
Nursing Facility Contracting Plan Phase One Report

**As Required By
S.B. 7, 83rd Legislature, Regular Session, 2013**

**Health and Human Services Commission
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Table of Contents

Executive Summary	1
Introduction.....	2
Background.....	2
Contract Template Requirements	3
Nursing Facility Credentialing Requirements	3
Appeals Processes	4
Termination Provisions	4
Prompt Payment and Liquidated Damages Provisions for Failure to Meet Prompt Payment Requirements.....	5
Medical Necessity Criteria	5
Member Freedom of Choice in Making a Nursing Facility Selection	6
Discharge Planning.....	6
Prior Authorization Requirements.....	7
Conclusion	8

Executive Summary

S.B. 7, 83rd Legislature, Regular Session, 2013, requires the Texas Health and Human Services Commission (HHSC) to develop two reports on delivering nursing facility benefits through managed care: *Phase One, Nursing Facility Contract Planning* (completed October 2013); and *Phase Two, Nursing Facility Portal Testing Plan* (completed July 2014). S.B. 7 also requires the Phase One and Phase Two reports be delivered to the STAR+PLUS Nursing Facility Advisory Committeeⁱ. This report addresses the contract planning phase for nursing facilities.

Nursing facilities are residential facilities that provide care for people whose medical condition regularly requires the skills of licensed nurses. They provide for the medical, social and psychological needs of each resident, including room and board, social services, over-the-counter drugs (prescription drugs are covered through the Medicaid Vendor Drug program or Medicare Part D), medical supplies and equipment, rehabilitative services, and personal needs items.ⁱⁱ

Nursing facility benefits are a Medicaid covered service currently paid through a fee-for-service (FFS) delivery system. This is where health care providers are paid for each service (like an office visit, test, or procedure).ⁱⁱⁱ Beginning September 1, 2014^{iv}, nursing facility benefits will be delivered through the STAR+PLUS Medicaid managed care model. Through STAR+PLUS, individuals will get most or all of their Medicaid services from a managed care organization (MCO) under contract with the state. HHSC and the MCOs will enter into a contractual relationship in which the MCOs agree to provide specified Medicaid benefits, including nursing facility benefits, to people in exchange for a monthly payment from the state.^v

S.B. 7 directs HHSC to develop a contract template to be used by HHSC when contracting with an MCO to provide nursing facility benefits through STAR+PLUS. This report provides information on the implementation of *Phase One, Nursing Facility Contracting Plan*, and includes links to the HHSC Uniform Managed Care Contract (UMCC) and the Uniform Managed Care Manual (UMCM), which together constitute the HHSC contract template with the Medicaid MCOs.

ⁱ The governor, lieutenant governor, and speaker of the house of representatives, each appointed five members to the STAR+PLUS Nursing Facility Advisory Committee. The final appointments were made October 2014, and the committee convened for the first time on March 9, 2015.

ⁱⁱ <http://www.dads.state.tx.us/services/faqs-fact/nf.html>.

ⁱⁱⁱ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Fee-for-Service.html>.

^{iv} At the time this report was completed (October 2013), nursing facility benefits delivered through managed care was scheduled to implement September 1, 2015. In March 2014, HHSC postponed implementation to March 1, 2015.

^v <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html>.

Introduction

This report was completed in October 2013 and only reflects work up to that date.

S.B. 7, 83rd Legislature, Regular Session, 2013, directs HHSC to deliver nursing facility benefits through the STAR+PLUS Medicaid managed care model beginning September 1, 2014^{vi}. S.B. 7 also establishes a legislatively-appointed Nursing Facility Advisory Committee. Additional bill provisions require:

- HHSC to maintain the minimum reimbursement rate paid to nursing facilities, including the staff rate enhancement;
- STAR+PLUS MCOs to pay nursing facilities not later than the tenth day after the date the nursing facility submits a clean claim for reimbursement; and
- STAR+PLUS MCOs to provide discharge planning, transitional care, and other education programs to physicians and hospitals regarding available long-term care settings.

HHSC also must develop two reports regarding the implementation of nursing facility benefits into STAR+PLUS:

- *Phase One: Nursing Facility Contracting Plan* must be completed, and a report submitted to the Nursing Facility Advisory Committee by October 1, 2013; and
- *Phase Two: Nursing Facility Portal Testing Plan* must be completed, and a report submitted to the Nursing Facility Advisory Committee by July 15, 2014.

