 added by Version 2.2				
4.	RFP § 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	Transition Period Quarterly during	Each calendar day of non-compliance	HHSC may assess up to \$250 per calendar day if the report/deliverable is not submitted, late, inaccurate, or

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – HHSC STAR Health MCO RFP, Deliverables/Liquidated Damages Matrix**

Version 2.3

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
		submitted according to the timeframes and requirements stated in the Contract (including all attachments), and the Uniform Managed Care Manual. (Specific Reports or deliverables listed separately in this matrix are subject to the specified liquidated damages.)	the Operations Period		incomplete.
5.	RFP § 7 Transition Phase Requirements RFP § 8 Operations Phase Requirements and General Scope of Work	The MCO must be operational no later than the agreed upon Operations Start Date. HHSC, or its agent, will determine when the MCO is considered to be operational based on the requirements in Section 3, Transition Phase Requirements and Section 8, Operations Phase Requirements and General Scope of Work.	Transition Period Operations Period	Each calendar day, or portion thereof, of non-compliance	HHSC may assess up to \$10,000 per calendar day, or portion thereof, for each day beyond the Operations Start date that the MCO is not operational until the day that the MCO is operational, including all systems.
6.	RFP § 7 Transition Phase Requirement RFP § 8 Operational Phase Requirements and Scope of Work UMCM	After the Operational Start Date, the MCO's MIS system must meet all requirements in Sections 7 and 8.	Transition Quarterly during Operations Period	Per calendar day, or portion of it, of non-compliance	HHSC may assess up to \$5,000 per calendar day, or portion thereof, for non-compliance.
7.	RFP § 7 Transition Phase Requirements UMCM	Final versions of the Provider Directory must be submitted to the Administrative Services Contractor no later than 90 calendar days	Transition Period	Each calendar day, or portion thereof, of non-compliance	HHSC may assess up to \$1,000 per calendar day, or portion thereof, for each day that the directory is not submitted, late, inaccurate, or

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – HHSC STAR Health MCO RFP, Deliverables/Liquidated Damages Matrix**

Version 2.3

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
		prior to the Operational Start Date.			incomplete.
8.	RFP § 7.2.5 System Readiness Review	<p>The MCO must develop, and submit for HHSC review and approval, the following information no later than 120 days prior to the Operational Start Date and within 15 Business Days of HHSC's written request at any time during the Contract:</p> <ul style="list-style-type: none"> <li>• Disaster Recovery Plan;</li> <li>• Business Continuity Plan;</li> <li>• Security Plan;</li> <li>• Joint Interface Plan;</li> <li>• Risk Management Plan; and</li> <li>• Systems Quality Assurance Plan.</li> </ul>	Transition Period	Each calendar day or portion thereof of non-compliance, per report	HHSC may assess up to \$1,000 per calendar day or portion thereof per deliverable that is not submitted, late, inaccurate, or incomplete.
9.	RFP §§ 7.2.7 Operations Readiness and 8.1.25 Fraud, Waste, and Abuse	The MCO must submit or comply with the requirements of the HHSC-approved Fraud and Abuse Compliance Plan.	Transition, Operations, and Turnover	Each incident of noncompliance	HHSC may assess up to \$1,000 per calendar day for each incident of noncompliance.
	Item 9 modified by Version 2.1				
10.	Attachment B-1, Section 8.1.3 Access to Care UMCM Chapter 5.14 Geo-Mapping	The MCO must comply with the contract's mileage standards and benchmarks for member access.	Quarterly during the Operations Period	Per incident of noncompliance and per Provider type	HHSC may assess up to \$1,000 per quarter and per Provider type.
11.	RFP § 8.1.4 Provider Network	(1) No more than 15 percent of the MCO's total hospital admissions may occur in out-of-	Quarterly during the Operations	Per incident of non-compliance	HHSC may assess up to \$25,000 per quarter per standard.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – HHSC STAR Health MCO RFP, Deliverables/Liquidated Damages Matrix**

