Subject: [Records Center] Public Information Request :: R012199-040522
Date: Monday, April 11, 2022 at 10:39:03 AM Eastern Daylight Time
From: TEXAS AG Public Information
To: AO Records

EXTERNAL SENDER

Attachments:
RQ-0424-KP_ack_email_Redacted.pdf
RQ-0426-KP_ack_email_Redacted.pdf
RQ-0420-KP_ammended_request_ack_email_Redacted.pdf
Request_for_Opinion__RQ-0420-KP__ack_email_Redacted.pdf
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Krause_OAG_Opinion_Request_080221.pdf
RQ0420KP.pdf

--- Please respond above this line ---

April 11, 2022

AMERICAN OVERSIGHT

Ms. Emma Lewis
American Oversight
records@americanoversight.org
VIA E-MAIL ONLY

Re: Public Information Request No. R012199

Dear Ms. Lewis:

This e-mail is in response to your public information request to the Office of the Attorney General ("OAG"), received by the OAG on April 4, 2022.

The OAG has reviewed its files and has located the attached documents that are responsive to your request. Although the Public Information Act allows a governmental body to charge for providing documents under certain circumstances, the attached documents are being provided to you at no charge.

Please note the OAG has redacted personal e-mail addresses from the attached documents pursuant to section 552.137 of the Government Code and the previous determination issued by the Open Records Division. See Open Records Decision No. 684 (2009) (governmental bodies may withhold certain information without necessity of requesting decision from Open Records Division).

If you have any questions, please contact publicrecords@oag.texas.gov.

Sincerely,

Marisol Bernal-Leon
Public Information Coordinator's Office
Office of the Attorney General

To monitor the progress or update this request please log into the Public Records Center

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RECEIVED
By Opinion Committee at 11:59 am, Aug 26, 2021

FILE# **RQ-0420-KP**

TEXAS HOUSE *of* REPRESENTATIVES I.D.# **48996**

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

August 26, 2021

The Honorable Ken Paxton
Attorney General of Texas
Attn: Opinion Committee
PO Box 12548
Austin, Texas 78711-2548
opinion.committee@oag.texas.gov

c/o Charlotte M. Harper, Deputy Chair, Opinion Committee

Re: Attorney General Opinion Request No. RQ-0420-KP; Modification of Request

Dear General Paxton:

On July 30, 2021, I submitted a request for your opinion regarding the definition or two terms ("Specialty provider" and "Continuity of Care with Out of Network Providers/Coordination of Benefits") originally enacted in 2019 by Senate Bill 1207 and codified as Government Code section 533.038. You assigned the request file number RQ-0420-KP. I wish to amend my request in light of the Health and Human Services Commission's recent adoption of administrative rules that purport to implement S.B. 1207. In my view, the adopted rules do not correspond to the Legislature's intent in providing the benefits enumerated in section 533.038.

The entire motivation for section 533.038 was to address shortcomings in Commission's policies that compelled families and guardians to confront a terrible choice when encountering barriers to access timely care:

- Terminate beneficial provider and care relationships—many nurtured over several years—because their Medicaid health plan cannot or will not enroll the preferred provider,
- Pay for such care out of their own pockets, or worse,
- Forego care altogether if the family cannot financially afford such care, thus potentially resulting in increased risk of hospitalization, increased emergency room visits, and potential institutionalization due to the delay in appropriate access.

If anything, S.B. 1207 was specifically intended to spare families these awful choices. Regrettably, the Commission's rules do not appear to fully reflect this intent.

On August 12, 2021, the Commission adopted administrative rules to implement S.B. 1207 that originally were published as proposed rules on February 12, 2021. 46 Tex.Reg. 997 (Feb. 12,

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Members: *Stephanie Klick, Leo Pacheco, Reggie Smith*
Darren Keyes, Committee Clerk & General Counsel
Darren.Keyes_hc@house.texas.gov

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2021). The preamble to the adopted rules notes that the Commission received comments on the proposed rules from 26 parties, including Representative Tan Parker and, before publication, Senator Charles Perry, Representative Jeff Leach and myself (Feb.10, 2021).

I am not privy to all comments filed in connection with the proposed rules, but virtually all of the comments described in the preamble opposed the rules, several commenters disputing the policies' conformity to legislative intent. Despite the great weight of objections to the proposed rules, the Commission made no changes on adoption. Instead, the Commission rejected the comments either by invoking its own expertise or preexisting policies, deferring answers to an as-yet unscheduled rulemaking to implement Senate Bill 1648 of the recently-concluded 87th regular session, or by simply declaring (without explaining) that the adopted rules implement legislative intent.

I do not believe either the adoption of the February proposed rules or the pledge to adopt rules to implement S.B 1648 moot the issues raised by my original request or the comments to the recently adopted rules.

In view of these developments, I wish to clarify my questions:

1. *May the Commission, consistent with the plain language of section 533.038 and legislative intent, condition an individual's continuity of care on the person having other insurance (as it did in its adopted rules) when the Legislature did not impose such precondition?*

   "Coordination of benefits" and "continuity of care" are independent concepts. The former ensures Medicaid is the payer of last resort as required by federal law when a Medicaid recipient has other insurance. The latter (encompassed in subsection (g) of section 533.038) ensures a Medicaid recipient does not lose access to a provider with which the recipient has an established relationship. I do not believe the Commission was delegated authority to limit the right to continuity of care assured under the statute to Medicaid recipients who have other insurance.

2. *May the Commission, consistent with the plain language of section 533.038 and legislative intent, limit access to the continuity of care assured under subsection (g) only to children (persons under the age of 21)?*

3. *May the Commission, consistent with the plain language of section 533.038 and legislative intent, define "complex medical needs" under subsection (g) to mean specific levels of care defined in its pre-existing contracts with managed care organizations?*

4. *May the Commission, consistent with the legislative intent expressed in SB 1207 and SB 1648, limit the definition of "specialty provider" to a schedule of disciplines described in* ***preexisting commission contracts****—i.e., physicians who practice certain medical specialties, audiologists, chiropractors, dieticians, optometrists, and podiatrists?*

   In my view, the answer to each of these questions is, "No." The legislature did not limit

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the benefits of subsection (g) to children. Neither does the legislative history support the limits placed on the definition of "complex medical needs" or "specialty provider" in the Commission's adopted rules. The Legislature did not limit the scope of these terms, and the unanimous testimony before both houses of the Legislature in 2019 (S.B. 1207) or 2021 (S.B. 1648) and the multiple advisory committees the Commission is required by state and federal law to consult before enacting Medicaid program policies supported a broad definition of both terms.

The testimony indicates that, rather than the narrow taxonomy the Commission adopted, the terms "complex medical needs" and "specialty provider" were meant to be broadly construed to first, go further than pre-existing Commission policies, and second, to include any provider that is not a primary care provider.

The Commission was granted broad authority to develop and implement the program authorized under S.B. 1207. But none of the conditions described above were expressly authorized by S.B. 1207. And considering the broad support for the benefit in 2019, it does not seem that the Legislature delegated the Commission authority to, in effect, amend the statute in ways that limit access to it. Indeed, the cruel irony of the adopted rules is that some of the families and individuals who appeared and testified in support of the bill will not be eligible to benefit from it. The rules also further restrict many Medicaid beneficiaries' rights to continuity of care. This the Legislature did not authorize.

I recognize that I speak only for myself; however, I believe that the legislative record and public testimony will support my views. I also believe that other members of the Legislature will soon weigh in and express similar views. I know that you and your staff will carefully review the record to assist all interested parties to better understand and adjust their expectations.

Your office requested interested parties submit briefs on my request by September 2nd. In light of the new developments described above, I request that your office consider the clarifications to my original questions and extend the time for interested parties to brief your office on the issues.

Thank you, as always, for your service to Texans.

Matt Krause

Matt Krause
State Representative, District 93
Chairman, Texas House Committee on General Investigating

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KEN PAXTON
ATTORNEY GENERAL OF TEXAS

February 18, 2022

The Honorable Matt Krause
Chair, House Committee on General
Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Opinion No. KP-0401

Re: Whether certain medical procedures performed on children constitute child abuse (RQ-0426-KP)

Dear Representative Krause:

You ask whether the performance of certain medical and chemical procedures on children—several of which have the effect of sterilization—constitute child abuse.[1] You specifically ask about procedures falling under the broader category of "gender reassignment surgeries." Request Letter at 1. You state that such procedures typically are performed to "transition individuals with gender dysphoria to their desired gender," and you identify the following specific "sex-change procedures":

> (1) sterilization through castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, and vaginoplasty; (2) mastectomies; and (3) removing from children otherwise healthy or non-diseased body part or tissue.

Id. at 1 (footnotes omitted). Additionally, you ask whether "providing, administering, prescribing, or dispensing drugs to children that induce transient or permanent infertility" constitutes child abuse. *See id*. at 1–2. You include the following categories of drugs: (1) puberty-suppression or puberty-blocking drugs; (2) supraphysiologic doses of testosterone to females; and (3) supraphysiologic doses of estrogen to males. *See id.*

[1] *See* Letter from Honorable Matt Krause, Chair, House Comm. on Gen. Investigating, to Honorable Ken Paxton, Tex. Att'y Gen. at 1 (Aug. 23, 2021), https://www2.texasattorneygeneral.gov/opinions/opinions/51paxton/rq/2021/pdf/RQ0426KP.pdf ("Request Letter"); *see also* Letter from Honorable Jaime Masters, Comm'r, Tex. Dept. of Family & Protective Servs., to Honorable Greg Abbott, Governor, State of Tex. at 1 (Aug. 11, 2021), https://gov.texas.gov/uploads/files/press/Response_to_August_6_2021_OOG_Letter_08.11.2021.pdf (on file with the Op. Comm.) (hereinafter "Commissioner's Letter").

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You qualify your question with the following statement: "Some children have a medically verifiable genetic disorder of sex development or do not have the normal sex chromosome structure for male or female as determined by a physician through genetic testing that require procedures similar to those described in this request." *Id.* at 2. In other words, in rare circumstances, some of the procedures you list are borne out of medical necessity. For example, a minor male with testicular cancer may need an orchiectomy. This opinion does not address or apply to medically necessary procedures.

I. Executive Summary

Based on the analysis herein, each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

- These procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." TEX. FAM. CODE § 261.001(1)(A).

- These procedures and treatments can "caus[e] or permit[] the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning." *Id*. § 261.001(1)(B).

- These procedures and treatments can cause a "physical injury that results in substantial harm to the child." *Id*. § 261.001(1)(C).

- These procedures and treatments often involve a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" particularly by parents, counselors, and physicians. *Id*. § 261.001(1)(D).

In addition to analysis under the Family Code, we discuss below the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards. Each of the procedures and treatments you ask about can constitute child abuse when performed on minor children.

II. Nature and context of the question presented

Forming the basis for your request, you contend that the "sex change" procedures and treatments you ask about are typically performed to transition individuals with gender dysphoria to their desired gender. *See* Request Letter at 1. The novel trend of providing these elective sex changes to minors often has the effect of permanently sterilizing those minor children. While you refer to these procedures as "sex changes," it is important to note that it remains medically impossible to truly change the sex of an individual because this is determined biologically at

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conception. No doctor can replace a fully functioning male sex organ with a fully functioning female sex organ (or vice versa). In reality, these "sex change" procedures seek to destroy a fully functioning sex organ in order to cosmetically create the illusion of a sex change.

Beyond the obvious harm of permanently sterilizing a child, these procedures and treatments can cause side effects and harms beyond permanent infertility, including serious mental health effects, venous thrombosis/thromboembolism, increased risk of cardiovascular disease, weight gain, decreased libido, hypertriglyceridemia, elevated blood pressure, decreased glucose tolerance, gallbladder disease, benign pituitary prolactinoma, lowered and elevated triglycerides, increased homocysteine levels, hepatotoxicity, polycythemia, sleep apnea, insulin resistance, chronic pelvic pain, and increased cancer and stroke risk.[2]

While the spike in these procedures is a relatively recent development,[3] sterilization of minors and other vulnerable populations without clear consent is not a new phenomenon and has an unsettling history. Historically weaponized against minorities, sterilization procedures have harmed many vulnerable populations, such as African Americans, female minors, the disabled, and others.[4] These violations have been found to infringe upon the fundamental human right to procreate. Any discussion of sterilization procedures in the context of minor children must, accordingly, consider the fundamental right that is at stake: the right to procreate. Given the uniquely vulnerable nature of children, and the clear dangers of sterilization demonstrated throughout history, it is important to emphasize the crux of the question you present today—*whether facilitating (parents/counselors) or conducting (doctors) medical procedures and treatments that could permanently deprive minor children of their constitutional right to procreate, or impair their ability to procreate, before those children have the legal capacity to consent to those procedures and treatments, constitutes child abuse*.

The medical evidence does not demonstrate that children and adolescents benefit from engaging in these irreversible sterilization procedures. The prevalence of gender dysphoria in children and adolescents has never been estimated, and there is no scientific consensus that these sterilizing procedures and treatments even serve to benefit minor children dealing with gender dysphoria. As stated by the Centers for Medicare and Medicaid Services, "There is not enough high-quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively."[5] Also, "several studies show a higher rate of regret at being sterilized among younger women than among those

[2]*See* Timothy Cavanaugh, M.D., *Cross-Sex Hormone Therapy*, FENWAY HEALTH (2015), https://www.lgbtqiahealtheducation.org/wp-content/uploads/Cross-Sex-Hormone-Therapy1.pdf.

[3]SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/ (demonstrating a spike in referrals to Gender Identify Development Services around the mid-2010s).

[4]Alexandra Stern, Ph.D., *Forced sterilization policies in the US targeted minorities and those with disabilities – and lasted into the 21st Century*, (Sept. 23, 2020), https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st.

[5]Centers for Medicare and Medicaid Services, Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) (Aug. 30, 2016), http://www.lb7.uscourts.gov/documents/17-264URL1DecisionMemo.pdf.

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who were sterilized at a later age." 43 FED. REG. at 52,151, 52,152. This further indicates that minor children are not sufficiently mature to make informed decisions in this context.

There is no evidence that long-term mental health outcomes are improved or that rates of suicide are reduced by hormonal or surgical intervention. "Childhood-onset gender dysphoria has been shown to have a high rate of natural resolution, with 61-98% of children reidentifying with their biological sex during puberty. No studies to date have evaluated the natural course and rate of gender dysphoria resolution among the novel cohort presenting with adolescent-onset gender dysphoria."[6] One of the few relevant studies monitored transitioned individuals for 30 years. It found high rates of post-transition suicide and significantly elevated all-cause mortality, including increased death rates from cardiovascular disease and cancer, although causality could not be established.[7] The lack of evidence in this field is why the Centers for Medicare & Medicaid Services rejected a nationwide coverage mandate for adult gender transition surgeries during the Obama Administration. Similarly, the World Professional Association for Transgender Health states that with respect to irreversible procedures, genital surgery should not be carried out until patients reach the legal age of majority to give consent for medical procedures in a given country.[8]

Generally, the age of majority is eighteen in Texas. TEX. CIV. PRAC. & REM. CODE § 129.001. With respect to consent to sterilization procedures, Medicaid sets the age threshold even higher, at twenty-one years old. Children and adolescents are promised relief and asked to "consent" to life-altering, irreversible treatment—and to do so in the midst of reported psychological distress, when they cannot weigh long-term risks the way adults do, and when they are considered by the State in most regards to be without legal capacity to consent, contract, vote, or otherwise. Legal and ethics scholars have suggested that it is particularly unethical to radically intervene in the normal physical development of a child to "affirm" a "gender identity" that is at odds with bodily sex.[9]

State and federal governments have "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). Thus, states routinely regulate the medical profession and routinely update their regulations as new trends arise and new evidence becomes available. In the opioid context, for instance, states responded to an epidemic caused largely by pharmaceutical companies and medical professionals. Dismissing as "opioidphobic" any concern that "raising pain treatment to a 'patients' rights' issue could lead to overreliance on opioids," these experts created new pain standards and assured doctors that

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[6]SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/.

[7]*See* Cecilia Dhejne, et al., *Long-term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE, Issue 2, 5 (Feb. 22, 2011) (19 times the expected norm overall (Table 2), and 40 times the norm for biological females (Table s1)), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885.

[8]WORLD PROFESSIONAL ASS'N FOR TRANSGENDER HEALTH, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* at 59 (7th ed. 2012), available at https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341.

[9]Ryan T. Anderson & Robert P. George, Physical Interventions on the Bodies of Children to "Affirm" their "Gender Identity" Violate Sound Medical Ethics and Should Be Prohibited, PUBLIC DISCOURSE: THE JOURNAL OF THE WITHERSPOON INSTITUTE (Dec. 8, 2019), https://www.thepublicdiscourse.com/2019/12/58839/.

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prescribing more opioids was largely risk free.[10] *Id.* As we know now, the results were—indeed, *are*—nothing short of tragic.[11] There is always the potential for novel medical determinations to promote purported remedies that may not improve patient outcomes and can even result in tragic harms. The same potential for harm exists for minors who have engaged in the type of procedures or treatments above.

The State's power is arguably at its zenith when it comes to protecting children. In the Supreme Court's words, that is due to "the peculiar vulnerability of children." *Bellotti v. Baird*, 443 U.S. 622, 634 (1979); *see also Ginsberg v. New York*, 390 U.S. 629, 640 (1968) ("The State also has an independent interest in the well-being of its youth."). The Supreme Court has explained that children's "inability to make critical decisions in an informed, mature manner" makes legislation to protect them particularly appropriate. *Bellotti*, 443 U.S. at 634. The procedures that you ask about impose significant and irreversible effects on children, and we therefore address them with extreme caution, mindful of the State's duty to protect its children. *See generally T.L. v. Cook Children's Med. Ctr.*, 607 S.W.3d 9, 42 (Tex. App.—Fort Worth 2020), *cert. denied*, 141 S. Ct. 1069 (2021) ("Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae.* In this respect, the [child]'s liberty interest may, in appropriate circumstances, be subordinated to the State's *parens patriae* interest in preserving and promoting the welfare of the child.") (citation omitted).

III. To the extent that these procedures and treatments could result in sterilization, they would deprive the child of the fundamental right to procreate, which supports a finding of child abuse under the Family Code.

A. The procedures you describe can and do cause sterilization.

The surgical and chemical procedures you ask about can and do cause sterilization.[12] Similarly, the treatments you ask about often involve puberty-blocking medications. Such medications suppress the body's production of estrogen or testosterone to prevent puberty and are being used in this context to pause the sexual development of a person that occurs during puberty. The use of these chemical procedures for this purpose is not approved by the federal Food and Drug Administration and is considered an "off-label" use of the medications. These chemical procedures prevent a person's body from developing the capability to procreate. There is insufficient medical evidence available to demonstrate that discontinuing the medication resumes a normal puberty process. *See generally Hennessy-Waller v. Snyder*, 529 F. Supp. 3d 1031, 1042 (D. Ariz. 2021), citing *Bell v. Tavistock and Portman NHS Foundation Trust*, 2020 EWHC 3274,

[10] *See* David W. Baker, *The Joint Commission's Pain Standards: Origins and Evolution* 4 (May 5, 2017) (footnotes omitted), https://perma.cc/RZ42-YNRC ("[N]o large national studies were conducted to examine whether the standards improved pain assessment or control.").