Under the *Phase One, Nursing Facility Contracting Plan*, HHSC is directed HHSC to develop a contract template to be used by HHSC when contracting with an MCO to provide nursing facility services through STAR+PLUS. This report provides information on the implementation of *Phase One, Nursing Facility Contracting Plan*, including links to the HHSC Uniform Managed Care Contract (UMCC) and the Uniform Managed Care Manual (UMCM), which together constitute the HHSC contract template with the Medicaid MCOs.

Background

Nursing facility benefits are a Medicaid covered service currently paid through a fee-for-service (FFS) delivery system. This is where health care providers are paid for each service (like an office visit, test, or procedure).^{vii} Beginning September 1, 2014, nursing facility benefits will be delivered through the STAR+PLUS Medicaid managed care model. Through STAR+PLUS, individuals will get most or all of their Medicaid services from a managed care organization

^{vi} At the time this report was completed (October 2013), nursing facility benefits delivered through managed care was scheduled to implement September 1, 2015. In March 2014, HHSC postponed implementation to March 1, 2015.

^{vii} <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Fee-for-Service.html>.

(MCO) under contract with the state. HHSC and the MCOs will enter into a contractual relationship in which the MCOs agree to provide specified Medicaid benefits, including nursing facility benefits, to people in exchange for a monthly payment from the state.^{viii}

Providing nursing facility services through STAR+PLUS is expected to improve quality of care for nursing facility residents and to promote care in the least restrictive, most appropriate setting. To prepare for this implementation and pursuant to S.B. 7, 83rd Legislature, Regular Session, 2013, HHSC reviewed its existing UMCC and UMCM.

The UMCC and the UMCM together document HHSC's contractual relationship with the Medicaid MCOs.

- The UMCC sets forth terms and conditions for an MCO's participation as a managed care organization in one or more of the Medicaid managed care programs administered by HHSC. Under the terms of UMCC, MCOs are required to provide comprehensive health care services to qualified recipients through a managed care delivery system.
- The UMCM contains HHSC policies and procedures required of all MCOs participating in the Medicaid managed care. The UMCM, as amended or modified, is incorporated by reference into the Contract.

Contract Template Requirements

S.B. 7 directs HHSC to develop a contract template to be used by HHSC when contracting with an MCO to provide nursing facility services through STAR+PLUS. This plan must include:

1. nursing facility credentialing requirements;
2. appeals processes;
3. termination provisions;
4. prompt payment and liquidated damages provisions for failure to meet prompt payment requirements;
5. medical necessity criteria;
6. member freedom of choice in making a nursing facility selection;
7. discharge planning; and
8. prior authorization requirements.

HHSC reviewed the existing UMCC, together with the UMCM, and identified areas in which the required nursing facility provisions will be incorporated. The sections identified below will be updated as appropriate to ensure S.B. 7 provisions for nursing facility services are covered.

Nursing Facility Credentialing Requirements – Credentialing means the process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care

^{viii} <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html>.

provider to determine eligibility and to deliver Medicaid covered services. HHSC has a number of provisions in the UMCC that are listed below related to credentialing:

- UMCC, Attachment A, UMCC Terms and Conditions, Article 2, Definitions
- UMCC, Attachment B-1, Section 7.2.8.1, Readiness Review
- UMCC, Attachment B-1, Section 8.1.4, Provider Network
- UMCC, Attachment B-1, Section 8.1.4.4, Credentialing and Recredentialing
- UMCC, Attachment B-1, Section 8.1.4.12, Provider Protection Plan
- UMCM, Chapter 3, Critical Elements
- UMCM, Chapter 5, Deliverables, Reports, Due Dates
- UMCM, Chapter 8, Provider

Appeals Processes – An appeal is the formal process by which a member or his or her representative, request a review of the MCO’s action. The UMCC defines a Medicaid action as: (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 service; (4) the failure to provide services in a timely manner; (5) the failure of an MCO to act within the timeframes set forth 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 Medicaid member’s request to obtain services outside of the provider network. An adverse determination is one type of action.