Version 2.3

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
	UMCM Chapter 5.38 Out of Network Utilization Report	<p>network facilities.</p> <p>(2) No more than 20 percent of the MCO's total emergency room visits, by service delivery area, may occur in out-of-network facilities</p> <p>(3) No more than 20 percent of total dollars billed to the MCO for "other outpatient services" may be billed by out-of-network providers.</p>	Period		
12.	<p>RFP § 8.1.4.8 Provider Hotline</p> <p>§ 8.1.20.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies</p>	<p>A: The MCO must operate a toll-free Provider telephone line for Provider inquiries from 8 a.m. to 5 p.m., local time for all areas of the state, Monday through Friday, excluding state-approved holidays.</p> <p>B: Performance Standards:</p> <ol style="list-style-type: none"> <li>1. Call pickup rate – At least 99% of calls are answered on or before the fourth ring or an automated call pick-up system is used.</li> <li>2. Busy signal – No more than 1% of incoming calls receive a busy signal.</li> <li>3. Call abandonment rate – Call abandonment rate is 7% or less.</li> </ol> <p>C. Average hold time is 2 minutes</p>	<p>Quarterly during the Operations Period</p> <p>Turnover Period</p>	<p>A. Each incident of non-compliance</p> <p>B. Each percentage point below the standard for 1, each percentage point above the standard for 2 and 3</p> <p>C. Per month, for each 30 second time increment, or portion of it, by which the average hold time exceeds the maximum acceptable hold time</p>	<p>HHSC may assess:</p> <p>A. Up to \$100 for each hour, or portion thereof, that appropriately staffed toll-free lines 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.</p> <p>B. Up to \$100 for each percentage point for each standard that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated toll-free lines.</p> <p>C. Up to \$100.00 for each 30 second time increment, or portion thereof, by which the MCO's average hold time exceeds the maximum acceptable hold time.</p>

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – HHSC STAR Health MCO RFP, Deliverables/Liquidated Damages Matrix**

Version 2.3

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
		or less.			
13.	RFP § 8.1.5.1 Member Materials	No later than the fifth Business Day following the receipt of the enrollment file from the Administrative Services Contractor, the MCO must mail a Member's ID card and Member Handbook to the Member or Member's Caregiver per the requirements listed in <b>Section 8.1.5.1.</b>	Transition, Operations, Turnover	Each incident that materials are not mailed to the Member or Member's Caregiver.	HHSC may assess up to \$500 per incident of the MCO's failure to mail Member Materials to the Member or Member's Caregiver.
14.	RFP § 8.1.5.1 Member Materials UMCM Chapter 4.3  Item 14 modified by Version 2.2	The MCO must meet all Marketing and Member Materials policy requirements and may not engage in prohibited marketing practices.	Transition, Quarterly during the Operations Period	Per incidence of noncompliance	HHSC may assess up to \$1,000 per incident of noncompliance.
14.1	Contract Attachment B-1, RFP §8.1.6 Marketing & Prohibited Practices UMCM Chapter 4.13  Item 14.1 added by Version 2.2	The MCO must meet all Social Media policy requirements and may not engage in any prohibited Social Media practices.	Ongoing	Per incident of noncompliance	HHSC may assess up to \$500 per business day for each incident of noncompliance.
15.	RFP § 8.1.5.6 Nurse and Member Hotline Requirements	A: The MCO must operate a toll-free Nurse Hotline that Providers, Members, DFPS Staff, Caregivers, and Medical Consenters can call 24 hours a day, seven days a week. In addition, the MCO must operate a toll-free Member Hotline that Members, DFPS Staff,	Ongoing during Operations and Period	A. Per hotline, each incident of non-compliance  B. Per hotline, each percentage point below the standard for 1 and 3, each percentage point	HHSC may assess:  A. Per hotline, up to \$100 for each hour or portion thereof that appropriately staffed toll-free lines 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