[11] *See generally* U.S. HEALTH & HUMAN SERVS., WHAT IS THE U.S. OPIOID EPIDEMIC?, https://www.hhs.gov/opioids/about-the-epidemic/index html.

[12] *See* Philip J. Cheng, *Fertility Concerns of the Transgender Patient*, TRANSL ANDROL UROL. 2019;9(3):209-218 (explaining that hysterectomy, oophorectomy, and orchiectomy "results in permanent sterility"), https://www ncbi nlm nih.gov/pmc/articles/PMC6626312/.

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¶ 134 (Dec. 1, 2020) (referring to *Bell's* conclusion that a clinic's practice of prescribing puberty-suppressing medication to individuals under age 18 with gender dysphoria and determining such treatment was experimental). Thus, because the procedures you inquire about can and do result in sterilization, they implicate a minor child's constitutional right to procreate.

B. The United States Constitution protects a fundamental right to procreation.

The United States Supreme Court recognizes that the right to procreate is a fundamental right under the Fourteenth Amendment. *See Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). Almost a century ago, the Court explained the unique concerns sterilization poses respecting this fundamental right:

> The power to sterilize, if exercised, may have subtle, far reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and disappear. There is no redemption for the individual whom the law touches. Any experiment which the State conducts is to his irreparable injury. He is forever deprived of a basic liberty.

Id. To the extent the procedures you describe cause permanent damage to reproductive organs and functions of a child before that child has the legal capacity to consent, they unlawfully violate the child's constitutional right to procreate. *See generally* 43 FED. REG. at 52,146–52,152 (discussing ripeness for coercion and regret rates among minor children).

C. Because children are legally incompetent to consent to sterilization, procedures and treatments that result in a child's sterilization are unauthorized and infringe on the child's fundamental right to procreate.

Under Texas law, a minor is a person under eighteen years of age that has never been married and never declared an adult by a court. *See* TEX. CIV. PRAC. & REM. CODE § 129.001; TEX. FAM. CODE §§ 1.104, 101.003 (including a minor on active duty in the military, one who does not live with a parent or guardian and who manages their own financial affairs, among others). State law recognizes seven instances in which a minor can consent to certain types of medical treatment on their own. *See id.* § 32.003. None of the express provisions relating to a minor's ability to consent to medical treatment addresses consent to the procedures used for "gender-affirming" treatment. *See generally id.*

The lack of authority of a minor to consent to an irreversible sterilization procedure is consistent with other law. The federal Medicaid program does not allow for parental consent, has established a minimum age of 21 for consent to sterilization procedures, and imposes detailed requirements for obtaining that consent. 42 C.F.R. §§ 441.253(a); 441.258 ("Consent form requirements"). Federal Medicaid funds may not be used for any sterilization without complying with the consent requirements, meaning a doctor may not be reimbursed for sterilization procedures performed on minors. *Id*. § 441.256(a).

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The higher age limit for sterilization procedures was implemented due to a number of special concerns, including historical instances of forced sterilization. *See* 43 FED. REG. 52146, 52148. "[M]inors and other incompetents have been sterilized with federal funds and . . . an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization." *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977). In addition, the 21-year minimum age-of-consent rule accounted for concerns that minors were more susceptible to coercion than those over 21 and that younger women had higher rates of regret for sterilization than those who were sterilized at a later age. 43 FED. REG. at 52,151 (pointing to comments suggesting that "persons under 21 are more susceptible to coercion than those over 21 and are more likely to lack the maturity to make an informed decision" and acknowledging "these considerations favor protecting such individuals by limiting their access to the procedure"); *see id.* at 52,151–52,152 (pointing to "several studies [that] show a higher rate of regret at being sterilized among younger women than among those who were sterilized at a later age").

Regarding parental consent, Texas law generally recognizes a parent's right to consent to a child's medical care. TEX. FAM. CODE § 151.001(a)(6) ("A parent of a child has the following rights and duties: . . . (6) the right to consent to the child's . . . medical and dental care, and psychiatric, psychological, and surgical treatment . . ."). But this general right to consent to certain medically necessary procedures does not extend to elective (not medically necessary) procedures and treatments that infringe upon a minor child's constitutional right to procreate. Indeed, courts have analyzed the imposition of unnecessary medical procedures upon children in similar circumstances in the past to determine whether doing so constitutes child abuse.

One such situation that the law has addressed is often referred to as "Munchausen by proxy" or "factitious disorder imposed on another":

> [A] psychological disorder that is characterized by the intentional feigning, exaggeration, or induction of the symptoms of a disease or injury in oneself or another and that is accompanied by the seeking of excessive medical care from various doctors and medical facilities typically resulting in multiple diagnostic tests, treatments, procedures, and hospitalizations. Unlike the malingerer, who consciously induces symptoms to obtain something of value, the patient with a factitious disorder consciously produces symptoms for unconscious reasons, without identifiable gain.[13]

In situations such as this, an individual intentionally seeks to procure—often by deceptive means, such as exaggeration—unnecessary medical procedures or treatments either for themselves or others, usually their children. In Texas, courts have found that these "Munchausen by proxy" situations can constitute child abuse. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure

[13] *Factitious disorder*, MERRIAM-WEBSTER.COM DICTIONARY, https://www merriam-webster.com/dictionary/factitious%20disorder.

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may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code).[14]

In the context of elective sex change procedures for minors, the Legislature has not provided any avenue for parental consent, and no judicial avenue exists for the child to proceed with these procedures and treatments without parental consent. By comparison, Texas law respecting abortion requires parental consent and, in extenuating circumstances, permits non-parental consent for a minor to obtain an abortion. TEX. OCC. CODE § 164.052(19) (requiring written consent of a child's parent before a physician may perform an abortion on an unemancipated minor); TEX. FAM. CODE § 33.003 (authorizing judicial approval of a minor's abortion without parental consent in limited circumstances). But the Texas Legislature has not decided to make those same allowances for consent to sterilization, and thus a parent cannot consent to sterilization procedures or treatments that result in the permanent deprivation of a minor child's constitutional right to procreate.[15] Thus, no avenue exists for a child to consent to or obtain consent for an elective procedure or treatment that causes sterilization.

IV. The procedures and treatments you describe can constitute child abuse under the Family Code.

Having established the legal and cultural context of this opinion request, we now consider whether these procedures and treatments qualify as child abuse under the Family Code. *See* Request Letter at 1. Where, as a factual matter, one of these procedures or treatments cannot result in sterilization, a court would have to go through the process of evaluating, on a case-by-case basis, whether that procedure violates any of the provisions of the Family Code—and whether the procedure or treatment poses a similar threat or likelihood of substantial physical and emotional harm. Thus, where a factual scenario involving non-medically necessary, gender-based procedures or treatments on a minor causes or threatens to cause harm or irreparable harm[16] to the child—comparable to instances of Munchausen syndrome by proxy or criminal injury to a child—or demonstrates a lack of consent, etc., a court could find such procedures to constitute child abuse under section 261.001.

A. The Texas Legislature defines child abuse broadly.

Family Code chapter 261 provides for the reporting and investigation of abuse or neglect of a child. *See* TEX. FAM. CODE §§ 261.001–.505; *see also* TEX. PENAL CODE § 22.04 (providing for the offense of injury to a child). Section 261.001 defines abuse through a broad and nonexclusive list of acts and omissions. TEX. FAM. CODE § 261.001(1); *see also In re Interest of*

[14]*See also* Tex. Dep't of Fam. & Protective Servs., Tex. Practice Guide for Child Protective Servs. Att'ys, § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp.

[15]Federal Medicaid programs will not reimburse for these types of procedures on minors, regardless of whether the child or parent consents, because of the numerous concerns outlined in the Federal Register provisions discussed above. *See* 43 FED. REG. at 52,146–52,159.

[16] For example, a non-medically necessary procedure or treatment that seeks to alter a minor female's breasts in such a way that would or could prevent that minor female from having the ability to breastfeed her eventual children likely causes irreparable harm and could form the basis for a finding of child abuse.

AMERICAN OVERSIGHT

S.M.R., 434 S.W.3d 576, 583 (Tex. 2014). Of course, this broad definition of abuse would apply to and include criminal acts against children, such as "female genital mutilation"[17] or "injury to a child."[18]

Your questions implicate several components of section 261.001(1). Subsection 261.001(1)(A) identifies "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." Subsection 261.001(1)(B) provides that "causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning" is abuse. Subsection 261.001(1)(C) includes as abuse a "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child." And subsection 261.001(1)(D) includes "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child."

Offering some clarity to the scope of "abuse" under subsection 261.001(1), the Texas Department of Family and Protective Services ("Department") adopted rules giving meaning to the key terms and phrases used in the definition. The Department acknowledges that emotional abuse is a subset of abuse that includes "[m]ental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." 40 TEX. ADMIN. CODE § 707.453(a) (Tex. Dept. of Fam. & Protective Servs., What is Emotional Abuse?). The Department's rules provide that "[m]ental or emotional injury" means

> [t]hat a child of any age experiences significant or serious negative effects on intellectual or psychological development or functioning. . . . and exhibits behaviors indicative of observable and material impairment . . . . mean[ing] discernable and substantial damage or deterioration to a child's emotional, social, and cognitive development.

Id. § 707.453(b)(1)–(2).

With respect to physical injuries, the Department further clarified the meaning of the phrase "[p]hysical injury that results in substantial harm to the child," explaining that it means in relevant part a

---

[17]A person commits an offense if the person: (1) knowingly circumcises, excises, or infibulates any part of the labia majora or labia minora or clitoris of another person who is younger than 18 years of age; (2) is a parent or legal guardian of another person who is younger than 18 years of age and knowingly consents to or permits an act described by Subdivision (1) to be performed on that person; or (3) knowingly transports or facilitates the transportation of another person who is younger than 18 years of age within this state or from this state for the purpose of having an act described by Subdivision (1) performed on that person. TEX. HEALTH & SAFETY CODE § 167.001.

[18]A person commits an offense if he intentionally, knowingly, recklessly, or with criminal negligence, by act or intentionally, knowingly, or recklessly by omission, causes to a child, elderly individual, or disabled individual: (1) serious bodily injury; (2) serious mental deficiency, impairment, or injury; or (3) bodily injury. TEX. PENAL CODE § 22.04.

AMERICAN OVERSIGHT

> real and significant physical injury or damage to a child that includes but is not limited to . . . [a]ny of the following, if caused by an action of the alleged perpetrator directed toward the alleged victim: . . . *impairment of or injury to any bodily organ or function*; . . . .

Id. § 707.455(b)(2)(A) (emphasis added). The Department's rules also define a "[g]enuine threat of substantial harm from physical injury" to include the

> *declaring or exhibiting the intent or determination to inflict real and significant physical injury or damage to a child.* The declaration or exhibition does not require actual physical contact or injury.

Id. § 707.455(b)(1) (emphasis added).

Subsection 261.001(1) and these rules define "abuse" broadly to include mental or emotional injury in addition to a physical injury. To the extent the specific procedures about which you ask may cause mental or emotional injury or physical injury within these provisions, they constitute abuse.

Further, the Legislature has explicitly defined "female genital mutilation" and made such act a state jail felony. *See* TEX. HEALTH & SAFETY CODE § 167.001(a)–(b). While the Legislature has not elsewhere defined the phrase "genital mutilation", nor specifically for males of any age,[19] the Legislature's criminalization of a particular type of genital mutilation supports an argument that analogous procedures that include genital mutilation—potentially including gender reassignment surgeries—could constitute "abuse" under the Family Code's broad and non-exhaustive examples of child abuse or neglect.[20] *See* TEX. FAM. CODE § 261.001(1)(A)–(M); *see generally* Commissioner's Letter at 1 (concluding that genital "mutilation may cause a genuine threat of substantial harm from physical injury to the child"). Thus, many of the procedures and treatments you ask about can constitute "female genital mutilation," a standalone criminal act. But even where these procedures and treatments may not constitute "female genital mutilation" under Texas law, a court could still find that these procedures and treatments constitute child abuse under section 261.001 of the Family Code.

B. Each of these procedures and treatments can constitute abuse under Texas Family Code § 261.001(1)(A), (B), (C), or (D).

The Texas Family Code is clear—causing or permitting substantial harm to the child or the child's growth and development is child abuse. Courts have held that an unnecessary surgical

[19]Your letter does not mention nor request an analysis under federal law. However, under federal law, there are at least two definitions of female genital mutilation, 8 U.S.C § 1374 and 18 U.S.C. § 116. For purposes of this opinion, we have not considered federal statutes, nor have we undertaken any analysis under state or federal constitutions beyond that included here.

[20]The Eighty-seventh Legislature considered multiple bills that would have amended Family Code subsection 261.001(1) to expressly include in the definition of abuse the performing of surgery or other medical procedures on a child for the purpose of gender transitioning or gender reassignment. Those bills did not pass. *See, e.g.*, Tex. H.B. 22, 87th Leg., 3d C.S. (2021).

AMERICAN OVERSIGHT

procedure that removes a healthy body part from a child can constitute a real and significant injury or damage to the child. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code). The *Williamson* case involved a "victim of medical child abuse, sometimes referred to as Munchausen Syndrome by Proxy." *Id.* at 5. Munchausen syndrome by proxy is "where an alleged perpetrator . . . attempts to gain medical procedures and issues for [their] child for secondary gain for themselves . . . . [A]s a result, the children are subjected to multiple diagnostic tests, therapeutic procedures, sometimes operative procedures, in order to treat things that aren't really there." *Williamson*, 356 S.W.3d at 11. In the *Williamson* case, the abuse was perpetrated on the child when he was five and six years old by his mother. *Id.* The evidence showed that two surgeries performed on the child "were not medically necessary and that [his mother] knowingly and intentionally caused the unnecessary procedures to be performed by fabricating, exaggerating, and inducing the symptoms leading to the surgeries." *Id.*

Similarly, in *Austin v. State*, a court of appeals upheld the conviction for felony injury of a child of a mother suffering from Munchausen syndrome by proxy who injected her son with insulin. *See* 222 S.W.3d 801, 804 (Tex. App.—Austin 2007, pet. ref'd); *see also In re McCabe*, 580 S.E.2d 69, 73 (N.C. Ct. App. 2003) (concluding that abuse through Munchausen syndrome by proxy was abuse under state statute defining abuse in a similar manner as chapter 261); *Matter of Aaron S.*, 625 N.Y.S.2d 786, 793 (Fam. Ct. 1993), *aff'd sub nom. Matter of Suffolk Cnty. Dep't of Soc. Servs on Behalf of Aaron S.*, 626 N.Y.S.2d 227 (App. Div. 1995) (finding that a mother neglected her son by subjecting him to a continuous course of medical treatment for condition which he did not have and that he was a neglected child under state statute governing abuse of a child). In guidance documents published for its child protective services attorneys, the Texas Department of Family and Protective Services explains that "Munchausen by proxy syndrome is relatively rare, but when it occurs, it is frequently a basis for a finding of child abuse."[21] Whether motivated by Munchausen syndrome by proxy or otherwise, it is clear that unnecessary medical treatment inflicted on a child by a parent can constitute child abuse under the Family Code.

By definition, procedures and treatments resulting in sterilization cause "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child" by surgically altering key physical body parts of the child in ways that render entire body parts, organs, and the entire reproductive system of the child physically incapable of functioning. Thus, such procedures and treatments can constitute child abuse under section 261.001(1)(C). Even where the procedure or treatment does not involve the physical removal or alteration of a child's reproductive organs (*i.e.* puberty blockers), these procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning" by subjecting a child to the mental and emotional injury associated with lifelong sterilization—an impairment to

[21] TEX. DEP'T OF FAM. & PROTECTIVE SERVS., TEX. PRACTICE GUIDE FOR CHILD PROTECTIVE SERVS. ATT'YS, § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp (citing *Reid v. State*, 964 S.W.2d 723 (Tex. App.—Amarillo 1998, pet. ref'd) (mem. op.) (expert testimony admitted regarding general acceptance of Munchausen diagnosis as a form of child abuse)).

AMERICAN OVERSIGHT

one's growth and development. Therefore, a court could find these procedures and treatments to be child abuse under section 261.001(1)(A). Further, attempts by a parent to consent to these procedures and treatments on behalf of their child may, if successful, "cause or permit the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning[,]" and could be child abuse under section 261.001(1)(B). Additionally, the failure to stop a doctor or another parent from conducting these treatments and procedures on a minor child can constitute a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" and this "failure to make a reasonable effort to prevent" can also constitute child abuse under section 261.001(1)(D). Any person that conducts or facilitates these procedures or treatments could be engaged in child abuse, whether that be parents, doctors, counselors, etc.

It is important to note that anyone who has "a reasonable cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report" as described in the Family Code. TEX. FAM. CODE § 261.101(a). Further, "[i]f a professional has reasonable cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, and the professional has reasonable cause to believe that the child has been abused as defined by Section 261.001, the professional shall make a report not later than the 48th hour after the hour the professional first has reasonable cause to believe that the child has been or may be abused or neglected or is a victim of an offense under Section 21.11, Penal Code." TEX. FAM. CODE § 261.101(b). The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers. *Id*. A failure to report under these circumstances is a criminal offense. TEX. FAM. CODE § 261.109(a).

AMERICAN OVERSIGHT

S U M M A R Y

Each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

When considering questions of child abuse, a court would likely consider the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards.

Very truly yours,



K E N P A X T O N
Attorney General of Texas

BRENT E. WEBSTER
First Assistant Attorney General

LESLEY FRENCH
Chief of Staff

MURTAZA F. SUTARWALLA
Deputy Attorney General for Legal Counsel

AARON REITZ
Deputy Attorney General for Legal Strategy

RALPH M. MOLINA
Special Counsel to the First Assistant Attorney General

VIRGINIA K. HOELSCHER
Chair, Opinion Committee

CHARLOTTE M. HARPER
Assistant Attorney General, Opinion Committee

AMERICAN OVERSIGHT

From: Shane Birdwell
To: Opinion_Committee
Subject: OAG Opinion Request
Date: Monday, August 2, 2021 3:35:48 PM
Attachments: OAG Opinion Request with Exhibits.pdf

Hello,

Please see the attached document regarding a request for an OAG Opinion on the following:

1. Specialty Provider definition; and
2. Continuity of Care with out of Network Providers/Coordination of Benefits

In addition to a formal letter, there are also several attachments, including:

1. V1.13 Star Kids Managed Care Contract
2. HHSC Star Kids MCAC 2021 recommendations for "specialty provider"
3. HHSC/MCAC proposed new draft rules Section 353.7
4. 4 legislative intent letters defining "specialty provider"
5. Declaration from former HHSC Chief Council, Steve Aragon
6. SB1207 Clarification and Definitions

Let me know if you have any questions or require any additional information.