- UMCC, Attachment A, UMCC Terms and Conditions, Article 2, Definitions
- UMCC, Attachment B-1, Section 7.2.8.1, Readiness Review
- UMCC, Attachment B-1, Section 8.1.4.4, Credentialing and Recredentialing
- UMCC, Attachment B-1, Section 8.1.5.9, Member Complaint and Appeal Process
- UMCC, Attachment B-1, Section 8.1.20.2, Reports
- UMCC, Attachment B-1, Section 8.2.4 Provider Complaints and Appeals
- UMCC, Attachment B-1, Section 8.2.6 Member Complaint and Appeal System
- UMCM, Chapter 3, Critical Elements
- UMCM, Chapter 5, Deliverables, Reports, Due Dates

Termination Provisions – The UMCC contains several provisions outlining termination processes between HHSC and an MCO. The contract also addresses termination of provider contracts between an MCO and a provider:

- UMCC, Attachment A, UMCC Terms and Conditions, Article 10, Terms and Conditions of Payment, Section 10.01, Calculation of Monthly Capitation Payment
- UMCC, Attachment A, UMCC Terms and Conditions, Article 12, Remedies and Disputes
- UMCC, Attachment A, UMCC Terms and Conditions, Article 13, Assurances and Certifications, Section 13.07, Outstanding Debts and Judgments
- UMCC, Attachment B-1, Section 3.3.2, Conflicts of Interest

- UMCC, Attachment B-1, Section 4.08, Subcontractors
- UMCC, Attachment B-1, Section 4.11, Prohibition Against Performance Outside the United States
- UMCC, Attachment B-1, Section 8.1.4.9, Termination of Provider Contracts
- UMCC, Attachment B-1, Section 8.1.20.2, Reports
- UMCM, Chapter 5, Deliverables, Reports, Due Dates
- UMCM, Chapter 6, Financial

Prompt Payment and Liquidated Damages Provisions for Failure to Meet Prompt Payment Requirements – The UMCC and UMCM contain a number of provisions related to HHSC payment to the MCOs, and to the adjudication (payment or denial) of claims between the MCOs and the providers. The contract also includes the following liquidated damages provisions:

- UMCC, Attachment A, UMCC Terms and Conditions, Article 2, Definitions
- UMCC, Attachment A, UMCC Terms and Conditions, Article 3, General Terms and Conditions, Section 3.03, Funding
- UMCC, Attachment A, UMCC Terms and Conditions, Terms and Conditions of Payment
- UMCC, Attachment A, UMCC Terms and Conditions, Article 12, Remedies and Disputes, Section 12.13, Dispute Resolution
- UMCC, Attachment B-1, Section 8.1.4.8, Provider Reimbursement
- UMCC, Attachment B-1, Section 8.1.18.5, Claims Processing Requirements
- UMCC, Attachment B-1, Section 8.1.21, Pharmacy Services
- UMCC, Attachment B-1, Section 8.2.1, Continuity of Care and Out-of-Network Providers
- UMCC, Attachment B-1, Section 8.2.3, Medicaid Significant Traditional Providers
- UMCC, Attachment B-3, Deliverables/Liquidated Damages Matrix
- UMCM, Chapter 2, Texas Claims Procedures
- UMCM, Chapter 5, Deliverables, Reports, Due Dates
- UMCM, Chapter 10, Contract Management Tools

Medical Necessity Criteria – The UMCC refers to Texas Administrative Code (T.A.C.) rules for medical necessity. In [T.A.C. §353.2](#), medically necessary means, for Medicaid members over age 20, non-behavioral health services that are: (1) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life; (2) provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions; (3) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies; (4) consistent with the member's diagnoses; (5) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; (6) not experimental or investigative; and

(7) not primarily for the convenience of the member or provider. Reference to medical necessity is made in the following sections:

- UMCC, Attachment A, Terms and Conditions, Article 2, Definitions
- UMCC, Attachment A, Terms and Conditions, Article 5, Member Eligibility and Enrolment, Section 5.02, Member Enrollment and Disenrollment
- UMCC, Attachment B-1, Section 7.2.8.1, Readiness Review
- UMCC, Attachment B-1, Section 8.1.2, Covered Services
- UMCC, Attachment B-1, Section 8.1.3, Access to Care
- UMCC, Attachment B-1, Section 8.1.4, Provider Network
- UMCC, Attachment B-1, Section 8.1.4.8, Provider Reimbursement
- UMCC, Attachment B-1, Section 8.1.8, Utilization Management
- UMCC, Attachment B-1, Section 8.1.16, Financial Requirements for Covered Services
- UMCC, Attachment B-1, Section 8.1.18.5, Claims Processing Requirements
- UMCC, Attachment B-1, Section 8.2.1, Continuity of Care and Out-of-Network Providers
- UMCC, Attachment B-1, Section 8.2.2, Provisions Related to Covered Services for Medicaid Members
- UMCC, Attachment B-1, Section 8.2.4.2, Appeal of Provider Claims
- UMCM, Chapter 3, Critical Elements
- UMCM, Chapter 5, Deliverables, Reports, Due Dates