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
		<p>Caregivers and Medical Consenters can call 24 hours a day, seven days a week.</p> <p>B: Performance Standards:</p> <ol style="list-style-type: none"> <li>1. Call pickup rate – At least 99% of calls are answered on or before the fourth ring or an automated call pickup system is used.</li> <li>2. Busy signal – No more than 1% of incoming calls receive a busy signal.</li> <li>3. At least 80% of calls must be answered by toll-free line staff within 30 seconds from the time the call is placed in queue after selecting an option.</li> <li>4. Call abandonment rate - Call abandonment rate is 7% or less.</li> </ol> <p>C. Average hold time is 2 minutes or less.</p>		<p>above the standard for 2 and 4</p> <p>C. Per month, for each 30 second time increment, or portion of it, by which the average hold time exceeds the maximum acceptable hold time</p>	<p>MCO fails to implement its Disaster Recovery Plan.</p> <p>B. Per hotline, up to \$100 for each percentage point for each standard that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated toll-free lines.</p> <p>C. Up to \$100 for each 30 second time increment, or portion of it, by which the MCO's average hold time exceeds the maximum acceptable hold time.</p>
16.	RFP § 8.1.17.3 Behavioral Health Hotline Requirements	A: The MCO must have a Behavioral Health Services Hotline, answered by a live voice, available 24 hours per day, 7 days a week, toll-free throughout the state which addresses routine and crisis Behavioral Health calls.	Quarterly during the Operations Period, Turnover Period	<p>A. Each incident of non-compliance</p> <p>B. Each incident of noncompliance</p> <p>C. Per month, each percentage point</p>	<p>HHSC may assess:</p> <p>A. Up to \$100 for each hour or portion thereof that appropriately staffed toll-free lines 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</p>

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#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
		<p>B: Hotline staff must include or have access to qualified Behavioral Health Services Professionals to assess behavioral health emergencies.</p> <p>C. Performance Standards:</p> <ol style="list-style-type: none"> <li>1. Call pickup rate – At least 99% of calls are answered on or before the fourth ring or an automated call pickup system is used.</li> <li>2. Busy signal – 0% of incoming calls receive a busy signal.</li> <li>3. At least 80% of calls must be answered by toll-free line staff within 30 seconds from the time the call is placed in queue after selecting an option.</li> <li>4. Call abandonment rate - Call abandonment rate is 7% or less.</li> </ol> <p>D. Average hold time is 2 minutes or less.</p>		<p>below the standard for 1 and 3, each percentage point above the standard for 2 and 4</p> <p>D. Per month, for each 30 second time increment, or portion of it, by which the average hold time exceeds the maximum acceptable hold time</p>	<p>damages unless the MCO fails to implement its Disaster Recovery Plan.</p> <p>B. Up to \$100 per incident for each occurrence that HHSC identifies through its recurring monitoring processes that toll-free line staff were not qualified or did not have access to qualified professionals to assess behavioral health emergencies.</p> <p>C. Up to \$100 for each percentage point for each standard that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated toll-free lines.</p> <p>D. Up to \$100 for each 30 second time increment, or portion thereof, by which the MCO's average hold time exceeds the maximum acceptable hold time.</p>
17.	RFP § 8.1.20.1 Formulary and Preferred Drug List	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 also identify	Ongoing	Each calendar day of noncompliance	HHSC may assess up to \$10,000 per calendar day for each incident of noncompliance.
Item 17 modified by Versions 2.1 and 2.2					

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		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. 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.			
17.1	Contract Attachment B-1, 8.1.20.1 Formulary and PDL  Formulary and PDL Adherence	MCO must adhere to HHSC's formularies and the Medicaid PDL.	Ongoing	Per incident of noncompliance	HHSC may assess up to \$500 for each incident per Member and per drug of non-compliance per MCO Program, not to exceed \$10,000 per calendar day.
	Item 17.1 added by Version 2.1				
18.	RFP § 8.1.20.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies	The MCO must reimburse a pharmacy for providing a 72-hour emergency supply as outlined in this section.  The MCO must instruct a pharmacy to dispense a 72-hour emergency supply of the prescription as outlined in this section or must make a PA determination within 24 hours of the request.	Ongoing	Per incident of noncompliance	HHSC may assess up to \$5,000 per incident of noncompliance.
	Item 18 modified by Version 2.1				
19.	RFP § 8.1.20.5 Pharmacy	The MCO fails to include valid	Ongoing	Each incident of	HHSC may assess up to \$500 for each