Thanks,

Shane Birdwell
Chief of Staff - Representative Matt Krause
O: (512) 463-0562 | F: (512) 463-2053
PO Box 2910 • Austin, TX 78768
Shane.Birdwell@house.texas.gov
Representative Matt Krause

AMERICAN OVERSIGHT

From: Darren Keyes_HC
To: Opinion_Committee
Cc: Matt Krause; Shane Birdwell; Scott Stier
Subject: Opinion Request dated March 28, 2022
Date: Monday, March 28, 2022 3:13:31 PM
Attachments: AG Opinion Request dated 3-28-22.pdf

Please see the attached opinion request from Chairman Krause. Don't hesitate to call me if you have any questions.

Respectfully,

Darren Keyes
General Counsel
House Committee on General Investigating
Chairman Matt Krause
E2.170 | 512-463-0780

AMERICAN OVERSIGHT

TEXAS HOUSE *of* REPRESENTATIVES

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

March 28, 2022

Office of the Attorney General
Attention: Opinion Committee
P.O. Box 12548
Austin, Texas 78711-2548
opinion.committee@oag.texas.gov

Re: Whether the federal government has failed to uphold its obligations to protect Texas from invasion under Article IV, Section 4 of the U.S. Constitution, and whether Texas has the sovereign power to defend itself from invasion?

Dear General Paxton:

President Biden has failed to enforce federal immigration laws and stop the surge of illegal aliens coming into Texas along the Mexico border. I am writing to ask for your legal opinion of whether or not the federal government has failed—intentionally or unintentionally—to uphold its obligations to protect our state from invasion under Article IV, Section 4 of the U.S. Constitution and whether Texas has the sovereign power to defend itself from such invasion. Undoubtedly, you are aware of the circumstances at the Texas-Mexico border, but the House Committee on General Investigating held a hearing on April 20, 2021, which disclosed important and relevant information on this topic from numerous Texas agencies.[1]

Recently, the Arizona Attorney General issued an opinion determining that the lawlessness and violence at the Arizona border constitutes "actually invaded" and "invasion" under the U.S. Constitution and that Arizona retained the sovereign power under the U.S. Constitution to defend itself from such an invasion.[2] I found the Arizona opinion's analysis and conclusions compelling.

Please expedite your response on this urgent matter for the safety and protection of Texas residents. Thank you for your attention to this request.

Sincerely,

Matt Krause

Matt Krause
Chairman
Texas House Committee on General Investigating

[1] Issues Regarding the Status of Immigrants at the Texas-Mexico Border: Hearing Before the Comm. on Gen. Investigating, 87th Leg., R.S. (2021), https://capitol.texas.gov/tlodocs/87R/handouts/C2802021042008001/C2802021042008001.pdf.
[2] The Federal Government's Duty To Protect the States And The States' Sovereign Power Of Self Defense When Invaded, Ariz. Att'y Gen. Op. No. I22-001 (February 7, 2022), https://www.azag.gov/sites/default/files/2022-02/I22_001b.pdf.

Capitol Office: E2.170 • P.O. Box 2910 • Austin, Texas 78768-2910 • (512) 463-0780
Members: Stephanie Klick, Reggie Smith, John Turner
Darren Keyes, Committee Clerk & General Counsel
Darren.Keyes_hc@house.texas.gov

AMERICAN OVERSIGHT

From:	OPINIONCOMMITTEE
To:	Matt.Krause@house.texas.gov
Cc:	shane.birdwell@house.texas.gov
Bcc:	Martinez, Steven; Skinner, Nancy; Moales, Demetrius; Charles.perry@senate.texas.gov; Matthew.Dowling@senate.texas.gov; jeff.leach@house.texas.gov; tan.parker@house.texas.gov; Karen.ray@hhsc.state.tx.us; karen.ray@hhs.texas.gov; jonathan.miles@hhs.texas.gov; jonathan.miles@hhsc.state.tx.us; Caroline.Sunshine@hhs.texas.gov; Kent.sullivan@tdi.texas.gov; james.person@tdi.texas.gov; info@txfragilekids.org.com; ; ; amy.cresap@gov.texas.gov
Subject:	Request for Opinion (RQ-0420-KP)
Date:	Tuesday, August 3, 2021 11:04:27 AM
Attachments:	RQ-0420-KP.pdf

Dear Representative Krause:

Please find attached our letter acknowledging receipt of your July 30, 2021 request for an Attorney General opinion.

Opinion Committee
Office of the Attorney General of Texas
(512) 463-2110

AMERICAN OVERSIGHT

From:	OPINIONCOMMITTEE
To:	Matt.Krause@house.texas.gov
Cc:	shane.birdwell@house.texas.gov; scott.stier@house.texas.gov
Bcc:	Steven Martinez; Demetrius Moales; Jennie Hoelscher; Becky Casares; Nancy Skinner
Subject:	RQ-0420-KP status
Date:	Monday, January 31, 2022 5:00:16 PM
Attachments:	RQ-0420-KP status.pdf

Representative Krause:

Please find attached our letter regarding the status of your July 30, 2021 request for an attorney general opinion. Thank you.

Opinion Committee
Office of the Attorney General of Texas
(512) 463-2110

AMERICAN OVERSIGHT

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

January 31, 2022

The Honorable Matt Krause
Chair, House Committee on General Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Via E-Mail

Re: The meaning of specialty provider and other terms for purposes of implementing Senate Bill 1207 from the 86th Legislature (RQ-0420-KP)

Dear Representative Krause:

Thank you for requesting a written opinion from this office.

Section 402.042 of the Government Code requires this office to issue an opinion within 180 days of receiving a request for one unless we explain to the requestor in writing before the deadline why the opinion will be delayed.

Accordingly, we are notifying you that we will not issue an opinion on your request within 180 days of the date received because we need more time to review the law, complete the analysis that your request requires, and finalize the formal opinion. We will make every effort to issue this opinion as soon as possible.

Sincerely,

Virginia K. Hoelscher
Chair, Opinion Committee

VKH/som

Attachment: Request No. 0420-KP

AMERICAN OVERSIGHT
TX-AG-22-0325-A-000022

TEXAS HOUSE *of* REPRESENTATIVES

RECEIVED
By Opinion Committee at 3:47 pm, Aug 02, 2021

RQ-0420-KP
FILE# **ML-48983-21**
I.D.# **48983**

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

July 30, 2021

Via Email
Office of the Attorney General
c/o Opinions Division
P.O. Box 12548
Austin, Texas 78711-2548
Email: opinion.committee@oag.texas.gov

Dear General Paxton,

During the 86th Legislative Session a bipartisan coalition of legislators passed Senate Bill 1207 to help children in the Medically Dependent Child Program (MDCP) in Texas. Unfortunately there have been issues with the implementation of portions of SB1207 and therefore I request an opinion on the following topics:

1. Specialty Provider definition; and
2. Continuity of Care with Out of Network Providers/Coordination of Benefits definition

If you or your team has any questions or if there is anything my office can do, please reach out to my Chief of Staff, Shane Birdwell, at shane.birdwell@house.texas.gov or (512) 463-0562.

Sincerely,

Matt Krause

Chairman Krause
General Investigating

Capitol Office: E2.170 • P.O. Box 2910 • Austin, Texas 78768-2910 • (512) 463-0780
Members: *Stephanie Klick, Leo Pacheco, Reggie Smith*
Darren Keyes, Committee Clerk & General Counsel
Darren.Keyes_hc@house.texas.gov

AMERICAN OVERSIGHT

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

August 3, 2021

The Honorable Matt Krause
Chair, House Committee on General Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Via E-Mail

Re: The meaning of specialty provider and other terms for purposes of implementing Senate Bill 1207 from the 86th Legislature (RQ-0420-KP)

Dear Representative Krause:

We received your request for an attorney general opinion and have designated it as Request No. 0420-KP. Section 402.042 of the Government Code provides that the Attorney General shall issue an opinion not later than the 180th day after the date that an opinion request is received, unless before that deadline the Attorney General notifies the requesting person in writing that the opinion will be delayed. TEX. GOV'T CODE § 402.042(c)(2). We received your request on August 2, 2021, setting a due date for your opinion of January 31, 2022.

By copy of this letter we are notifying those listed below of your request and asking them to submit briefing on your questions if they have a special interest or expertise in the subject matter. If you are aware of other interested parties, please forward this request for briefing to them or let us know, so that we may notify them as soon as possible. We ask that the briefs be submitted by September 2, 2021, to ensure that this office will have adequate time to review and consider arguments relevant to the request from all interested parties. Briefs may be submitted by e-mail to opinion.committee@oag.texas.gov. Please note that briefs and other correspondence are subject to the Public Information Act.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Charlotte M. Harper
Deputy Chair, Opinion Committee

CMH7/som

AMERICAN OVERSIGHT
TX-AG-22-0325-A-000024

Attachment: Request No. 0420-KP

cc: The Honorable Charles Perry, Texas State Senate
The Honorable Jeff Leach, Texas House of Representatives
The Honorable Tan Parker, Texas House of Representatives
Ms. Karen Ray, Chief Counsel, Texas Department of Health and Human Services
Mr. Jonathan Miles, General Counsel, Texas Department of Health and Human Services
Medical Care Advisory Committee, Texas Department of Health and Human Services
Star Kids Managed Care Advisory Committee, Texas Department of Health and Human Services
State Medicaid Managed Care Advisory Committee, Texas Department of Health and Human Services
Mr. Kent Sullivan, Commissioner of Insurance, Texas Department of Insurance
Mr. James Person, General Counsel, Texas Department of Insurance
Protect Texas Fragile Kids
Ms. Laura J. Warren, Executive Director, Texas Parent to Parent
Ms. Tricia Hall, Executive Director, Texas Pediatric Society
Ms. Jamie Dudensing, Chief Executive Officer, Texas Association of Health Plans
Ms. Amy Cresap, General Counsel Division, Office of the Governor

AMERICAN OVERSIGHT

TEXAS HOUSE *of* REPRESENTATIVES

RECEIVED
By Opinion Committee at 3:47 pm, Aug 02, 2021

RQ-0420-KP
FILE# **ML-48983-21**
I.D.# **48983**

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

July 30, 2021

Via Email
Office of the Attorney General
c/o Opinions Division
P.O. Box 12548
Austin, Texas 78711-2548
Email: opinion.committee@oag.texas.gov

Dear General Paxton,

During the 86th Legislative Session a bipartisan coalition of legislators passed Senate Bill 1207 to help children in the Medically Dependent Child Program (MDCP) in Texas. Unfortunately there have been issues with the implementation of portions of SB1207 and therefore I request an opinion on the following topics:

1. Specialty Provider definition; and
2. Continuity of Care with Out of Network Providers/Coordination of Benefits definition

If you or your team has any questions or if there is anything my office can do, please reach out to my Chief of Staff, Shane Birdwell, at shane.birdwell@house.texas.gov or (512) 463-0562.

Sincerely,

Matt Krause

Chairman Krause
General Investigating

Capitol Office: E2.170 • P.O. Box 2910 • Austin, Texas 78768-2910 • (512) 463-0780
Members: *Stephanie Klick, Leo Pacheco, Reggie Smith*
Darren Keyes, Committee Clerk & General Counsel
Darren.Keyes_hc@house.texas.gov

AMERICAN OVERSIGHT

From: OPINIONCOMMITTEE
To: Matt.Krause@house.texas.gov
Cc: shane.birdwell@house.texas.gov
Bcc: ; Martinez, Steven; Skinner, Nancy; Moales, Demetrius; Charles.Perry@senate.texas.gov; Matthew.Dowling@senate.texas.gov; jeff.leach@house.texas.gov; tan.parker@house.texas.gov; Karen.ray@hhsc.state.tx.us; karen.ray@hhs.texas.gov; jonathan.miles@hhs.texas.gov; jonathan.miles@hhsc.state.tx.us; Caroline.Sunshine@hhs.texas.gov; Kent.sullivan@tdi.texas.gov; james.person@tdi.texas.gov; info@txfragilekids.org.com; ; amy.cresap@gov.texas.gov; Hoelscher, Jennie; Casares, Becky
Subject: RQ-0420-KP status
Date: Thursday, August 26, 2021 2:38:25 PM
Attachments: RQ-0420-KP_status.pdf

Representative Krause:

Please find attached our letter acknowledging receipt of your amended request to RQ-0420-KP.

Thank you.

Opinion Committee
Office of the Attorney General of Texas
(512) 463-2110

AMERICAN OVERSIGHT

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

August 26, 2021

The Honorable Matt Krause
Chair, House Committee on General Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Via E-Mail

Re: The meaning of specialty provider and other terms for purposes of implementing Senate Bill 1207 from the 86th Legislature (RQ-0420-KP)

Dear Representative Krause:

We have received your amended request to RQ-0420-KP, which you submitted in light of the Health and Human Service Commission's recent adoption of administrative rules. In addition to the original subjects asked, you include new questions for our consideration.

We want to ensure all interested parties are informed of the additional questions and have an opportunity to provide input. By copy of this letter, we are notifying those listed below of your amended request and inviting them to submit briefing on your questions if they have a special interest or expertise in the subject matter. If you are aware of other interested parties, please forward this request for briefing to them or let us know, so that we may notify them as soon as possible. We ask that the briefs be submitted by September 24, 2021, to ensure that this office will have adequate time to review and consider arguments relevant to the request from all interested parties. Briefs may be submitted by e-mail to opinion.committee@oag.texas.gov. Please note that briefs and other correspondence are subject to the Public Information Act.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Virginia K. Hoelscher
Chair, Opinion Committee

VKH/som

AMERICAN OVERSIGHT
TX-AG-22-0325-A-000028

Attachment: Request No. 0420-KP

cc: The Honorable Charles Perry, Texas State Senate
The Honorable Jeff Leach, Texas House of Representatives
The Honorable Tan Parker, Texas House of Representatives
Ms. Karen Ray, Chief Counsel, Texas Department of Health and Human Services
Mr. Jonathan Miles, General Counsel, Texas Department of Health and Human Services
Medical Care Advisory Committee, Texas Department of Health and Human Services
Star Kids Managed Care Advisory Committee, Texas Department of Health and Human Services
State Medicaid Managed Care Advisory Committee, Texas Department of Health and Human Services
Mr. Kent Sullivan, Commissioner of Insurance, Texas Department of Insurance
Mr. James Person, General Counsel, Texas Department of Insurance
Protect Texas Fragile Kids
Ms. Laura J. Warren, Executive Director, Texas Parent to Parent
Ms. Tricia Hall, Executive Director, Texas Pediatric Society
Ms. Jamie Dudensing, Chief Executive Officer, Texas Association of Health Plans
Ms. Amy Cresap, General Counsel Division, Office of the Governor

AMERICAN OVERSIGHT

RECEIVED
By Opinion Committee at 11:59 am, Aug 26, 2021

FILE# **RQ-0420-KP**

TEXAS HOUSE *of* REPRESENTATIVES I.D.# **48996**

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

August 26, 2021

The Honorable Ken Paxton
Attorney General of Texas
Attn: Opinion Committee
PO Box 12548
Austin, Texas 78711-2548
opinion.committee@oag.texas.gov

c/o Charlotte M. Harper, Deputy Chair, Opinion Committee

Re: Attorney General Opinion Request No. RQ-0420-KP; Modification of Request

Dear General Paxton:

On July 30, 2021, I submitted a request for your opinion regarding the definition or two terms ("Specialty provider" and "Continuity of Care with Out of Network Providers/Coordination of Benefits") originally enacted in 2019 by Senate Bill 1207 and codified as Government Code section 533.038. You assigned the request file number RQ-0420-KP. I wish to amend my request in light of the Health and Human Services Commission's recent adoption of administrative rules that purport to implement S.B. 1207. In my view, the adopted rules do not correspond to the Legislature's intent in providing the benefits enumerated in section 533.038.

The entire motivation for section 533.038 was to address shortcomings in Commission's policies that compelled families and guardians to confront a terrible choice when encountering barriers to access timely care:

- Terminate beneficial provider and care relationships—many nurtured over several years—because their Medicaid health plan cannot or will not enroll the preferred provider,
- Pay for such care out of their own pockets, or worse,
- Forego care altogether if the family cannot financially afford such care, thus potentially resulting in increased risk of hospitalization, increased emergency room visits, and potential institutionalization due to the delay in appropriate access.

If anything, S.B. 1207 was specifically intended to spare families these awful choices. Regrettably, the Commission's rules do not appear to fully reflect this intent.

On August 12, 2021, the Commission adopted administrative rules to implement S.B. 1207 that originally were published as proposed rules on February 12, 2021. 46 Tex.Reg. 997 (Feb. 12,

Capitol Office: E2.170 • P.O. Box 2910 • Austin, Texas 78768-2910 • (512) 463-0780
Members: *Stephanie Klick, Leo Pacheco, Reggie Smith*
Darren Keyes, Committee Clerk & General Counsel
Darren.Keyes_hc@house.texas.gov

AMERICAN OVERSIGHT

2021). The preamble to the adopted rules notes that the Commission received comments on the proposed rules from 26 parties, including Representative Tan Parker and, before publication, Senator Charles Perry, Representative Jeff Leach and myself (Feb.10, 2021).

I am not privy to all comments filed in connection with the proposed rules, but virtually all of the comments described in the preamble opposed the rules, several commenters disputing the policies' conformity to legislative intent. Despite the great weight of objections to the proposed rules, the Commission made no changes on adoption. Instead, the Commission rejected the comments either by invoking its own expertise or preexisting policies, deferring answers to an as-yet unscheduled rulemaking to implement Senate Bill 1648 of the recently-concluded 87th regular session, or by simply declaring (without explaining) that the adopted rules implement legislative intent.

I do not believe either the adoption of the February proposed rules or the pledge to adopt rules to implement S.B 1648 moot the issues raised by my original request or the comments to the recently adopted rules.

In view of these developments, I wish to clarify my questions:

1. *May the Commission, consistent with the plain language of section 533.038 and legislative intent, condition an individual's continuity of care on the person having other insurance (as it did in its adopted rules) when the Legislature did not impose such precondition?*

   "Coordination of benefits" and "continuity of care" are independent concepts. The former ensures Medicaid is the payer of last resort as required by federal law when a Medicaid recipient has other insurance. The latter (encompassed in subsection (g) of section 533.038) ensures a Medicaid recipient does not lose access to a provider with which the recipient has an established relationship. I do not believe the Commission was delegated authority to limit the right to continuity of care assured under the statute to Medicaid recipients who have other insurance.