Member Freedom of Choice in Making a Nursing Facility Selection – Federal law requires qualified recipients have a choice of Medicaid managed care health plans in any given service area. HHSC will have at least two STAR+PLUS MCOs per service area. Reference to choice is made in the sections identified below:

- UMCC, Attachment A, Terms and Conditions, Article 5, Member Eligibility and Enrollment, Section 5.08, Modified Default Enrollment Process
- UMCC, Attachment B-1, 4.3.11, Care Management and/or Service Coordination
- UMCC, Attachment B-1, 8.1.3.2, Access to Network Providers
- UMCC, Attachment B-1, Section 8.1.4, Provider Network
- UMCC, Attachment B-1, Section 8.1.4.2, Primary Care Providers
- UMCM, Chapter 8, Provider

Discharge Planning – Discharge is defined as a formal release of a member from an inpatient hospital stay when the need for continued care at an inpatient level has concluded. Movement or transfer from one acute care hospital or long-term care hospital/facility and readmission to

another within 24 hours for continued treatment is not a discharge under the UMCC. Reference to discharge planning is made in the following sections:

- UMCC, Attachment A, Terms and Conditions, Article 2, Definitions
- UMCC, Attachment B-1, 8.1.4.6, Provider Relations including Manual, Materials, and Training
- UMCC, Attachment B-1, 8.1.5.7, Member Education
- UMCC, Attachment B-1, 8.1.15.8, Local Mental Health Authority (LMHA)
- UMCC, Attachment B-1, 8.2.2, Provisions Related to Covered Services for Medicaid Members
- UMCC, Attachment B-1, 8.3.2.5, Discharge Planning

Prior Authorization Requirements – Prior authorization is a tool used by MCOs to ensure benefits are administered as designed and that plan members receive services that are safe, effective for their condition, and provide the greatest value.^{ix} Physicians must receive approval by the MCO for the benefit requested otherwise the service may not be covered (paid for). Reference to prior authorizations is made in the following sections:

- UMCC, Attachment A, Terms and Conditions, Article 2, Definitions
- UMCC, Attachment A, Terms and Conditions, Article 4, Contract Administration and Management
- UMCC, Attachment B-1, Section 7.2.8.1, Readiness Review
- UMCC, Attachment B-1, Section 8.1.2, Covered Services
- UMCC, Attachment B-1, Section 8.1.3, Access to Care
- UMCC, Attachment B-1, 8.1.4.6, Provider Relations including Manual, Materials, and Training
- UMCC, Attachment B-1, 8.1.4.12, Provider Protection Plan
- UMCC, Attachment B-1, 8.1.5.6, Member Hotline
- UMCC, Attachment B-1, Section 8.1.5.9, Member Complaint and Appeal Process
- UMCC, Attachment B-1, Section 8.1.8, Utilization Management
- UMCC, Attachment B-1, Section 8.1.8.1, Compliance with State and Federal Prior Authorization Requirements
- UMCC, Attachment B-1, Section 8.1.21, Pharmacy Services
- UMCC, Attachment B-1, Section 8.1.21.2, Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies
- UMCC, Attachment B-1, Section 8.2.1, Continuity of Care and Out-of-Network Providers
- UMCC, Attachment B-1, 8.2.2, Provisions Related to Covered Services for Medicaid Members

^{ix} [The Academy of Managed Care Pharmacy's Concepts in Managed Care Pharmacy.](#)

- UMCM, Chapter 3, Critical Elements
- UMCM, Chapter 5, Deliverables, Reports, Due Dates

Conclusion

S.B. 7, 83rd Legislature, Regular Session, 2013, requires HHSC to develop two reports on delivering nursing facility benefits through managed care: *Phase One, Nursing Facility Contract Planning* (completed October 2013); and *Phase Two, Nursing Facility Portal Testing Plan* (completed July 2014). This report addresses the contract planning phase for nursing facilities. HHSC will use the [UMCC](#) and the [UMCM](#) template when contracting with the MCOs. Together, the [UMCC](#) and the [UMCM](#) serve as the framework through which HHSC shall ensure: 1) nursing facility services are provided appropriately to STAR+PLUS Medicaid recipients whose medical condition regularly requires these services; and 2) that nursing facility providers are paid timely for their services.