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	Rebate Program UMCM, Chapters 2.0 and 2.2	national drug codes (NDCs) on encounters for outpatient prescription drugs, including physician-administered drugs.		noncompliance	incident of noncompliance.
20.	RFP § 8.1.20.16 E-Prescribing	The MCO fails to provide timely data updates to the national e-prescribing network.	Ongoing	Each calendar day of noncompliance	HHSC may assess up to \$5,000 per calendar day of noncompliance.
21.	RFP § 8 Operational Phase Requirements and Scope of Work RFP § 8.1.23.1 Financial Reporting Requirements UMCM Chapter 5.0	Financial Statistical Reports (FSR): The MCO must file quarterly and annual FSRs. Quarterly reports are due no later than 30 days after the conclusion of each State Fiscal Quarter (SFQ). The first annual SFY FSR report is due no later than 120 days after the end of the Contract Year, and subsequent annual reports are due no later than 365 days after the end of each Contract Year.	Quarterly during the Operations Period Turnover Period	Per calendar day, or portion thereof, of non-compliance	HHSC may assess up to \$1,000 per calendar day, or portion thereof, per FSR that is not submitted, late, inaccurate, or incomplete.
22.	RFP § 8.1.23.1 Financial Reporting Requirements; UMCM Chapters 5.6.2 and 5.6.1	Claims Lag Report must be submitted by the last day of the month following the reporting period.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day/per Program the report is not submitted, late, inaccurate, or incomplete.
23.	RFP § 8.1.23.1, Financial Reporting Requirements	Financial Disclosure Report: an annual submission no later than 30 days after the end of each calendar year and update after any change, no later than 30 days after the change.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or incomplete.

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24.	RFP § 8.1.23.1, Financial Reporting Requirements	Affiliate Report: on an as-occurs basis and annually by August 31 of each year in accordance with the <b>Uniform Managed Care Manual</b> . The “as-occurs” update is due within 30 days of the event triggering the change.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or incomplete.
25.	RFP § 8.1.23.1, Financial Reporting Requirements  Item 25 modified by Version 2.1	TDI Examination Report: furnish HHSC with a full and complete copy of any TDI Examination Report issued by TDI no later than 10 calendar days after receipt of the final version from TDI.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or incomplete.
26.	RFP § 8.1.23.1, Financial Reporting Requirements	TDI Financial Filings: Submit copies to HHSC of reports submitted to TDI.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.
27.	RFP § 8.1.23.1, Financial Reporting Requirements	Filings with Other Entities, and Other Annual Financial Reports: submit an electronic copy of the reports or filings pertaining to the MCO, or its parent, or its parent’s parent.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.
28.	RFP § 8.1.23.1, Financial Reporting Requirements; UCMCM Ch. 5.3.11	Audit Reports—comply with UCMCM requirements regarding notification or submission of audit reports.	Operations	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.
29.	RFP § 8.1.23.1, Financial Reporting Requirements;	Report of Legal and Other Proceedings and Related Events—comply with UCMCM	Transition, Operations	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted,