2. *May the Commission, consistent with the plain language of section 533.038 and legislative intent, limit access to the continuity of care assured under subsection (g) only to children (persons under the age of 21)?*

3. *May the Commission, consistent with the plain language of section 533.038 and legislative intent, define "complex medical needs" under subsection (g) to mean specific levels of care defined in its pre-existing contracts with managed care organizations?*

4. *May the Commission, consistent with the legislative intent expressed in SB 1207 and SB 1648, limit the definition of "specialty provider" to a schedule of disciplines described in* ***preexisting commission contracts****—i.e., physicians who practice certain medical specialties, audiologists, chiropractors, dieticians, optometrists, and podiatrists?*

   In my view, the answer to each of these questions is, "No." The legislature did not limit

AMERICAN OVERSIGHT

the benefits of subsection (g) to children. Neither does the legislative history support the limits placed on the definition of "complex medical needs" or "specialty provider" in the Commission's adopted rules. The Legislature did not limit the scope of these terms, and the unanimous testimony before both houses of the Legislature in 2019 (S.B. 1207) or 2021 (S.B. 1648) and the multiple advisory committees the Commission is required by state and federal law to consult before enacting Medicaid program policies supported a broad definition of both terms.

The testimony indicates that, rather than the narrow taxonomy the Commission adopted, the terms "complex medical needs" and "specialty provider" were meant to be broadly construed to first, go further than pre-existing Commission policies, and second, to include any provider that is not a primary care provider.

The Commission was granted broad authority to develop and implement the program authorized under S.B. 1207. But none of the conditions described above were expressly authorized by S.B. 1207. And considering the broad support for the benefit in 2019, it does not seem that the Legislature delegated the Commission authority to, in effect, amend the statute in ways that limit access to it. Indeed, the cruel irony of the adopted rules is that some of the families and individuals who appeared and testified in support of the bill will not be eligible to benefit from it. The rules also further restrict many Medicaid beneficiaries' rights to continuity of care. This the Legislature did not authorize.

I recognize that I speak only for myself; however, I believe that the legislative record and public testimony will support my views. I also believe that other members of the Legislature will soon weigh in and express similar views. I know that you and your staff will carefully review the record to assist all interested parties to better understand and adjust their expectations.

Your office requested interested parties submit briefs on my request by September 2nd. In light of the new developments described above, I request that your office consider the clarifications to my original questions and extend the time for interested parties to brief your office on the issues.

Thank you, as always, for your service to Texans.

Matt Krause

Matt Krause
State Representative, District 93
Chairman, Texas House Committee on General Investigating

AMERICAN OVERSIGHT

From:	OPINIONCOMMITTEE
To:	Matt.Krause@house.texas.gov; kelly.hancock@senate.texas.gov
Cc:	shane.birdwell@house.texas.gov
Bcc:	Steven Martinez; Demetrius Moales; Nancy Skinner; William Hill; Jennie Hoelscher
Subject:	RQ-0424-KP status
Date:	Monday, February 14, 2022 6:52:53 PM
Attachments:	RQ-0424-KP_status.pdf

Senator Hancock & Representative Krause:

Please find attached our letter regarding the status of your August 16, 2021 and September 28, 2021 requests for an attorney general opinion. Thank you.

Opinion Committee
Office of the Attorney General of Texas
(512) 463-2110

AMERICAN OVERSIGHT

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

February 14, 2022

The Honorable Kelly Hancock
Chair, Senate Committee on Veteran Affairs & Border Security
Texas State Senate
Post Office Box 12068
Austin, Texas 78711-2068

The Honorable Matt Krause
Chair, House Committee on General Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Via E-Mail

Re: Whether a legislator or a member of the public may inspect or obtain copies of anonymous voted ballots (RQ-0424-KP)

Dear Senator Hancock and Representative Krause:

Thank you for requesting a written opinion from this office.

Section 402.042 of the Government Code requires this office to issue an opinion within 180 days of receiving a request for one unless we explain to the requestor in writing before the deadline why the opinion will be delayed.

Accordingly, we are notifying you that we will not issue an opinion on your request within 180 days of the date received because we need more time to review the law, complete the analysis that your request requires, and finalize the formal opinion. We will make every effort to issue this opinion as soon as possible.

Sincerely,

Virginia K. Hoelscher
Chair, Opinion Committee

VKH/som

Attachment: Request No. 0424-KP

AMERICAN OVERSIGHT
TX-AG-22-0325-A-000034

RECEIVED
By Opinion Committee at 4:50 pm, Aug 16, 2021

TEXAS HOUSE *of* REPRESENTATIVES

RQ-0424-KP
FILE# **ML-48990-21**
I.D.# **48990**

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

August 16, 2021

The Honorable Ken Paxton
Office of the Attorney General
Attn: Opinion Committee
PO Box 12548
Austin, TX 78711-2548
opinion.committee@oag.texas.gov

Re: Whether the public or a legislator may inspect anonymous voted ballots

Dear General Paxton,

In order to promote public confidence in Texas elections, members of the public as well as members of the legislature are interested in auditing the results of Texas elections. However, election administrators have cited certain sections of the Election Code as preventing the release of materials necessary to conduct such an audit. The materials include voted ballots that by their nature in how Texas conducts its elections are anonymous and voted ballots that are not anonymous but have had any voter-identifying data contained on the ballots redacted (referred to herein as "anonymous voted ballots.").

Texas Election Code Section 66.058 prescribes a 22-month period for the preservation of precinct election records, which includes voted ballots, and provides that it is a criminal offense if the custodian of election records makes an unauthorized entry to the records.

Election Code Section 1.012 states that, except as provided by the Election Code or the Public Information Act, all election records, including voted ballots, are public information. Under that section, election records that are public information shall be made available to the public.

Texas Government Code Chapter 552, the Public Information Act, prescribes the procedures for the public to request public information. Separately, Government Code Section 552.008 provides authority and procedures for members of the legislature to request public information for legislative purposes, including confidential information.

In a question of first impression over thirty years ago, Open Records Decision No. 505, dated September 2, 1988, opined that "voted ballots from a primary election become public information available for public inspection after the 22-month retention period."

Capitol Office: E2.170 • P.O. Box 2910 • Austin, Texas 78768-2910 • (512) 463-0780
Members: *Stephanie Klick, Leo Pacheco, Reggie Smith*
Darren Keyes, Committee Clerk & General Counsel
Darren.Keyes_hc@house.texas.gov

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Technology and conditions have changed since 1988. Open Records Decision No. 505 did not consider the anonymous nature of voted ballots and was not apparently limited to anonymous voted ballots. Moreover, the opinion referenced portions of the Public Information Act that exempt disclosure of records that are "confidential" in light of sections of the Election Code that use the same term and equated the requirement in Election Code Section 66.058(b) to keep voted ballots preserved securely with requirements that the records must be kept confidential. If voted ballots are not confidential simply because they are secure, especially if they are anonymous voted ballots the release of which would not cause the secrecy of any person's votes to be revealed, then Election Code Section 1.012 appears to require that these records be made available to the public so that the public can adequately audit the results of elections.

Accordingly, if a member of the public, or a legislator, in their capacity as a member of the public, requests to inspect or to obtain copies of anonymous voted ballots, is the custodian of election records authorized to access such records for purposes of fulfilling the request? Is the member of the public entitled, generally, to inspect or receive a copy of such anonymous voted ballots?

Even if Open Records Decision No. 505 is interpreted to mean that the requirement in Election Code Section 66.058(b) requiring voted ballots to be kept secure means they also are confidential and cannot be accessed for purposes of fulfilling requests under the Public Information Act, legislators may examine the voted ballots in light of Texas Government Code Section 552.008 granting a special right of access to legislators for legislative purposes, even to confidential records.

Thus, if a legislator requests to inspect or to obtain copies of anonymous voted ballots for legislative purposes, is the custodian of election records authorized to access such records for purposes of fulfilling the request?

Thank you for your attention to this matter. Please contact my office if we can be of assistance to you in rendering an opinion on this important question regarding individual and legislative access to public information and the ability of the legislature and the public to audit Texas elections.

Respectfully,



Matt Krause
State Representative, District 93
Chairman, Texas House Committee on General Investigating

AMERICAN OVERSIGHT

COMMITTEE ON VETERAN AFFAIRS & BORDER SECURITY, *CHAIR*
COMMITTEE ON TRANSPORTATION

COMMITTEE ON FINANCE
COMMITTEE ON NATURAL RESOURCES &
ECONOMIC DEVELOPMENT

RECEIVED
By Opinion Committee at 4:30 pm, Sep 28, 2021

The Senate of The State of Texas

SENATOR KELLY HANCOCK

September 28, 2021

FILE# **RQ-0424-KP**
I.D.# **49037**

The Honorable Ken Paxton
Office of the Attorney General
Attn: Opinion Committee
P.O. Box 12548
Austin, TX 78711-2548

Re: Legislative Information Requests for Ballots

Dear Attorney General Paxton,

I respectfully request your opinion related to access by legislators to certain election records that may or may not be confidential, including voted ballots and other similar records which are submitted during the course of an election.

Members of the Legislature have expressed interest in researching the results of certain Texas elections in order to promote public confidence in Texas elections. However, election administrators and district attorneys have cited certain sections of the Election Code as preventing the release of materials necessary to conduct such an audit.

Texas Election Code § 66.058 prescribes a 22-month period for the preservation of precinct election records, which includes voted ballots, and provides that it is a criminal offense if the custodian of election records makes an unauthorized entry to the records. Texas Government Code § 552.008 provides authority and procedures for members of the legislature to request public information for legislative purposes, including confidential information.

If a member of the legislature requests to inspect or to obtain regular photocopies of the physical, original voted ballots or related election records for legislative purposes, is the custodian of election records authorized to access such records for purposes of fulfilling the request? Is the member of the legislature entitled, generally, to inspect or receive regular photocopies of physical, original, voted ballots or similar records that are asserted to be confidential?

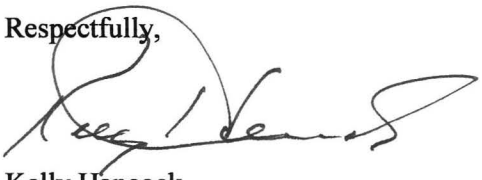
CAPITOL OFFICE:
4E.2 • P.O. BOX 12068 • AUSTIN, TEXAS 78711
(512) 463-0109 • FAX: (512) 463-7003

DISTRICT OFFICE:
9121 BELSHIRE DRIVE, SUITE 200
NORTH RICHLAND HILLS, TEXAS 76182
(817) 595-3892 • (877) 514-3806

AMERICAN OVERSIGHT
TX-AG-22-0325-A-000037

Thank you for your attention to this matter. Please contact my office if we can be of assistance to you in rendering an opinion on this important question regarding legislative access to election records and the ability of the legislature to conduct research into Texas elections.

Respectfully,



Kelly Hancock
Texas Senate, District 9
Chairman, Veteran Affairs & Border Security

AMERICAN OVERSIGHT

From:	OPINIONCOMMITTEE
To:	Matt.Krause@house.texas.gov
Cc:	shane.birdwell@house.texas.gov
Bcc:	generalcounsel@sos.texas.gov; susanr@county.org; michaelp@county.org; mcarew@co.hood.tx.us; amy.cresap@gov.texas.gov; Martinez, Steven; Moales, Demetrius; Skinner, Nancy
Subject:	Request for Opinion (RQ-0424-KP)
Date:	Tuesday, August 17, 2021 4:39:23 PM
Attachments:	RQ-0424-KP.pdf

Dear Representative Krause:

Please find attached our letter acknowledging receipt of your August 16, 2021 request for an Attorney General opinion.

Opinion Committee
Office of the Attorney General of Texas
(512) 463-2110

AMERICAN OVERSIGHT

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

August 17, 2021

The Honorable Matt Krause
Chair, House Committee on General Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Via E-Mail

Re: Whether a legislator or a member of the public may inspect anonymous voted ballots (RQ-0424-KP)

Dear Representative Krause:

We received your request for an attorney general opinion and have designated it as Request No. 0424-KP. Section 402.042 of the Government Code provides that the Attorney General shall issue an opinion not later than the 180th day after the date that an opinion request is received, unless before that deadline the Attorney General notifies the requesting person in writing that the opinion will be delayed. TEX. GOV'T CODE § 402.042(c)(2). We received your request on August 16, 2021, setting a due date for your opinion of February 14, 2022.

By copy of this letter we are notifying those listed below of your request and asking them to submit briefing on your questions if they have a special interest or expertise in the subject matter. If you are aware of other interested parties, please forward this request for briefing to them or let us know, so that we may notify them as soon as possible. We ask that the briefs be submitted by September 16, 2021, to ensure that this office will have adequate time to review and consider arguments relevant to the request from all interested parties. Briefs may be submitted by e-mail to opinion.committee@oag.texas.gov. Please note that briefs and other correspondence are subject to the Public Information Act.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Virginia K. Hoelscher
Chair, Opinion Committee

VKH/som

AMERICAN OVERSIGHT
TX-AG-22-0325-A-000040

Attachment: Request No. 0424-KP

cc: Mr. Adam Bitter, General Counsel, Secretary of State
Ms. Susan M. Redford, Executive Director, Texas Association of Counties
Mr. Michael Pichinson, General Counsel, Texas Association of Counties
Ms. Michele Carew, President, Texas Association of Election Administrators
Ms. Kelley Shannon, Executive Director, Freedom of Information Foundation of Texas
Ms. Amy Cresap, General Counsel Division, Office of the Governor

AMERICAN OVERSIGHT

RECEIVED
By Opinion Committee at 4:50 pm, Aug 16, 2021

TEXAS HOUSE *of* REPRESENTATIVES

RQ-0424-KP

FILE# **ML-48990-21**

I.D.# **48990**

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

August 16, 2021

The Honorable Ken Paxton
Office of the Attorney General
Attn: Opinion Committee
PO Box 12548
Austin, TX 78711-2548
opinion.committee@oag.texas.gov

Re: Whether the public or a legislator may inspect anonymous voted ballots

Dear General Paxton,

In order to promote public confidence in Texas elections, members of the public as well as members of the legislature are interested in auditing the results of Texas elections. However, election administrators have cited certain sections of the Election Code as preventing the release of materials necessary to conduct such an audit. The materials include voted ballots that by their nature in how Texas conducts its elections are anonymous and voted ballots that are not anonymous but have had any voter-identifying data contained on the ballots redacted (referred to herein as "anonymous voted ballots.").

Texas Election Code Section 66.058 prescribes a 22-month period for the preservation of precinct election records, which includes voted ballots, and provides that it is a criminal offense if the custodian of election records makes an unauthorized entry to the records.

Election Code Section 1.012 states that, except as provided by the Election Code or the Public Information Act, all election records, including voted ballots, are public information. Under that section, election records that are public information shall be made available to the public.

Texas Government Code Chapter 552, the Public Information Act, prescribes the procedures for the public to request public information. Separately, Government Code Section 552.008 provides authority and procedures for members of the legislature to request public information for legislative purposes, including confidential information.

In a question of first impression over thirty years ago, Open Records Decision No. 505, dated September 2, 1988, opined that "voted ballots from a primary election become public information available for public inspection after the 22-month retention period."

Capitol Office: E2.170 • P.O. Box 2910 • Austin, Texas 78768-2910 • (512) 463-0780
Members: *Stephanie Klick, Leo Pacheco, Reggie Smith*
Darren Keyes, Committee Clerk & General Counsel
Darren.Keyes_hc@house.texas.gov

AMERICAN OVERSIGHT

Technology and conditions have changed since 1988. Open Records Decision No. 505 did not consider the anonymous nature of voted ballots and was not apparently limited to anonymous voted ballots. Moreover, the opinion referenced portions of the Public Information Act that exempt disclosure of records that are "confidential" in light of sections of the Election Code that use the same term and equated the requirement in Election Code Section 66.058(b) to keep voted ballots preserved securely with requirements that the records must be kept confidential. If voted ballots are not confidential simply because they are secure, especially if they are anonymous voted ballots the release of which would not cause the secrecy of any person's votes to be revealed, then Election Code Section 1.012 appears to require that these records be made available to the public so that the public can adequately audit the results of elections.

Accordingly, if a member of the public, or a legislator, in their capacity as a member of the public, requests to inspect or to obtain copies of anonymous voted ballots, is the custodian of election records authorized to access such records for purposes of fulfilling the request? Is the member of the public entitled, generally, to inspect or receive a copy of such anonymous voted ballots?

Even if Open Records Decision No. 505 is interpreted to mean that the requirement in Election Code Section 66.058(b) requiring voted ballots to be kept secure means they also are confidential and cannot be accessed for purposes of fulfilling requests under the Public Information Act, legislators may examine the voted ballots in light of Texas Government Code Section 552.008 granting a special right of access to legislators for legislative purposes, even to confidential records.

Thus, if a legislator requests to inspect or to obtain copies of anonymous voted ballots for legislative purposes, is the custodian of election records authorized to access such records for purposes of fulfilling the request?

Thank you for your attention to this matter. Please contact my office if we can be of assistance to you in rendering an opinion on this important question regarding individual and legislative access to public information and the ability of the legislature and the public to audit Texas elections.

Respectfully,



Matt Krause
State Representative, District 93
Chairman, Texas House Committee on General Investigating

AMERICAN OVERSIGHT

From: Shane Birdwell
To: Opinion_Committee
Cc: Matt Krause; Darren Keyes_HC
Subject: Krause - Election Ballots Opinion Request
Date: Monday, August 16, 2021 4:46:35 PM
Attachments: 8.16.21 Krause OAG Opinion Request - Election Ballots.pdf

---

Hello,

Please see the attached letter from Chairman Krause requesting an opinion regarding election ballots.

Let me know if you have any questions.

Thanks,

Shane Birdwell
Chief of Staff - Representative Matt Krause
O: (512) 463-0562 | F: (512) 463-2053
PO Box 2910 • Austin, TX 78768
Shane.Birdwell@house.texas.gov
Representative Matt Krause

AMERICAN OVERSIGHT

From:	OPINIONCOMMITTEE
To:	Matt.Krause@house.texas.gov
Cc:	shane.birdwell@house.texas.gov
Bcc:	Martinez, Steven; Moales, Demetrius; Skinner, Nancy; Eddy.tinajero@dfps.texas.gov; Sherif.Zaafran@tmb.state.tx.us; Brint.Carlton@tmb.state.tx.us; scott.freshour@tmb.state.tx.us; president@texmed.org; ; acluinfo@aclutx.org; ; info@transtexas.org; amy.cresap@gov.texas.gov
Subject:	Request for Opinion (RQ-0426-KP)
Date:	Tuesday, August 24, 2021 2:41:05 PM
Attachments:	RQ-0426-KP.pdf

Dear Representative Krause:

Please find attached our letter acknowledging receipt of your August 23, 2021 request for an Attorney General opinion.

Opinion Committee
Office of the Attorney General of Texas
(512) 463-2110

AMERICAN OVERSIGHT

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

August 24, 2021

The Honorable Matt Krause
Chair, House Committee on General Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Via E-Mail

Re: Whether certain medical procedures performed on children without medical necessity constitute child abuse (RQ-0426-KP)

Dear Representative Krause:

We received your request for an attorney general opinion and have designated it as Request No. 0426-KP. Section 402.042 of the Government Code provides that the Attorney General shall issue an opinion not later than the 180th day after the date that an opinion request is received, unless before that deadline the Attorney General notifies the requesting person in writing that the opinion will be delayed. TEX. GOV'T CODE § 402.042(c)(2). We received your request on August 23, 2021, setting a due date for your opinion of February 22, 2022.

By copy of this letter we are notifying those listed below of your request and asking them to submit briefing on your questions if they have a special interest or expertise in the subject matter. If you are aware of other interested parties, please forward this request for briefing to them or let us know, so that we may notify them as soon as possible. We ask that the briefs be submitted by September 23, 2021, to ensure that this office will have adequate time to review and consider arguments relevant to the request from all interested parties. Briefs may be submitted by e-mail to opinion.committee@oag.texas.gov. Please note that briefs and other correspondence are subject to the Public Information Act.

If you have any questions, please do not hesitate to contact me.

Sincerely,
Virginia K. Hoelscher
Chair, Opinion Committee

VKH/d1m4

AMERICAN OVERSIGHT
TX-AG-22-0325-A-000046

Attachment: Request No. 0426-KP

cc: Ms. Jaime Masters, Commissioner, Texas Department of Family and Protective Services
Ms. Vicki Kozikoujekian, Legal Counsel, Texas Department of Family and Protective Services
Sherif Zaafran, M.D., President, Texas Medical Board
Mr. Stephen “Brint” Carlton, Executive Director, Texas Medical Board
Mr. Scott Freshour, General Counsel, Texas Medical Board
E. Linda Villarreal, M.D., President, Texas Medical Association
Mr. Donald P. "Rocky" Wilcox, JD, Vice President and General Counsel, Texas Medical Association
Ms. Oni K. Blair, Executive Director, American Civil Liberty Union – Texas
Mr. Johnathan M. Saenz, President, Texas Values
Ms. Karole Fedrick, Education Liaison, Texas Eagle Forum
Mr. Ricardo Martinez, CEO, Equality Texas
Mr. Emmett Schelling, Executive Director, Transgender Education Network of Texas
Ms. Amy Cresap, General Counsel Division, Office of the Governor

AMERICAN OVERSIGHT

RECEIVED
By Opinion Committee at 10:34 am, Aug 23, 2021

TEXAS HOUSE *of* REPRESENTATIVES

RQ-0426-KP
FILE# **ML-48993-21**
I.D.# **48993**

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

August 23, 2021

Office of the Attorney General
Attention Opinion Committee
P.O. Box 12548
Austin, Texas 78711-2548
opinion.committee@oag.texas.gov

Re: Whether sex change procedures performed on children without medical necessity constitute child abuse

Dear General Paxton:

On August 6, 2021, Governor Abbott requested the Commissioner of the Texas Department of Family and Protective Services ("DFPS") to issue a determination of "whether genital mutilation of a child for purposes of gender transitioning through reassignment surgery constitutes child abuse." On August 11, 2021, the Commissioner of DFPS replied that "genital mutilation of a child through reassignment surgery is child abuse." Genital mutilation is not defined in either letter. The Governor's letter states, "This broad definition of 'abuse' should cover a surgical procedure that will sterilize the child, such as orchiectomy or hysterectomy, or remove otherwise healthy body parts, such as penectomy or mastectomy." However, the Commissioner's letter does not reciprocate by defining "genital mutilation" or specifying what procedures constitute "abuse." The Commissioner's letter may unintentionally create ambiguity on an issue that needs clarity.

According to legislative testimony and other sources, medical practitioners perform various sex-change procedures on children. These procedures include (1) sterilization through castration, vasectomy, hysterectomy, oophorectomy[1], metoidioplasty[2], orchiectomy[3], penectomy[4], phalloplasty[5], and vaginoplasty[6]; (2) mastectomies; and (3) removing from children otherwise healthy or non-diseased body part or tissue. Do these procedures constitute "genital mutilation" as referenced in the Commissioner's letter and thus constitute "abuse" under Texas Family Code Chapter 261?

Additionally, medical practitioners are providing, administering, prescribing, or dispensing drugs to children that induce transient or permanent infertility, including: (A) puberty-suppression or puberty-

[1] Surgical removal of one or both ovaries.
[2] Surgical "creation" of a penis using existing genital tissue after the clitoris has been enlarged through the use of testosterone therapy.
[3] Surgical removal of one or both testicles.
[4] Surgical amputation of the penis.
[5] Surgical "creation" of a penis.
[6] Surgical "creation" of a vagina involving removal of the penis, as well as the testicles and scrotum, if an orchiectomy was not previously performed.

Capitol Office: E2.170 • P.O. Box 2910 • Austin, Texas 78768-2910 • (512) 463-0780
Members: *Stephanie Klick, Leo Pacheco, Reggie Smith*
Darren Keyes, Committee Clerk & General Counsel
Darren.Keyes_hc@house.texas.gov

AMERICAN OVERSIGHT

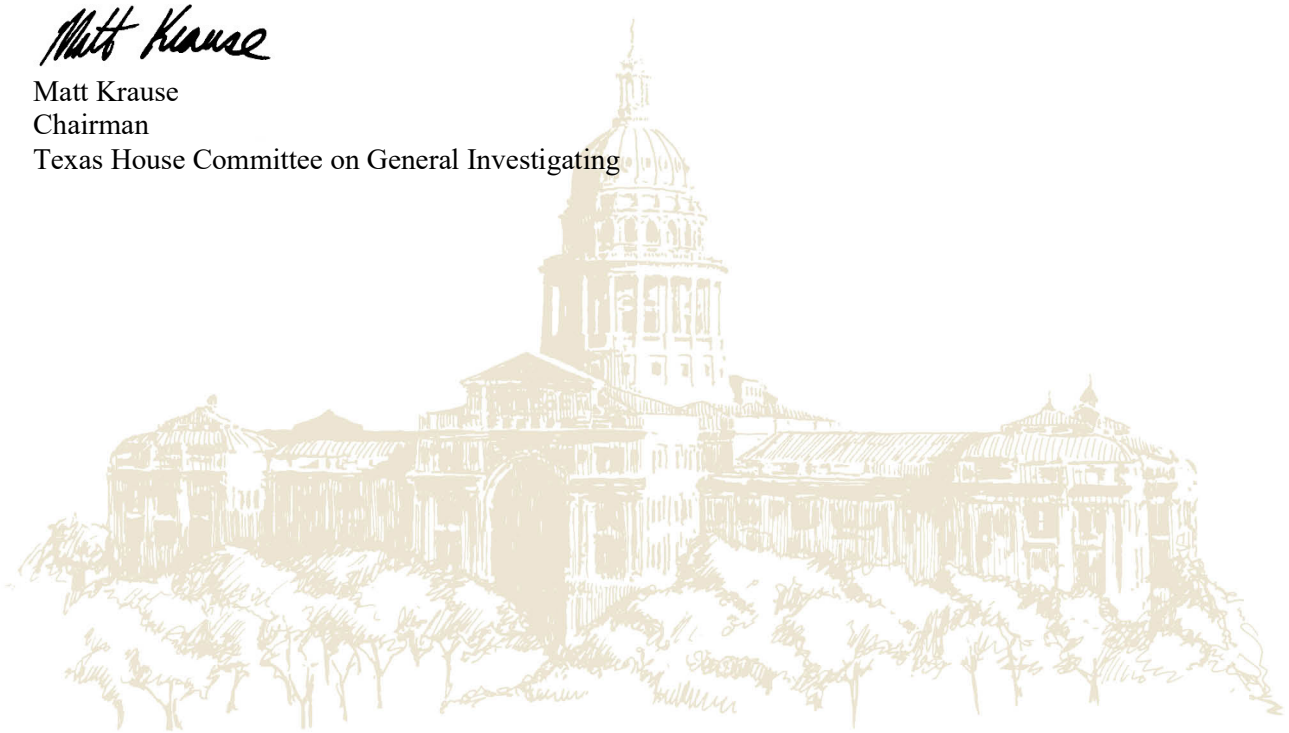
blocking drugs, (B) supraphysiologic[7] doses of testosterone to females; and (C) supraphysiologic doses of estrogen to males. Do these chemical procedures constitute "abuse" under Texas Family Code Chapter 261?

Some children have a medically verifiable genetic disorder of sex development or do not have the normal sex chromosome structure for male or female as determined by a physician through genetic testing that require procedures similar to those described in this request. Any clarification should consider whether an exception exists for instances of medical necessity.

Thank you for considering this request.

Sincerely,

Matt Krause
Chairman
Texas House Committee on General Investigating



[7] Supraphysiologic means exceeding what is normally found in healthy individuals. The term is usually used to refer to a hormone or medication given in a stronger dose than the amount the body can produce on its own.

Capitol Office: E2.170 • P.O. Box 2910 • Austin, Texas 78768-2910 • (512) 463-0780
Members: *Stephanie Klick, Leo Pacheco, Reggie Smith*
Darren Keyes, Committee Clerk & General Counsel
Darren.Keyes_hc@house.texas.gov

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From: Darren Keyes HC
To: Opinion Committee
Cc: Matt Krause; Shane Birdwell
Subject: Krause - Opinion Request
Date: Monday, August 23, 2021 10:19:43 AM
Attachments: AG Opinion Request 8-23-21.pdf

Please see the attached opinion request from Chairman Krause. Don't hesitate to call me if you have any questions.

Respectfully,

Darren Keyes
General Counsel
House Committee on General Investigating
Chairman Matt Krause
E2.170 | 512-463-0780

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From:	OPINIONCOMMITTEE
To:	Matt.Krause@house.texas.gov
Cc:	shane.birdwell@house.texas.gov; darren.keyes_hc@house.texas.gov
Bcc:	Steven Martinez; Nancy Skinner; Jennie Hoelscher; Demetrius Moales; Charlotte Harper
Subject:	RQ-0426 issued as KP-0401 Texas Attorney General Opinion
Date:	Monday, February 21, 2022 2:15:44 PM
Attachments:	KP-0401.pdf

Issued today:

Opinion No. KP-0401
Re: Whether certain medical procedures performed on children without medical necessity constitute child abuse (RQ-0426-KP)

Opinion Committee
Office of the Attorney General of Texas
(512) 463-2110

AMERICAN OVERSIGHT

From: Darren Keyes HC
To: Opinion Committee
Cc: Matt Krause; Scott Stier
Subject: Correspondence re: Opinion Request (RQ-0426)
Date: Friday, December 10, 2021 1:32:07 PM
Attachments: RQ-0426 Letter.pdf

Please see the attached correspondence from Chairman Krause.

Respectfully,

Darren Keyes
General Counsel
House Committee on General Investigating
Chairman Matt Krause
E2.170 | 512-463-0780

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RECEIVED
By Opinion Committee at 1:41 pm, Dec 10, 2021

TEXAS HOUSE *of* REPRESENTATIVES

FILE# **RQ-0426-KP**
I.D.# **49062**

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

December 10, 2021

Office of the Attorney General
P.O. Box 12548
Austin, Texas 78711-2548
opinion.committee@oag.texas.gov

Re: RQ-0426

Dear General Paxton:

On August 23, 2021, I submitted a request for opinion (RQ-0426) regarding whether sex change procedures performed on children without medical necessity constitute child abuse. Today marks 108 days since the request was submitted. On December 8, 2021, you sent a letter to the Commissioner of the Texas Department of Family and Protective Services referencing RQ-0426 and stating, "This request *was not* requested to be expedited." Although there is no statutory framework for an "expedited" opinion, please allow this letter to serve as my official request to expedite your response.

Moreover, I note that previous requests for opinion have been answered within days in some cases. As an example, your opinion, KP-0025, was provided in 3 days, even though the request did not include a request for an expedited response. Earlier this year, your opinion, KP-0363, was provided just 2 days after the requestor asked for an expedited response.[1] You provided an opinion, KP-0386, just 15 days after a request for expedited response.[2] And another opinion, KP-0388, was provided just 36 days after a request for expedited response.[3] Surely, the safety and protection of Texas children is worthy of an urgent response. Thank you for your prompt attention to this important matter.

Sincerely,

Matt Krause
Chairman
Texas House Committee on General Investigating

[1] Letter from Honorable Dan Patrick, Lt. Gov. of the State of Tex., to Honorable Ken Paxton, Tex. Att'y Gen. at 1 (Mar. 15, 2021), https://www2.texasattorneygeneral.gov/opinions/opinions/51paxton/rq/2021/pdf/ RQ0401KP.pdf ("Request Letter")
[2] Letter from Honorable Dee Hobbs, Williamson Cnty. Att'y, to Honorable Ken Paxton, Tex. Att'y Gen. at 1 (Sept. 2, 2021), https://www2.texasattorneygeneral.gov/opinions/opinions/51paxton/rq/2021/pdf/RQ0429KP.pdf
[3] Letter from Honorable Donna Campbell, Chair, Senate Comm. on Nominations, to Honorable Ken Paxton, Tex. Att'y Gen. at 1 (Aug. 18, 2021), https://www2.texasattorneygeneral.gov/opinions/opinions/51paxton/rq/2021/pdf/RQ0425KP.pdf.

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Members: Stephanie Klick, Reggie Smith, John Turner
Darren Keyes, Committee Clerk & General Counsel
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TX-AG-22-0325-A-000053

TEXAS HOUSE *of* REPRESENTATIVES

RECEIVED
By Opinion Committee at 3:47 pm, Aug 02, 2021

RQ-0420-KP
FILE# **ML-48983-21**
I.D.# **48983**

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

July 30, 2021

Via Email
Office of the Attorney General
c/o Opinions Division
P.O. Box 12548
Austin, Texas 78711-2548
Email: opinion.committee@oag.texas.gov

Dear General Paxton,

During the 86th Legislative Session a bipartisan coalition of legislators passed Senate Bill 1207 to help children in the Medically Dependent Child Program (MDCP) in Texas. Unfortunately there have been issues with the implementation of portions of SB1207 and therefore I request an opinion on the following topics:

1. Specialty Provider definition; and
2. Continuity of Care with Out of Network Providers/Coordination of Benefits definition

If you or your team has any questions or if there is anything my office can do, please reach out to my Chief of Staff, Shane Birdwell, at shane.birdwell@house.texas.gov or (512) 463-0562.

Sincerely,

Matt Krause

Chairman Krause
General Investigating

Capitol Office: E2.170 • P.O. Box 2910 • Austin, Texas 78768-2910 • (512) 463-0780
Members: *Stephanie Klick, Leo Pacheco, Reggie Smith*
Darren Keyes, Committee Clerk & General Counsel
Darren.Keyes_hc@house.texas.gov

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Health and Human Services Commission

STAR Kids Contract Terms

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	October 1, 2015	Initial version of Attachment A, "STAR Kids Managed Care Contract Terms and Conditions" that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2016	All references to Frew v. Janek are changed to Frew v. Traylor. All references to "Fraud and Abuse" are changed to "Fraud, Waste, and Abuse." Definition for Abuse, Neglect, or Exploitation is modified to update the citations. Definition for Clinical Prior Authorization or Clinical PA is added. Definition for Long-Term Services and Supports (LTSS) is modified to clarify the services included for STAR Kids. Definition for Self-employed Direct Provider is added. Definition for Texas Medicaid Provider Procedures Manual is modified to remove the publication frequency. Section 4.11 "E-Verify System" is renamed "Employment Verification" and the requirements updated. 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.
Revision	1.2	November 1, 2016	All instances of "Frew v. Traylor" are changed to "Frew v. Smith" and all instances of "Alberto N., et al. v. Traylor, et al." are changed to "Alberto N., et al. v. Smith, et al." to conform to the change in HHSC leadership on June 1, 2016. Definition for Breach is added. Definition for Discovery/Discovered is added. Definition for Individual Service Plan (ISP) is added. Definition for NorthSTAR is deleted. Definition for Nursing Services is modified to include PPECC services.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition for Pre-appeal is deleted. Definition for Prescribed Pediatric Extended Care Center (PPECC) is added. Definition for Service Coordination is modified to change "STAR+PLUS" to "STAR Kids" in item 1. Definition for Significant Traditional Provider (STP) is modified to align with the STAR+PLUS definition. Definition for STAR Kids is modified to add 1915(c) waiver services. Section 3.07 is modified to align the timeframe in item 1 with the other managed care contracts. Section 4.02 is modified to align item (d)(2) with Section 8.1.5.6 of the contract. Section 5.03 is modified to modify item (b)(2) to remove the reference to FFCHE, to modify item (b)(3) to add commercial insurers, to modify item (b)(4) to add STAR Heath, to delete item (b)(5), and to remove Dual Demonstration from items 1 and 6 and to remove item 9 in the table under item (b)(7). Section 7.02 is modified to add item (a)(16) to require MCOs to report all Member health care information upon HHSC's request and subsequent items are renumbered. Item (a)(18) is deleted as redundant. Section 9.04 is modified to add an explanation of "reasonable notice." Section 11.09 MCO's Breach Notice, Reporting and Correction Requirements is added.
Revision	1.3	March 1, 2017	Definition for "Court-Ordered Commitment" is modified to add a reference to the Texas Code of Criminal Procedure, Chapter 46B. Definition for “Texas Women's Health Program” is changed to “Healthy Texas Women Program” and the citation is updated. Definition for “National CLAS Standards” is added. Section 4.02 (c) is modified to specify notification must be in writing. Section 5.03 is modified to clarify items (b) and (e). Section 7.02 is modified to add a reference to CFR Part 4.8 in (a)(4), to remove reference (a)(9)