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	UMCM Ch. 5.8	requirements regarding the disclosure of certain matters involving the MCO, its Affiliates, or its Material Subcontractors, as specified. This requirement is both on an as-occurs basis and an annual report due annually on August 31.			late, inaccurate, or incomplete.
30.	RFP § 8.1.23.1, Financial Reporting Requirements	Employee Bonus and/or Incentive Payment Plan, Registration Statement (aka "Form B"), and Third Party Recovery (TPR) Reports	Operations	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.
31.	RFP § 8 Operational Phase Requirements and Scope of Work 8.1.24 Management Information System Requirements UMCM	The MCO's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.	Quarterly during the Operations Period  Turnover Period	Per calendar day, or portion of it, of non-compliance	HHSC may assess up to \$5,000 per calendar day, or portion of it, of noncompliance.
32.	RFP § 8.1.24.1 Encounter Data  Item 32 modified by Version 2.1	The MCO must submit 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 calendar day after the last day of the month in which the claim(s) are adjudicated. Pharmacy Encounter Data must be submitted no later than 25 calendar days after the date of adjudication and include all	Quarterly during Operations Period	Per incident of non-compliance	Liquidated Damages: a) Failure to submit Encounter Data (non-pharmacy): 1. For the initial quarter: HHSC may assess up to \$2,500, per month if the MCO fails to submit monthly Encounter Data in a quarter. 2. For each subsequent quarter: HHSC may assess

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		<p>Encounter Data and Encounter Data adjustments.</p> <p>Additionally, 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.</p>			<p>up to \$5,000, per month for each month in any subsequent Quarter that the MCO fails to submit monthly Encounter Data.</p> <p>b) Encounter Data Reconciliation (non-pharmacy): Additionally, HHSC may assess up to \$2,500 per Quarter if the MCO is not within the 2% variance. HHSC may assess up to \$5,000 per Quarter for each additional Quarter that the MCO is not within the 2% variance.</p> <p>c) Pharmacy Encounter Data:</p> <ol style="list-style-type: none"> <li>1. HHSC may assess up to \$10,000 per quarter, per program that if the MCO fails to submit pharmacy Encounter Data in a timely manner for the initial quarter.</li> <li>2. For each subsequent quarter: HHSC may assess up to \$15,000 per quarter, per program that the MCO fails to submit Pharmacy Encounter Data in a timely manner.</li> </ol> <p>d) Pharmacy Encounter Data Reconciliation: Additionally, HHSC may assess up to \$2,500 per Quarter, per Program that if the MCO is not within the 2% variance. HHSC may assess up to \$5,000 per Quarter, per Program, for each additional Quarter that the MCO is not within the 2% variance.</p>

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33.	RFP § 8 Operational Phase Requirements and Scope of Work  § 8.1.24.5 Claims Processing Requirements and § 8.1.20.14 Pharmacy Claims and File Processing  UMCM Chapters 2.0 and 2.2	<p>For a Clean Claim not adjudicated within 30 days of receipt by the MCO, the MCO must pay providers 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.</p> <p>The MCO must adjudicate all Clean Claims 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.</p>	Quarterly during the Operations Period  Turnover Period	Per incident of non-compliance	HHSC may assess up to \$1,000 per claim, if the MCO fails to pay interest timely.
34.	RFP § 8 Operational Phase Requirements and Scope of Work  8.1.24.5 Claims	The MCO must comply with the claims processing requirements and standards as described in Section 8.1.24.5 and in Chapters 2.0 and 2.2 of the UMCM.	Quarterly during the Operations Period  Turnover Period	Except for pharmacy claims, per quarterly reporting period, per claim type	Except for pharmacy claims, HHSC may assess up to \$5,000 for the first quarter that the MCO's Claims Performance percentages by claim type fall below the performance standards. HHSC may

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	Processing Requirements UMCM Chapters 2.0 and 2.2  Item 34 modified by Version 2.1			For pharmacy claims: Per quarterly reporting period, per MCO Program.	assess up to \$25,000 per quarter for each additional quarter that the Claims Performance percentages by claim type fall below the performance standards.  HHSC may assess liquidated damages of up to \$5,000 for the first quarter that an MCO's pharmacy Claims Performance percentages by Program, fall below the performance standards. HHSC may assess up to \$25,000 per quarter for each additional quarter that the Claims Performance percentages by Program, fall below the performance standards.
35.	RFP § 8.1.25 Fraud, Waste, and Abuse  Item 35 modified by Version 2.1	The MCO must respond to Office of Inspector General request for information in the manner and format requested.	Transition, Operations, and Turnover	Each calendar day of noncompliance	HHSC may assess up to \$1,000 per calendar day, per MCO Program, that the report is not submitted, late, inaccurate, or incomplete. This amount will increase to \$5,000 per day per MCO program for the fourth and each subsequent occurrence within a 12-month period.
35.1	Attachment B-1, RFP § 8.1.25  Item 35.1 added by Version 2.1	The MCO must respond to Office of Inspector General request for payment hold amounts accurately and in the manner and format requested.	Transition, Operations, and Turnover	Per instance of noncompliance, per MCO Program.	HHSC may assess up to the difference between the amount reported and the amount received by HHSC OIG.
35.2	Attachment B-1, RFP § 8.1.25  Item 35.2 added by Version 2.1	The MCO fails to hold or improperly releases funds subject to a payment hold	Transition, Operations, and Turnover	Per instance of noncompliance, per MCO	HHSC may assess up to the amount not held or released

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35.3	Attachment B-1, RFP Section 8.1.25.2	The MCO fails to submit claims data as prescribed by OIG.	Transition, Operations, and Turnover	Each instance of noncompliance, per MCO	HHSC may assess up to \$1,000 per calendar day, per MCO Program, that the report is not submitted, late, inaccurate, or incomplete. This amount will increase to \$5,000 per day per MCO program for the fourth and each subsequent occurrence within a 12-month period.
	Item 35.3 added by Version 2.1				
35.4	Attachment B-1, RFP Section 8.1.19	The MCO must perform pre-payment review for identified providers as directed by OIG.	Transition, Operations, and Turnover	Each instance of noncompliance, per MCO Program	Failure to impose pre-payment review on a provider(s) as directed by OIG within 10 business days of receiving the request. \$1,000 per day, per program.
	Item 35.4 added by Version 2.3				
36.	RFP § 8.1.26.2 Reports, UCM Chapter 5.5	The MCO must submit a Fraudulent Practices Report 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).  The MCO must submit quarterly MCO Open Case List Reports.	Transition, Operations, and Turnover	Each calendar day of noncompliance	HHSC may assess up to \$1,000 per calendar day that the report is not submitted, late, inaccurate, or incomplete. This amount will increase to \$5,000 per day per MCO program for the fourth and each subsequent occurrence within a 12-month period.
	Item 36 modified by Version 2.1				
37.	RFP §8.1.26.2 Reports, §8.1.33.1 Member Complaint Process; §8.1.31.1 Provider Complaints	The MCO must submit a timely response to an HHSC Member or Provider Complaint received by HHSC and referred to the MCO. The MCO response must be submitted according to the timeframes and requirements stated within the MCO Notification	Quarterly during the Operations Period	Each incident or noncompliance	HHSC may assess up to \$250 per calendar day, or portion thereof, beyond the due date specified within the MCO Notification Correspondence.

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		Correspondence (letter, e-mail, etc.).			
38.	RFP § 8 Operational Phase Requirements and Scope of Work 8.1.26.2 Reports UMCM Chapters 2.0 and 5.0	Claims Summary Report: The MCO must submit quarterly Claims Summary Reports to HHSC, by claim type, by the 30th day following the reporting period unless otherwise specified.	Quarterly during the Operations Period Turnover Period	Per calendar day, or portion of it, of non-compliance, per claim type	HHSC may assess up to \$1,000 per calendar day, or portion thereof, that the report is not submitted, late, inaccurate, or incomplete.
39.	RFP § 8.1.26.2 Reports; UMCM Chapter 12 Frew  Item 39 modified by Versions 2.1 and 2.3	(a) Medicaid Managed Care Texas Health Steps Medical Checkups Reports – The MCO must submit an annual report of the number of New Members and Existing Members that receive timely Texas Health Steps (THSteps) medical checkups or refuse to obtain medical checkups.  (b) Frew Quarterly Monitoring Report – The MCO must submit each quarter responses to questions on this report’s template addressing the status of Frew Consent Decree paragraphs.	(a) Annually (b) Quarterly	(a) Per calendar day of noncompliance  (b) Per calendar day of noncompliance	HHSC may assess up to \$1,000 per calendar day the reports are not submitted, late, inaccurate, or incomplete.
40.	RFP § 8.1.31.1 Provider Complaints § 8.1.33.1 Member Complaint Process	The MCO must resolve at least 98% of Member and Provider Complaints within 30 calendar days, from the date the Complaint is received by the MCO.	Quarterly during the Operations Period	Each incident of non-compliance per reporting period	HHSC may assess up to \$250 per reporting period if the MCO fails to meet the performance standard.