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			regarding Alberto N, and to add item (d) regarding the precedence of the CFR. All subsequent subsections are re-lettered. Section 7.04 is modified to add new language to comply with new CMS managed Care Rules. See CFR 438.3(d) and (f). Section 9.02 (b) is modified to add item 4 Inspection and subsequent items are renumbered.
Revision	1.4	June 1, 2017	Contract amendment did not revise Attachment A, "STAR Kids Managed Care Contract Terms and Conditions."
Revision	1.5	September 1, 2017	Definition for "Adoption Assistance (AA) Member" is added. Definition for "Appeal" is modified to comply with 42 CFR §438.400. Definition for "Complaint and Internal MCO Appeal System" is added. Definition for "Farmworker Child(ren) (FWC)" is added. Definition for "Indian Health Care Provider" is added. Definition for "Individual Service Plan (ISP)" is modified for person-centeredness. Definition for "Inquiry" is added. Definition for "Local Behavioral Health Authority" is added. Definition for "Limited English Proficient (LEP)" is added. Definition for "Permanency Care Assistance (PCA) Member" is added. Definition for "Person-Centered" is added. Definition for "Post-Stabilization Care Services" is modified to comply with 42 C.F.R. §438.114. Definition for "Prevalent Language" is added. Definition for "Readily Accessible" is added. Definition for "Service Plan (SP)" is added.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition for "Fair Hearing" is renamed "State Fair Hearing" to comply with 42 CFR §438.400. Article 5 is modified to change the title from "Member Eligibility & Enrollment" to "Member Eligibility, Enrollment, and Disenrollment". Section 5.01 is modified to change the title from "Eligibility Determination" to "Eligibility Determination and Disenrollment" and to add requirements to comply with 42 C.F.R. §438.3(c). Section 7.03 "TDI licensure/ANHC certification and solvency" is deleted in its entirety. Article 9 is modified to add "and Litigation Hold" to the title. Section 9.01 is modified to extend the retention period to ten years to comply with 42 C.F.R. §438.230 and to add language requiring MCOs to maintain documents subject to litigation hold beyond regular retention schedules. HHSC proposes the rewrite of the Section 11.09. Section 14.04 is modified to comply with 42 CFR § 438.116.
Revision	1.6	March 1, 2018	All references to Dental Contractor have been removed. Definition for “Action” for Medicaid is modified. Definition for “Auxiliary Aids” is modified to comply with 1115 Waiver and the MDCP 1915(c) Waiver. Definition for “Breach” is modified to harmonize obligations for the MCO and to add clarification. Definition for “Complaint” for Medicaid is modified. Definition for Complaint and Internal MCO Appeal System removed Dental language. Definition for “Encounter Data” is modified to clarify MCO expectations. Definition for “Internal MCO or Dental Contractor Appeal (Medicaid only)” is removed. Definition for “MCO Internal Appeal” for Medicaid is added Definition for “Member Refusal” is added.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition for “Prevalent Language” is modified to elaborate on significant number of percentage and properly cite the C.F.R. Definition for “Retaliation” is added. Section 4.02 is modified to harmonize obligations for the MCO and to add clarification. Section 4.08 is modified to comply with 42 C.F.R. § 438.230 and clarifies the different mandatory provisions. Section 10.05 is modified to comply with 42 C.F.R. 438.3(e). Section 10.16 is modified to add two drugs to non-risk-based category. Sections 11.02, 11.09, 11.09.1, and 11.09.2 are modified to harmonize obligations for the MCO and to add clarification.
Revision	1.7	September 1,2018	Definition for “Agency Sensitive Information” is added. Definition for “Assisted Living Facility (ALF)” is added. Definition for “Auxiliary Aids and Services” is modified to correct spelling. Definition for “Case-by-case Services is added. Definition for “Community Services Specialist Provider” (CSSP) is modified to clarify who can be a CSSP. Definition “Confidential Information” is modified to comply with Tex.Admin.Code Rule §202.1. Definition for “Early Childhood Intervention” is modified to spell out acronym. Definition for “Effective Date of Coverage” is modified to apply to STAR Kids contract. Definition for “Financial Management Services Agency (FMSA)” is added. Definition for “FSR Reporting Period 16” is deleted. Definition for “Habilitation” is added. Definition for “Cost Limit” is modified to correct spelling.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition for “Information Resources” is added. Definition for Non-Urban County (Rural County) is deleted. Definition for “Performance Indicator Dashboard” is modified to comply with minimum standards for dashboard. Definitions for Rate Period 1 and Rate Period 2 are deleted. Definition “Qualified Mental Health Professional for Community Services (QMHP-CS)” is added. Definition for “Service Area” is modified to comply with STAR Kids contract. Definition for “Urban County” is deleted. Section 4.11 is modified to address corrective action requested by CMS audit. Section 5.04 is added to align with STAR+PLUS process. Section 7.02 is modified to provide reference to applicable laws and codes for EVV, including section 12006 of the 21st Century Cures Act (Public Law 114-255) and 1 Tex. Admin. Code § 354.1177(d). Section 11.08 is modified to include all state and federal regulations for vendors who create, receive, maintain, use, disclose, or have access to HHS Information Resources or data. Section 11.09.1 is modified to comply with Tex. Admin. Code Rule § 202.1.
Revision	1.8	January 1,2019	Definition for “Court-Ordered Commitment” is deleted. Definition for “Emergency Behavioral Health Condition” is modified.
Revision	1.9	March 1, 2019	Section 10.17 is modified to correct a citation.
Revision	1.10	September 1, 2019	Substance abuse is changed to substance use disorder to align with the language in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition for “Action” is renamed “Adverse Benefit Determination.” Global change for the term “Action” to “Adverse Benefit Determination” Definition for “Adverse Determination” is deleted. Definition for “Assisted Living Facility” transferred Title 40 Tex. Admin. Code to Title 26. Definition for “Change in Condition” is added Definition for “Clean Claim” is modified to move contractual language to Section 8.1.20.5. Definition for “Community First Choice” is modified to add the word “Habilitation” Definition for “Complaint” is modified to align with MCO appeal standards. Definition “Discharge” is added. Definition for “HHSC Office of the Inspector General” is added Definition for “Initial Contract Complaint” is added. Definition “Transfer” is added Definition for “Unexplained Death” is added Definition “Waste” is modified to comply with Texas Statute and Tex. Admin. Code. Section 4.02 is modified to comply with the Rider 152 Article II, 85th Texas Legislature. Section 5.03 “Span of Coverage” is modified to clarify payment responsibility for inpatient hospital stays with transfers, streamline explanation of payment responsibility, align all managed care contracts, and remove outdated information. Section 6.02 is modified to clarify language Section 9.01 is modified to add a requirement to retain certain documents for review by the OAG.
Revision	1.11	March 1, 2020	Definition for “Telepharmacy” is added.
Revision	1.12	September 1, 2020	Global Change to correct the references to UMCM

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition for “External Medical Review (EMR)” is added Definition for “Independent Review Organization (IRO” is added Definition for “Overpayment” is added Definitions for “Readiness Review” is modified to provide clarity and expectations when contracts are terminated, merged, or acquired. Definition for “Service Coordination” is modified to provide clarity for definition. Definition “Subcontractor” is modified to clarify Providers are not considered subcontractors Definition for “Texas Health Steps Outreach and Informing Unit” is added Definitions for “Transition Phase” is modified to provide clarity and expectations when contracts are terminated merged or acquired. Definitions for “Transition Plan” is added Definitions for “Turnover Phase” is modified to provide clarity and expectations when contracts are terminated merged or acquired. Definitions for “Turnover Plan” is modified to provide clarity and expectations when contracts are terminated merged or acquired. Definitions for “URAC/ **Utilization Review Accreditation Commission dba American Accreditation HealthCare Commission, Inc”** is modified to be consistent across all contracts. Section 5.01 is modified to extend the timeframe to notify HHSC a Member is no longer Medicaid-eligible. Article 12 is modified to be consistent with newly awarded STAR PLUS contract. Section 12.03 is modified to clarify compliance with requirements of 42 CFR 438.710(b). Section 12:15 is deleted. Section 17.02 is modified to comply with TX Insurance Code.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 17.03 is modified to comply with TDI Fidelity Bond.
Revision	1.13	March 01, 2021	Section 1.07 is added language required by CMS letter issued on September 4, 2020 to all State Medicaid Directors. Section 4.10 is modified to remove the option for the MCO to receive authorization or approval for performance of any work or maintenance of any information outside of the United States. As the language reads now, the MCO is forbidden from performing any work or maintaining any information related to or obtained pursuant to the Agreement to occur outside of the United States. Section 11.08 is modified to remove the option for the MCO to allow a contractor to obtain express prior written permission from HHSC and comply with HHSC conditions for safeguarding offshore HHSC information. As the language reads now, the MCO's information and security and privacy program must prohibit the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside of the United States.

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

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Article 1. Introduction

***Section 1.01* Purpose.**

The purpose of this Contract is to set forth the terms for the MCO's participation as a managed care organization in the STAR Kids 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 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 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.

(6) 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.

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

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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 Texas Government 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.

***Section 1.07* Loss of Program Authority**

Should any part of the Scope of Work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must do no work on that part after the effective date of the loss of program authority. HHSC must adjust Capitation Rates, or non-risk payments as applicable, to remove costs that are specific to any program or activity that is no longer authorized by law. If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work. If HHSC paid the MCO in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to HHSC. However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and HHSC included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

Article 2. Definitions

As used in this Contract, the following terms 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).

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 Texas 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.

Adoption Assistance (AA) Member means a Member in STAR or STAR Kids who is the subject of an adoption assistance agreement under the adoption assistance program as described in 40 Tex. Admin. Code Chapter 700, Subchapter H (Adoption Assistance Program).

Adverse Benefit Determination means:

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(1) the denial or limited authorization of a Member or provider requested Services, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

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

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

(4) the failure to provide services in a timely manner as determined by the State;

(5) the failure of an MCO to act within the timeframes provided in the Contract and 42 C.F.R. § 438.408(b);

(6) for a resident of a rural area with only one MCO, the denial of a Member's request to exercise his or her right, under 42 C.F.R. § 438.52(b)(2)(ii), to obtain services outside of the Network; or

(7) the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

Affiliate means any individual or entity that meets *any* of the following criteria: 1) owns or holds a five percent or greater interest in the MCO (either directly or through one or more intermediaries); 2) in which the MCO owns or holds a five percent 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 more intermediaries, controls, or is controlled by, or is under common control with, the MCO; or 6) any entity that would be considered to be an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

Agency Sensitive Information means information that is not subject to specific legal, regulatory, or other external requirements, but is considered HHSC sensitive and is not readily available to the public. "Agency Sensitive Information" could be subject to disclosure under the Texas Public Information Act, but disclosure should be controlled due to sensitivity.

Agreement 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**.

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**.

Assisted Living Facility (ALF) has the meaning assigned in 26 Tex. Admin. Code § 553.11.

Authorized Representative means any person or entity acting on behalf of the Member and with the Member's written consent in the Complaint and Appeals process.

Auxiliary Aids and Services means an accommodation that ensures that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals that do not need such accommodations and includes:

(1) qualified interpreters or other effective methods of making aurally delivered materials understood by persons with hearing impairments;

(2) taped texts, large print, Braille, or other effective methods to ensure visually delivered materials are available to individuals with visual impairments; and

(3) other effective methods to ensure that materials (delivered both aurally and visually) are available to those with cognitive or other Disabilities affecting communication.

Auxiliary Aids and Services are not adaptive aids described in the MDCP 1915(c) waiver.

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

Behavioral Health Services means Covered Services for the treatment of mental, emotional, or substance use disorders.

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

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

Business Continuity Plan (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.

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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.

Case-by-case Services means additional services for coverage beyond those specified in Attachment B-2; however, services required by EPSDT are not considered Case-by-case Services.

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

Case Management for Children and Pregnant Women is a Medicaid program for children with a 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 Kids Member's health, caregiver support, 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).

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.

Clinical Prior Authorization or Clinical PA means a drug review process authorized by HHSC that is conducted by a healthcare MCO prior to dispensing a drug. All HHSC authorized Clinical PAs are identified on the Medicaid Vendor Drug website. The Clinical PA is used for verifying that a Member's medical condition matches the clinical criteria for dispensing a requested drug.

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

Community-Based Services means services provided to STAR Kids Members in their home or other community-based settings. This term includes Specialty Therapy, Personal Care Services, or Nursing Services.

Community First Choice (CFC) means personal assistance services; Habilitation, acquisition, maintenance and enhancement of skills; emergency response services; and support management provided in a community setting for eligible Medicaid Members in STAR Kids 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

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become self-sufficient through outreach, Member navigation and follow-up, community health education and information, informal counseling, social support, advocacy, and more.

Community Resource Coordination Groups (CRCGs) means a statewide system of local interagency groups, including both public and private providers, which coordinate services for "multi-need" children and 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 Provider (CSSP) means a staff member of a Local Mental Health Authority who has documented full-time experience in the provision of Mental Health Targeted Case Management and Mental Health Rehabilitative Services prior to August 31, 2004. The provider who meets the following minimum requirements: (1) high school diploma or high school equivalency, and (2) three continuous years of 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, has had orientation or training in the ethics of interpreting, including accuracy and impartiality in interpretation.

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

Complaint means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Adverse Benefit Determination. Complaint has the same meaning as grievance, as provided by 42 C.F.R. § 438.400(b). Possible subjects for Complaints include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Complaint includes the Member's right to dispute an extension of time (if authorized by law) proposed by the MCO to make an authorization decision. There is no exception for the reporting of Initial Contact Complaints.

A Complainant's oral or written dissatisfaction with an Adverse Benefit Determination is considered a request for an MCO Appeal.

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

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, provided to or made available to MCO or that MCO may create, receive, maintain, use, disclose, or have access to on behalf of HHS that consists of or includes any or all of the following:

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

(2) Federal Tax Information as defined in Internal Revenue Code § 6103 and Internal Revenue Service Publication 1075;

(3) Personal Identifying Information (PII) as defined in Texas Business and Commerce Code, Chapter 521;

(4) Protected Health Information (PHI) in any form including without limitation, Electronic Protected Health Information as defined in 45 C.F.R. §160.103 or Unsecured Protected Health Information as defined in 45 CFR §164.402

(5) Sensitive Personal Information (SPI) as defined in Texas Business and Commerce Code, Chapter 521;

(6) Social Security Administration Data, including, without limitation, Medicaid information means disclosures of information made by the Social Security Administration or the Centers for Medicare and Medicaid Services from a federal system of records for administration of federally funded benefit programs under the Social Security Act, 42 U.S.C., Chapter 7;

(7) All privileged work product;

(8) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

Consolidated FSR Report or **Consolidated Basis** means FSR reporting results for all Programs and all 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.

Continuity of Care means care provided to a Member by the same Providers to ensure that the

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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.

Conversion Plan means a personalized short-term plan of care that documents historical healthcare information, Member preferences, and action items to ensure a smooth transition to a STAR Kids MCO.

Core Module means the component of the STAR Kids Screening and Assessment Instrument that determines Member preferences and assessment needs.

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.

Cost Limit means the established maximum dollar amount available to an MDCP STAR Kids Member for MDCP services.

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 **Attachment B-2** relating to "Covered Services" and **Section 8.1.2.3** relating to "Value-added 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:

1. Abuse, Neglect, or Exploitation;
2. the unauthorized use of restraint, seclusion, or restrictive interventions;
3. serious injuries that require medical intervention or result in hospitalization;
4. criminal victimization;
5. unexplained death;
6. medication errors; and
7. 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.

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

Day means a calendar day unless specified otherwise.

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.

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.

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

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.

Discharge means a formal release of a Member from an Inpatient 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 or facility and readmission to another within 24 hours for continued treatment is not a Discharge under this Contract.

Discovery/Discovered has the meaning assigned by 45 C.F.R. § 164.410.

Disease Management means a system of coordinated healthcare interventions and communications for populations with conditions in which Member self-care efforts are significant.

Disproportionate Share Hospital (or DSH) means a hospital that serves a higher than average number of Medicaid and other low-income Members

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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.

Dual Eligibles Medicare-Medicaid Plan (MMP) means a managed care plan in which the MCO contracts with CMS and the Texas HHSC to participate in the Texas Dual Eligible Integrated Care Demonstration Project.

Early Childhood Intervention (ECI) means 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.

Effective Date means the effective date of this Contract.

Effective Date of Coverage means the first day of the month for which the MCO has received payment for a Member.

Eligibles means 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 Behavioral Health Conditions include Emergency Detentions as defined under Chapter 573, Subchapter A, of the Texas Health and Safety Code and under Chapter 462, Subchapter C, of the Texas Health and Safety Code.

Emergency 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 Member's health in serious jeopardy;

(2) serious impairment to bodily functions;

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

(4) serious disfigurement; or

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

Employment Assistance means assistance provided to an individual to help the individual 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.

Encounter Data means a representation of a claim received and adjudicated by an MCO without alteration or omission, unless specifically directed by HHSC. The data must include information on receipt of items or services, including billing and rendering provider.

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 Organization (EPO) means an insurer with an Exclusive Provider Benefit Plan approved by TDI in accordance with 28 Tex. Admin. Code §§ 3.9201–3.9212.

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 MCO Internal 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.

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

External Medical Review (EMR) is an independent review of the relevant information the MCO used related to an Adverse Benefit Determination based on functional necessity or medical necessity. EMRs are conducted by third party organizations, known as Independent Review Organizations (IROs), contracted by HHSC.

External Quality Review Organization (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.

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.

Family Support Services means trainings, resources, or other support services provided to family members or other caregivers to enhance their ability to effectively care for the Member.

Farmworker Child(ren) (FWC) means a child or children birth through age 17 of a Migrant Farmworker.

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

Fee-for-Service (FFS) means the traditional 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.

Financial Management Services means assistance provided to Members who manage funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.

Financial Management Services Agency (FMSA) means an entity that contracts with HHSC or an MCO to provide financial management services as described in 40 Tex. Admin. Code § 41.309(a) to an employer or designated representative.

Financial Statistical Report see FSR.

Flexible Family Support Services (for MDCP only) means individualized, disability-related services that support independent living, participation in community-based child care, and participation in post-secondary education.

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

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

Functionally Necessary means services that are necessary to maintain or prevent loss of function.

Habilitation has the meaning assigned in 1 Tex. Admin. Code § 353.2. This service is provided to allow an individual to reside successfully in a community setting by assisting the individual to acquire, retain, and improve self-help, socialization, and daily living skills or assisting with and training the individual on activities of daily living and instrumental activities of daily living.

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;

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(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 a minimum, Emergency Services and inpatient and outpatient services.

Health and Human Services Commission (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 Home has the meaning assigned in Texas Government Code § 533.00253(a)(2).

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

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

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

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

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

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, or personal care services provided to individuals in their own home or independent living environment.

Home and Community-Based Services (HCBS) Waiver means specialized programs that provide Home and Community-Based LTSS as cost-effective alternatives to institutional care.

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.

Independent Review Organization (IRO) is a third-party organization contracted by HHSC that conducts an External Medical Review (EMR) during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity.

Indian Health Care Provider (IHCP) has the meaning assigned to it in 42 C.F.R. § 438.14 and means a health care program operated by the Indian Health Service (IHS) or by an Indian tribe, tribal organization, or urban Indian organization, otherwise known as an I/T/U, as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

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

Individual Service Plan (ISP) means an an individualized and person-centered plan in which a Member enrolled in the STAR Kids and Community Based Services program operated by the MCO, with assistance as needed, identifies and documents his or her preferences, strengths, and health and wellness needs in order to develop short-term objectives and action steps to ensure personal outcomes are achieved within the most integrated setting by using identified supports and services The ISP is supported by the results of the Member's

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program-specific assessment and must meet the requirements of 42 C.F.R. § 441.301.

Information Resources means the procedures, equipment, and software that are employed, designed, built, operated, and maintained to collect, record, process, store, retrieve, display, and transmit information, and associated personnel including consultants and contractors as defined in §2054.003(7), Texas Government Code "information resources", and as defined in 44 U.S.C. § 3502, NIST SP 800-53 rev 4.

Initial Contact Complaint means a Complaint that is resolved within one Business Day.

Initial Contract Period means the Effective Date of the Contract through August 31, 2019.

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

Inquiry a request by a consumer (Member or Provider) for information about HHS programs or services.

Integrated Primary Care means the systematic integration of Behavioral Health Services and routine primary care services.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) means an Intermediate Care Facility for Individuals with Intellectual Disabilities or related conditions that provides residential care and services for those individuals based on their functional needs.

ICF-IID Program means the Medicaid program serving individuals with intellectual disabilities or related conditions who receive care in intermediate care facilities other than a state supported living center.

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**.

Legally Authorized Representative (LAR) means the Member's representative defined by state or federal law, including Tex. Occ. Code § 151.002(6), Tex. Health & Safety Code § 166.164, and Tex. Estates Code Ch. 752.

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.

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

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

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

Local Health Department means a local health department established under Health and Safety Code § 121.031, Local Public Health Reorganization Act.

Local Mental Health Authority (or LMHA) has the meaning assigned in Texas 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, including state plan services available to all Members such as personal care services, private duty nursing, Day Activity and Health Services (DAHS), Community First Choice (CFC) services, and STAR Kids MDCP services.

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

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.

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

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

1. the other entity is an Affiliate of the MCO;
2. the Subcontract is considered by HHSC to be for a key type of service or function, including
   a. Administrative Services (including third party administrator, Network administration, and claims processing);
   b. delegated Networks (including behavioral health, dental, pharmacy, and vision);
   c. management services (including management agreements with parent)
   d. reinsurance or retrocession agreements;
   e. Disease Management;
   f. pharmacy benefit management (PBM) or pharmacy administrative services; or
   g. call lines (including nurse and medical consultation); or
3. any other Subcontract that exceeds, or is reasonably expected to exceed, the lesser of: a) $500,000 per year, or b) 1% of the MCO's annual Revenues under this Contract. Any Subcontracts between the MCO and a single entity that are split into separate agreements by time period, Program, or 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.

MCO Internal Appeal means the formal process by which a Member or his or her representative requests a review of the MCO's Adverse Benefit Determination by the MCO.

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

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 State Plan Services means the benefits provided under the Texas state plan for medical assistance.

Medical Assistance Only (MAO) means a person that does not receive SSI benefits but qualifies financially and functionally for Medicaid assistance.

Medical Home has the meaning assigned to a patient-centered Medical Home in Texas Gov't 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 Fragile means a serious, ongoing illness or a Chronic Condition that:

(1) has lasted or is anticipated to last 12 or more months;

(2) has required at least one month of hospitalization and which requires daily, ongoing medical treatments and monitoring by appropriately trained personnel which may include parents or other family members; or

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(3) requires the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living; or lives with an ongoing threat to his/her continued well-being.

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;

(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 Advocate means a designated MCO representative that works to assist a Member with complaints and concerns.

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 Refusal means a Member's or Member's LAR's unwillingness to participate in an assessment, service planning process or other program-related processes.

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 Texas 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 a Member to remain in the community.

MIS means Management Information System.

Mobile Crisis Teams mean multi-disciplinary care teams with specialized behavioral health training which are located across the state for the purpose of providing behavioral health crisis response where and when a crisis occurs.

National CLAS Standards means *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the *National CLAS Standards*). These standards were developed by the U.S. Department of Health and Human Services - Office of Minority Health and are "intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services." Originally developed in 2000, the CLAS Standards were then updated in 2013. For the list of CLAS Standards, see the Think Cultural Health website.

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

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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**.

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.

Nurse Hotline means the toll-free telephone line operated by the MCO that Providers, Members, and Members' LAR scan call for clinical information, guidance on specialty referrals or requests for specialty Provider consultations.

Nursing Facility (also called nursing home or skilled nursing facility) means an entity or institution that provides organized and structured nursing care and services, and is subject to licensure under Texas Health and Safety Code, Chapter 242, as defined in 40 Tex. Admin. Code § 19.101 and 1 Tex. Admin. Code § 358.103.

Nursing Services means nursing services provided on an intermittent, part-time, or continuous basis by a registered nurse or licensed vocational nurse. This term includes private duty nursing (PDN) and prescribed pediatric extended care center (PPECC) services.

OB/GYN means obstetrician-gynecologist.

Open Panel means Providers who are accepting new Members 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 (OON) means an appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the MCO for the delivery of Covered Services to the MCO's Members.

Overpayment means any payment made to a Network Provider by a MCO, PIHP, or PAHP to which the Network Provider is not entitled to under Title XIX or Title XXI of the Act or any payment to a MCO, PIHP, or PAHP by HHSC to which the MCO, PIHP, or PAHP is not entitled to under Title XIX or Title XXI of the Act.

Parties means HHSC and MCO, collectively.

Party means either HHSC or MCO, individually.

PCP Team means a Member's PCP, other Providers, and the Member's Medical Consenter, who agree to function as an interdisciplinary team. If requested by the Member's Medical Consenter, 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.

Peer Support Services means an evidence-based behavioral health model of care which consists of a qualified peer support provider who assists Members with recovery from mental health and substance use disorder challenges.

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 annually by HHSC to measure the MCO's performance on a number of quality measures.

Permanency Care Assistance (PCA) Member means a Member in STAR or STAR Kids who is the subject of a permanency care assistance program agreement under the permanency care assistance program as described in 40 Tex. Admin. Code § 700(J)(2) (Permanency Care Assistance Program).

Person-Centered means the opportunity to achieve greater independence and community integration, through exercising self-direction, incorporation of individual perceptions and experiences, personal preferences and choices, and control with respect to services and providers, while ensuring medical and non-medical needs are met via means that are exclusively for the benefit of the individual in reaching their personal outcomes and allowing them to have the quality of life and level of independence they desire.

Person-Centered Planning means a collaborative process that actively engages the Member, the Member's LARs, and Providers for the goal of designing and monitoring a plan of care that accounts for the Member's preferences and maximizes the Member's ability to reach the Member's full potential.

Personal Care Services (PCS) means support services furnished to a Member who has physical,

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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 has the meaning assigned to it in 42 C.F.R. § 438.114. Accordingly, the 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).

Prescribed Pediatric Extended Care Center (PPECC) means a facility licensed 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.

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

Prevalent Language has the meaning assigned to it in 42 C.F.R. § 438.10, and means a non-English language determined to be spoken by a significant number or percentage of potential Members and Members that are Limited English Proficient. For the purposes of the Contract, the terms "significant number or percentage" will mean ten percent of the population in a Service Area speaks the non-English language.

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

Private Duty Nursing (PDN) 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 25 Tex. Admin. 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.

Qualified Mental Health Professional for Community Services (QMHP-CS) means a staff member who has a Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, educational psychology, early childhood education, or early childhood intervention, or is a registered nurse, or a Licensed Practitioner of the Healing Arts.

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

Quality Vendor means the entity that contracts with HHSC to provide statistical support, evaluation, targeted analysis, and other quality-related activities in addition to the EQRO, if applicable.

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.

Readily Accessible has the meaning assigned to it in 42 C.F.R. § 438.10. Accordingly, the phrase means electronic information and services which comply with modern accessibility standards such as section 508 guidelines and section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

Readiness Review means HHSC or its agent's process of review, assessment, and determination of the MCO's ability, preparedness, and availability to fulfill its obligations under the Contract.

Recovery means a Member-driven process in which Members are able to learn, achieve personal goals, and participate to the fullest extent possible in their family lives and communities.

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 Care means direct care services that relieve a primary caregiver temporarily from caregiving activities for a Member.

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

Revenue means all revenue received by the MCO 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 the **UMCM**'s Chapter 6.

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.

SDX means State Data Exchange.

Security Plan means a document that contains detailed management, operational, and technical information about a system, its security requirements, and the controls implemented to provide protection against risks and vulnerabilities.

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.

Self-Management Education means educating and training a Member in order to help the Member assume responsibilities directly associated with the maintenance of his or her healthcare and well-being.

Service Area means the counties included in any HHSC defined areas as applicable to each MCO.

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

Service Coordinator(s) means the person with primary responsibility for providing service coordination to STAR Kids Members.

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

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

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

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

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

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

Significant Traditional Provider (STP) means Primary Care Providers, Long Term Services and Supports providers, and pharmacy providers identified by HHSC as having provided a significant level of care to Medicaid Fee-for-Service Members. Disproportionate Share Hospitals (DSH) are also Medicaid STPs.

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 25 Tex. Admin. 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 Kids means the managed care program for recipients under the age of 21 who receive SSI, SSI-related Medicaid, and/or 1915(c) waiver services.

STAR Kids Screening and Assessment Instrument (SAI) means the electronic assessment and screening tool that all STAR Kids MCOs are required to administer to help determine personal preferences, service needs, and necessity of additional assessments.

STAR Kids Screening and Assessment Process means all screenings, assessments, and other information- gathering methods the MCO uses to inform service decisions.

State 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 State Fair Hearings.

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 has the same meaning as assigned in 42 C.F.R. § 438.2.

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

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. § 1320a-6 and as described in the definition of Supplemental Security Income.

Support Network includes LARs, formal and informal caregivers, family members, and other individuals who take an active interest in the care of the Member.

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Supported Employment means assistance provided, in order to sustain competitive employment, to an individual 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 record.

Systems Quality Assurance Plan means the written plan developed by the MCO, and approved by HHSC, that describes the processes, techniques, and tools that the MCO will use for assuring that the MIS systems meet the Contract requirements.

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

TDI means the Texas Department of Insurance.

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

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

Telemonitoring has the meaning defined in 1 Tex. Admin. Code § 354.1434.

Telepharmacy has the same meaning as the term is defined in Occupations Code Section 562.110(a)(3), and as amended.

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 Health Steps Outreach and Informing Unit means the HHSC Texas Health Steps vendor contracted to provide outreach and education to parents, caretakers, and older children about Texas Health Steps benefits and services.

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 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.

Transfer means the movement of the Member from one Acute Care Hospital or long-term care Hospital or facility and readmission to another Acute Care Hospital or long-term care Hospital or facility within 24 hours for continued treatment.

Transition Assistance Services means a service to help Members transition from the nursing home to the community.

Transition Phase includes all activities the MCO is required to perform between the Effective Date and the Operational Start Date for each Service Area of a Contract resulting from an award through procurement or an assignment and assumption due to termination, merger, expiration, or acquisition.

Transition Plan means the written proposal for readiness developed by the MCO, approved by HHSC, to be employed during the Transition Phase.

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.

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 Kids and into adulthood.

Turnover Phase includes all activities the MCO is required to perform prior to, upon, and following the termination of the Contract or the Expiration Date in order to close out the Contract and transition Contract activities and operations to HHSC or a subsequent contractor.

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

Unexplained Death means a death with unknown causes including a death not caused by a previously identified diagnosis or a death that occurred during or after an unusual incident.

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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 means an independent, nonprofit accreditation entity that accredits health plans, case and disease management programs, pharmacy quality management programs as well as provider integration and coordination programs to increase healthcare quality.

Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within 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, Family Support Services, or positive incentives that HHSC agrees will promote wellness and improved health outcomes among Members. Value-added Services that promote wellness should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra Home Health Services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

Waste means practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services.

Article 3. General Terms

Section 3.01 Contract elements.

(a) Contract documentation.

The Contract between the Parties will consist of the **STAR Kids 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 Kids Managed Care Contract signature document**, and all amendments;

(2) **Attachment A** to the **STAR Kids Managed Care Contract document**– "**STAR Kids Contract Terms**," and all amendments;

(3) **Attachment B** to the **STAR Kids Managed Care Contract document**, RFP "Scope of Work/Performance Measures," and all amendments;

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

(5) **Attachment C** to the **STAR Kids Managed Care Contract document,** "The MCO's Proposal" and all 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

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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 7 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.

MCO must not assign any portion of its rights under or interests in the Contract or delegate any of its duties without prior written consent of HHSC. Any written request for assignment or delegation must be accompanied by written acceptance by the party to whom the assignment or delegation is made. Except where otherwise agreed in writing by HHSC, assignment or delegation will not release MCO from its obligations under the Contract. An HHSC-approved Material Subcontract will not be considered to be an assignment or delegation for purposes of this section.

(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, delegation, or transfer is made (an "Assignee") must assume all of the assigned or delegated 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

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of the Contract, and may execute an amendment to the Contract in accordance with **Article 8**.

(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) Claims Processing,

(4) Provider Network Development and Management;

(5) Benefit Administration and Prior Authorization;

(6) Service Coordination;

(7) Quality Improvement;

(8) Behavioral Health Services;

(9) Financial Functions;

(10) Reporting;

(11) Security Official as required in 45 C.F.R. § 164.308(a)(2) and Privacy Official as required in 45 C.F.R. § 164.530(a)(2);

(12) Executive Director as defined in **Section 4.03** (Executive Director); and

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(13) Medical Director as defined in **Section 4.04** (Medical Director)

(14) Special Investigative Unit (SIU)

(b) Support and Replacement of Key Personnel.

The MCO must maintain, throughout the Contract Term, the ability to supply its Key Personnel with the required resources necessary to meet Contract requirements and comply with applicable law. The MCO must ensure project continuity by timely replacement of Key Personnel, if necessary, with a sufficient number of persons having the requisite skills, experience, and other qualifications. Regardless of specific personnel changes, the MCO must maintain the overall level of expertise, experience, and skill reflected in the Key MCO Personnel job descriptions and qualifications included in the MCO's proposal.

(c) Notification of replacement of Key Personnel.

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

(d) Dedicated Staff

The MCO agrees to maintain staff dedicated exclusively to serving the STAR Kids Program in the following areas (with the exception listed in (1)(B)):

(1) Regional staff:

(A) Service Coordinators;

(B)Transition Specialists, who may be shared with STAR Health personnel serving MDCP Members; and

(C) Member Advocates;

(2) Member Hotline staff;

(3) Complaints and Appeals staff;

(4) Regional Internal Trainers; and

(5) Service Coordinator Managers

(e) Training for dedicated staff

Training curriculum must include the following components, at a minimum:

(1) vital timelines in the evaluation and delivery of services to Members; and

(2) symptoms and treatment of childhood medical and behavioral health conditions

Section 4.03 Executive Director.

(a) The MCO must employ a qualified individual to serve as the Executive Director for the STAR Kids Program. The Executive Director must be employed full-time by the MCO, be primarily dedicated to STAR Kids 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

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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 **Section 8.1.9**.

Section 4.05 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.

(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 4.06 Cooperation with HHSC and state administrative agencies.

(a) Cooperation with Other MCOs.

MCO agrees to reasonably cooperate with and work with the other MCOs in the HHSC 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, Waste, and Abuse in the HHSC programs;

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

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

Section 4.07 Conduct of MCO personnel.

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

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(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 4.08* Subcontractors and Agreements with Third Parties.**

(a) MCO remains fully responsible for the obligations, services, and functions performed by its Subcontractors to the same extent as if 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. The MCO must ensure its contracts with Subcontractors comply with all of the requirements of 42 C.F.R. § 438.230. HHSC reserves the right to require the replacement of any Subcontractor 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 Days prior to the termination date of a Material Subcontract for MIS systems operation or reporting;

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

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

HHSC may grant a written exception to these notice requirements if, in HHSC's reasonable determination, 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.

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The MCO must submit information required by HHSC for each proposed Material Subcontractor as indicated in **Section 7.3 (Transition Phase Schedule and Tasks)**. Refer to **Sections 8.1.1.2** (Additional Readiness Reviews and Monitoring Efforts) and **8.1.20** (Management Information System 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**, or any other consideration from a Subcontractor or any other third party, including 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 five Business Days after execution.

(j) Provider Contracts must include the requirement that subcontractors comply with the same requirements that the MCO must comply with in Article 7 "Governing Law and Regulations," Sections 7.02(a) and (b) of this attachment, including the **UMCM Chapter 8**.

(k) HHSC reserves the right to reject any Subcontract or require changes to any provisions that do not comply with the requirements or duties and responsibilities of this Contract or create significant barriers for HHSC in monitoring compliance with this Contract.

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

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

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

Section 4.09 HHSC's ability to contract with Subcontractors.

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

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***Section 4.10* 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 forbids the performance of any work or the maintenance of any information relating or obtained under this Agreement to occur outside of the United States.

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

(1) As used in this Section 4.10, 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) Subject to the exceptions specified in paragraph (e) of this Section 4.10, 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

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vendor proprietary software, must be performed within the United States.

(2) Subject to the exceptions specified in paragraph (e) of this Section 4.10, 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.

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(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 4.10** 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 4.10** constituting a material breach. HHSC will give the MCO notice of at least one Day before the effective date of the termination.

Section 4.11 Employment Verification

(a) MCOs must confirm the eligibility of all persons employed by the MCO to perform duties within Texas and all persons, including subcontractors, assigned by the MCO to perform work pursuant to the Contract.

(b) The MCO may not knowingly have a relationship with the following:

(1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in (b) (1) of this section.

A relationship as described in this section is as follows:

(1) A director, officer, or partner of the MCO.

(2) A subcontractor of the MCO as governed by 42 C.F.R. § 438.230.

(3) A person with ownership of five percent or more of the MCO.

(4) A person with an employment, consulting or other arrangement with the MCO for the provision of items and services that relate to the MCO's obligations under its contract with the State.

(c) The MCO must confirm the identity and determine the exclusion status, of any subcontractor of the MCO (as governed by 42 C.F.R. §438.230), as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO as defined in (b) of this section upon contract execution and through checks of federal databases that include the:

(1) U.S. Department of Health and Human Services, Office of Inspector General's List of Excluded Individuals and Entities (LEIE);

(2) System for Awards Management (SAM) [the successor to the Excluded Parties List System (EPLS)];

(3) Social Security Administration's Death Master File (SSA-DMF); and the

(4) National Plan & Provider Enumeration System.

(d) The MCO must consult the databases upon contracting and no less frequently than monthly thereafter. If the MCO finds a party that is excluded, it must promptly notify the entity and take action consistent with 42 C.F.R. § 438.610(c).

(e) The MCO must maintain records demonstrating compliance with this section in accordance with Section 9.01 below.

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Article 5. Member Eligibility, Enrollment, and Disenrollment

Section 5.01 Eligibility Determination and Disenrollment

The State or its designee will make eligibility determinations for each potential enrollee for the Program. Should a Member become ineligible for Medicaid, HHSC will disenroll the Member from the managed care plan. If an MCO becomes aware that a Member has moved outside of the MCOs service area or that a Member is no longer Medicaid-eligible, for example the Member has moved outside of the state or is deceased, the MCO must inform HHSC within 10 Business Days.

Section 5.02 Member Enrollment and Disenrollment.

(a) 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.

(b) 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 the CHIP program on the Effective Date of Coverage with the MCO will be disenrolled from the applicable Texas Medicaid or CHIP programs, effective the Day prior to the Effective Date of Coverage with the MCO.

(c) The HHSC Administrative Services Contractor will notify Members with the option to "opt-in" of their right to disenroll from the MCO and receive services through Fee-for-Service.