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41.	RFP § 8.1.31.2, Appeal of Provider Claims  Item 41 modified by Version 2.1	The MCO must resolve at least 98% of Provider Appeals within 30 calendar days from the date the Appeal is filed with the MCO.	Operations, Turnover	Per reporting period.	HHSC may assess up to \$5,000 per reporting period if the MCO fails to meet the performance standard.
42.	RFP § 8 Operational Phase Requirements and Scope of Work § 8.1.33.3 Standard Member Appeal Process	The MCO must resolve at least 98% of Member Appeals within 30 calendar days of the MCO's receipt.	Quarterly during the Operations Period	Per reporting period	HHSC may assess up to \$500 per quarterly reporting period if the MCO fails to meet the performance standard.
42.1	Contract Attachment B-1, RFP §§ 6, 7, 8 and 9 8.1.33.5 Access to Fair Hearing for Medicaid Members  Item 42.1 added by Version 2.2	The MCO must ensure that the appropriate staff members who have firsthand knowledge of the Member's appeal in order to be able to speak and provide relevant information on the case attend all State Fair Hearings as scheduled.	Transition Period, Quarterly during Operations Period	Per incident of noncompliance	HHSC may assess up to \$1000 for each State Fair Hearing that the MCO fails to attend as required by HHSC.
42.2	§8.2 Additional Requirements for MDCP  Item 42.2 added by Version 2.3	The MCO must complete and electronically submit the Screening and Assessment Instrument (SAI) to HHSC's Administrative Services Contractor in the specified format within 45 days: 1) from the date of referral for MDCP services; or 2) prior to the annual ISP expiration date for all Members receiving MDCP services as specified in Section 8.3.1.	Operations, Turnover	Per calendar day of noncompliance, per Member	HHSC may assess up to \$500 per calendar day per Member, for each day required documentation is late, inaccurate, not submitted, or incomplete.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – HHSC STAR Health MCO RFP, Deliverables/Liquidated Damages Matrix**

Version 2.3

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
43.	RFP § 9 Turnover Requirements § 9.3 Transfer of Data and Information § 9.4 Turnover Services	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.	At time of Transfer of Data and ongoing after Transfer of Data until satisfactorily completed during the Turnover Period	Per incident of non-compliance (failure to provide data or failure to provide data in required format)	HHSC may assess up to \$10,000 per calendar day, or portion thereof, that the data is not submitted, late, inaccurate, or incomplete.
44.	RFP § 9 Turnover Requirements § 9.4 Turnover Services  Item 44 modified by Version 2.1	Twelve months prior to the end of the contract period or any extension thereof, the MCO must propose a Turnover Plan covering the possible turnover of the records and information maintained to either the State (HHSC) or a successor MCO. If HHSC terminates the Contract prior to the expiration of the Initial Contract Period or Contract Period, then HHSC may require the MCO to propose or update the Turnover Plan sooner.	Measured at twelve months prior to the end of the Contract Period or any extension and ongoing until satisfactorily completed	Each calendar day, or portion thereof, of noncompliance	HHSC may assess up to \$1,000 per calendar day, or portion thereof, that the Turnover Plan is not submitted, late, inaccurate, or incomplete.
45.	RFP § 9 Turnover Requirements § 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.	Turnover Period	Each calendar day, or portion thereof, of noncompliance	HHSC may assess up to \$250 per calendar day, or portion thereof, that the report is not submitted, late, inaccurate, or incomplete.