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

(e) In cases where a Member loses Medicaid eligibility, if Medicaid eligibility is re-instated or re-established within 6 months from the date of loss, HHSC will retroactively restore a Member's managed care enrollment to avoid a gap in coverage. In these cases, the HHSC Administrator Services Contractor will retroactively enroll the Member into the same MCO the Member was in before losing coverage.

(f) The Member or the Member's LAR can change the PCP designation at any time.

(g) The MCO will begin providing Covered Services to all Members in all contracted Service Areas 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) Enrollment changes during an Inpatient Stay

(1) The following table describes payment responsibility for Medicaid enrollment changes that occur during an Inpatient Stay, as of the Member's Effective Date of Coverage with the receiving MCO (New MCO) or FFS.

	Scenario	Hospital Facility Charge	All Other Covered Services
1	Member retroactively enrolled in MCO Program	New MCO	New MCO
2	Member prospectively moves from FFS to MCO Program	FFS	New MCO
3	Member moves between MCOs in the same Program	Former MCO	New MCO
4	Member moves between MCO Programs	Former MCO	New MCO
5	Member moves from MCO Program to FFS	Former MCO	FFS

The responsible party will pay the Hospital facility charge until the earlier of: (1) date of Discharge from the Hospital, (2) date of Transfer, or (3) loss of Medicaid eligibility.

For Members who move into STAR Health, the date of Discharge from the Hospital for mental health stays includes extended stay Days, as described in the Texas Medicaid Provider Procedures Manual.

The responsible party will pay the CDTF charge until the earlier of: (1) date of discharge from the CDTF, or (2) loss of Medicaid eligibility. The New MCO may evaluate for medical

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necessity of the CDTF stay prior to the end of the authorized services period.

(2) The following table describes payment responsibility for Medicaid enrollment changes that occur during a stay in a residential substance use disorder treatment facility or residential detoxification for substance use disorder treatment facility (collectively, CDTF), beginning on the Member's Effective Date of Coverage with the receiving MCO (New MCO).

	Scenario	CDTF Charges	All Other Covered Services
1	Member retroactively enrolled in MCO Program	New MCO	New MCO
2	Member prospectively moves from FFS to an MCO Program	FFS	New MCO
3	Member moves between MCOs in the same Program	Former MCO	New MCO
4	Member moves between MCO Programs	Former MCO	New MCO
5	Member moves from MCO Program to FFS	Former MCO	FFS

(3) If the Member is receiving services through a Texas Children's Health Insurance Program (CHIP) MCO or CHIP exclusive provider organization prior to the Effective Date of Coverage, then the STAR Kids MCO will be responsible for all facility charges and all other Covered Services on the Effective Date of Coverage with the STAR Kids MCO.

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

(d) Movement from STAR Kids to STAR or STAR+PLUS at the age of 21

An adult Member loses eligibility for the STAR Kids program effective the month after their 21st birthday and is disenrolled from STAR Kids and enrolled in a STAR or STAR+PLUS MCO.

(e)This section intentionally left blank.

(f) Effective Date of STAR Kids Eligibility:

Medicaid eligibility is effective on the date the state's eligibility system identifies an individual as eligible for SSI or SSI-related Medicaid. 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). Following standard eligibility cut-off rules, HHSC will prospectively enroll an individual into the STAR Kids Model.

(g) Enrollment Changes with custom DME and Augmentative Device Prior Authorization

The following table describes payment responsibility for Medicaid enrollment changes that occur when a prior authorization exists for custom DME, before the delivery of the product.

	Scenario	Custom DME	All Other Covered Services
1	Member moves between STAR Kids MCOs	Former MCO	New MCO
2	Member moves from FFS to STAR Kids MCO	New MCO	New MCO

(h) Enrollment Changes with Home Modification

The following table describes payment responsibility for Medicaid enrollment changes that occur during a minor home modification service provided to an MDCP STAR Kids Waiver Member, before completion of the modification.

	Scenario	Minor Home Modification	All Other Covered Services
1	Member moves between STAR Kids	Former MCO	New MCO

(i) Enrollment Changes with STAR Kids MDCP Covered Services in Excess of the Cost Limit

	Scenario	STAR Kids MDCP Services in Excess of the Cost Limit	All Other Covered Services
1	Member moves between STAR Kids MCOs	Former MCO	New MCO

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***Section 5.04* Enrollment for infants born to pregnant women in STAR Kids.**

If a newborn is born to a Medicaid-eligible mother enrolled with a STAR Kids MCO, the HHSC Administrative Service Contractor will enroll the newborn into that MCO's STAR MCO product, if one exists. All rules related to STAR newborn enrollment will apply to the newborn. If the STAR Kids MCO does not have a STAR product, but the newborn is eligible for STAR, the newborn will be enrolled in traditional Fee-for-Service Medicaid, and given the opportunity to select a STAR MCO.

Article 6. Service Levels and Performance Measurement

***Section 6.01* Performance measurement.**

Satisfactory performance of this Contract will be measured by:

1. Adherence to this Contract, including all representations and warranties;

2. Delivery of the Services and Deliverables described in the RFP;

3. Results of audits performed by HHSC or its representatives in accordance with **Article 9** (Audit and Financial Compliance);

4. Timeliness, completeness, and accuracy of required reports; and

5. 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 Coordination Staffing.**

(a) HHSC and the MCO will meet to review the adequacy of the MCO's staffing of Service Coordination functions. 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, 438, 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) Texas Human Resources Code Chapters 32 and 36;

(9) Texas Penal Code Chapter 35A (Medicaid Fraud);

(10) 1 Tex. Admin. Code Chapter 353;

(11) 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:

(12) 1 Tex. Admin. Code Chapter 354, Subchapters I and K, as applicable;

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

(14) The Health Care and Education Reconciliation Act of 2010 ("HCERA"; Public Law 111-152) 42 C.F.R. Part 455;

(15) 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");

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

(17) all administrative rules governing the Program that are adopted in the Texas Administrative Code; and

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(18) MCO must comply with state laws regarding the use of Electronic Visit Verification, including Section 12006 of the 21st Century Cures Act (Public Law 114-255) and 1 Tex. Admin. Code § 354.1177(d).

(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**, 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) The MCO is responsible for compliance with changes in federal and state law that occur during the course of the contract term. If there are any conflicts between rules promulgated by CMS, including the C.F.R., and this Contract, then the federal rule takes precedence over the Contract and the MCO must comply with the C.F.R unless CMS has waived applicability of the C.F.R. provision to Texas Medicaid via a waiver.

(e) 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.

(f) 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.

(g) 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 This Section Intentionally Left Blank

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);

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

(6) Food and Nutrition Act of 2008 (7 U.S.C. §§ 2011 *et. seq.)*; and

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

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 Members 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

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national origin. MCO also agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

(c) MCO agrees to comply with Section 1557 of the Patient Protection and Affordable Care Act;

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

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

(f) MCO must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must be delivered no more than 10 Days after receipt of a complaint. For this section's purposes, notice must be directed to:

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

Section 7.05 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 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

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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 8.1.19.2** the MCO must submit an HSP for HHSC's approval during the Transition Phase, and maintain the HSP thereafter.

(2) MCO must report to HHSC's contract manager and HUB Office monthly, in the format required by **Chapter 5.4.4.5 of the UMCM**, its use of HUB subcontractors to fulfill the subcontracting opportunities identified in the HSP.

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

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

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

Section 7.08 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 ten Days' advance written notice before implementing a substantive and material change in the **UMCM** (a change that materially and substantively alters the

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MCO's ability to fulfill its obligations under the Contract). The **UMCM**, and all subsequent versions of the chapters that make up the **UMCM**, are 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 ten Business Days. HHSC is not required to provide advance written notice of changes that are not material and substantive in nature, such as corrections of clerical errors or policy clarifications (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 and Litigation Hold

Section 9.01 Financial record retention and audit.

The State, CMS, the OIG, the Comptroller, the Attorney General and their designees have the right to audit records or documents, related to this Contract of the MCO or MCOs subcontractor for ten years from the final date of the contract period or from the date of any audit, whichever is later.

MCO agrees to maintain, and require its Subcontractors to maintain, records, books, documents, and information (collectively "records") that are adequate to document that services are provided and payments are made in accordance with the requirements of this Contract, including **UMCM Chapter 18** and applicable federal and State requirement. The records must be retained by MCO and its Subcontractors for a period of ten years after the Contract Expiration Date or until the resolution of all litigation, claims, financial management reviews, or audits pertaining to this Contract, whichever is longer.

The MCO and the MCO's subcontractor must retain, as applicable, enrollee grievance and appeal records under 42 C.F.R. § 438.16, base data in 42 C.F.R. § 438.5(c), MLR reports under 42 C.F.R. 438.8(k), and the data, information, and documentation specified under 42 C.F.R. § 438.604, §438.606, §438.608, and §438.610 for a period no less than ten years from the expiration date of this Contract or from the date of the completion of any audit, whichever is later.

Additionally, MCO agrees to, and to require its Subcontractors to, retain all records in accordance with any litigation hold that is provided to them by HHSC and actively participate in the discovery process if required to do so, at no additional charge to HHSC. Litigation holds may require the MCO or its Subcontractors to keep the records longer than other records retention schedules. The MCO will be required to retain all records subject to the litigation hold until notified by HHSC when the litigation hold ends and then other approved records retention schedule(s) may resume. If MCO or its Subcontractors fail to retain the pertinent records after receiving a litigation hold from HHSC, the MCO agrees to pay to HHSC all damages, costs, and expenses incurred by HHSC arising from such failure to retain.

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) inspection;

(5) contract administration; or

(6) the making of copies, excerpts, or transcripts.

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(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 ten 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 locations(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 ten 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:

(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 any purposes HHSC needs to perform its regulatory function or to enforce the provisions of this

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Contract and also will be for the purposes 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.

(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 Subcontractorcorrectsany 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 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**.

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

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Capitation Rate determination process. Encounter Data provided by MCO must conform to all HHSC requirements. Encounter Data containing non-compliant information, including inaccurate Member or Member identification numbers, inaccurate provider identification numbers, or diagnosis or procedures codes insufficient to adequately describe the diagnosis or medical procedure performed, will not be considered in the MCO's experience for rate-setting purposes.

(c) Information or data, including complete and accurate Encounter Data, as requested by HHSC for rate-setting purposes, must be provided to HHSC:

(1) within 30 Days of receipt of the letter from HHSC requesting the information or data; and

(2) no later than March 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

(3) 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.

(c) Case-by-case services.

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

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

(a) 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.

(b) 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

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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.

(c) 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 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.

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

(b) Graduated Experience Rebate Sharing Method.

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:

(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.

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(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** and **5** 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** and **5** in accordance with **Section 8.05**, "Modification of HHSC Uniform Managed Care Manual."

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

(i) the payment of an Experience Rebate;

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

(iii) financial incentives, including without limitation any incentives described in **Attachment B-1**, **Section 6.2**; and

(iv) financial disincentives, including without limitation the liquidated damages described in **Attachment B-3**.

See **UMCM Chapter 6**.

(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.

(1) 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)**.

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 Kids 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

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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)** 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)**. 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)**.

(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** and **5** 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)**. 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** 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)** 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** 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

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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** 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** 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 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.

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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):

• $8.00 x 70,000 = $560,000.

(2) Multiply the predetermined percent of premiums in the administrative expense rate structure (for example, 5.75%), by the actual aggregate premiums earned by the MCO during the FSR Reporting Period (for example, $6,000,000).

• 5.75% x $6,000,000 = $345,000.

(3) Multiply the predetermined pharmacy administrative expense rate (for example, $1.80), by the actual number of Member Months for the Program during the FSR Reporting Period (for example, 70,000):

• $1.80 x 70,000 = $126,000.

(4) Add the totals of items 1, 2, and 3, plus applicable premium taxes and maintenance taxes (for example, $112,000), to determine the Admin Cap:

• ($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 consolidated on the same basis as is applied to the Experience Rebate consolidation for the FSR Reporting Period. Additional details are provided in the applicable FSR Template and FSR Instructions in the **UMCM Chapter 5**. 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.

(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)**, 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**.

***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.

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

The capitation rates do not include the costs of Medicaid wrap-around services for outpatient drugs and biological products for STAR Kids Members, as described in **Attachment B-1, Section 8.2.1.1**. 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 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.

Section 10.16 Non-Risk Payments for Certain Drugs

The capitation rates do not include the costs of certain clinician-administered and pharmacy drugs as identified in **UMCM Chapter 2**. For providing these drugs to Members, HHSC will make non-risk payments to the MCO based on Encounter Data received by HHSC's Administrative Services Contractor during an encounter reporting period.

For drugs dispensed by a pharmacy, the first non-risk payment will cover pharmacy Encounter Data received from the date the drugs are added to the Medicaid and CHIP formularies through the end of that State Fiscal Quarter. Thereafter, non-risk payments will cover quarterly encounter reporting periods. HHSC will make non-risk payments within a reasonable amount of time after the encounter reporting period, generally no later than 95 Days after HHSC's Administrative Services Contractor has processed the Encounter Data. Non-risk payments will be limited to the actual amounts MCOs paid to pharmacy providers for these drugs as represented in "Net Amount Due" field (Field 281) on the National Council for Prescription Drug Programs (NCPDP) encounter transaction up to the Fee-for-Service reimbursement amount. To be eligible for reimbursement, pharmacy encounters must contain a Financial Arrangement Code "14" in the "Line of Business" field (Field 270) on the NCPDP encounter transaction.

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For clinician-administered drugs, the first non-risk payment will cover medical Encounter Data received from the date specified in **UMCM Chapter 2** through the end of that State Fiscal Quarter. Thereafter, non-risk payments will cover state fiscal quarterly encounter reporting periods. HHSC will make non-risk payments within a reasonable amount of time after the encounter reporting period, but no later than 95 Days after HHSC's Administrative Services Contractor has processed the medical Encounter Data. Non-risk payments will be limited to the actual amounts MCOs paid to medical providers for the ingredient cost of these drugs up to the Fee-for-Service reimbursement amount.

***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. § 438.4 with respect to amounts paid by HHSC under this Agreement, the parties agree that HHSC will make a retroactive adjustment to capitation to the MCO for the full amount of the HIP Fee allocable to this Agreement, as follows:

Amount and method of payment: For each HIP Fee Year, HHSC will make an adjustment to capitation to the MCO for that portion of the HIP Fee that is attributable to the Capitation Payments paid by HHSC to the MCO for risks in the applicable HIP Data Year under the Agreement, less any applicable exclusions and appropriate credit offsets. This capitation adjustment will be determined by HHSC and will include the following:

1. The amount of the HIP Fee attributable to this Agreement;
2. 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
3. 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:

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

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

This provision will survive the termination of the Agreement.

Article 11. Disclosure and Confidentiality of Information

***Section 11.01* Confidentiality.**

(a) MCO and all Subcontractors, consultants, or agents must treat all information that is obtained through performance of the Services under the Contract, including information relating to applicants or recipients of 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.

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(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 report to HHSC any and all unauthorized disclosures or uses of HHSC's Confidential Information of which it or its Subcontractor(s), consultant(s), or agent(s) is aware or has knowledge in accordance with Section 11.09 of this Contract. MCO acknowledges that any publication or disclosure of HHSC's Confidential Information to others may cause immediate and irreparable harm to HHSC and may constitute a violation of state or federal laws. If MCO, its Subcontractor(s), consultant(s), or agent(s) should publish or disclose such Confidential Information to others without authorization, HHSC will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. HHSC will have the right to recover from MCO all damages and liabilities caused by or arising from MCO's, its Subcontractors', consultants', or agents' failure to protect HHSC's Confidential Information. MCO will defend with counsel approved by HHSC, indemnify and hold harmless HHSC from all damages, costs, liabilities, and expenses (including without limitation reasonable attorneys' fees and costs) caused by or arising from MCO's or its Subcontractors', consultants', or agents' failure to protect HHSC's Confidential Information. HHSC will not unreasonably withhold approval of counsel selected by the MCO.

(b) MCO will require its Subcontractor(s), consultant(s), and agent(s) to comply with the terms of this provision.

Section 11.03 Member Records

(a) MCO must comply with the requirements of state and federal laws, including the HIPAA requirements set forth in **Section 7.06** (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 Member records maintained by participating Network Providers.

Section 11.04 Requests for public information.

(a) HHSC agrees that it will promptly notify MCO of a request for disclosure of information filed in accordance with the Texas Public Information Act, 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

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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 and Privacy Requirements

a) Compliance.

The MCO agrees to comply with all applicable state and federal security and privacy requirements governing the creation, collection, access, use, storage, maintenance, disclosure, safeguarding and destruction of Texas HHS data including Agency Sensitive Information and Confidential Information.

(b) Protection.

The MCO will implement, maintain, document, and use appropriate administrative, technical and physical security measures to protect all Texas HHS Information Resources

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and data, including Agency Sensitive Information and Confidential Information.

(c) Reviews.

The MCO must comply with security and privacy controls compliance assessments, updates, and monitoring by Texas HHS as required by state and federal law or by Texas HHS's discretion. The security and privacy controls will be based on the National Institute of Standards and Technology (NIST) Special Publication 800-53 from the applicable state and federal requirements. The Texas HHS process is described in the Information Security Risk Assessment and Monitoring Procedures (IS-RAMP) that is published on the Texas HHS Internet website.

(d) Workforce.

The MCO must ensure that their workforce, including Subcontractors, who are granted specified Texas HHS authorized access to internal Texas HHS Information Resources, comply with the Texas HHS Acceptable Use Policy (AUP) and sign the Acceptable Use Agreement (AUA) prior to access, in accordance with 1 Tex. Admin. Code Chapter 202.22.

(e) Information Security and Privacy Officials.

The MCO must designate an Information Security Official and a Privacy Official who will be responsible for managing its security and privacy programs and Texas HHS requirements. The MCO will provide Texas HHS the names, phone numbers and email addresses of these officials. The Information Security Official and Privacy Official roles may be performed by the same individual.

(f) Program.

The MCO must establish an information security and privacy program and maintain information security and privacy policies and standards that are updated at least annually with respect to the management or handling of Texas HHS Information Resources or data. The program will:

(1) comply with all applicable legal and regulatory requirements for Texas HHS data protection;

(2) comply with Texas HHS Information Security Office's published or provided policies, standards, and controls (IS-Policy, IS-AUP, AUA, IS-Web and Mobile Minimum Security Standard, IS-RAMP, ISSG/IS-Controls);

(3) ensure the integrity, availability, and confidentiality by implementing technical, administrative and physical safeguards for Texas HHS Agency Sensitive Information and Confidential Information;

(4) protect against any anticipated threats or hazards to the security or integrity of such information;

(5) protect and monitor against unauthorized access to or use of such information that could result in harm to the person that is the subject of such information both logically and physically;

(6) routinely review, monitor, and remove unnecessary accounts that have access to Texas HHS Agency Sensitive Information or Confidential Information;

(7) coordinate with Texas HHS to determine the Texas HHS data types accessed, transmitted, stored, or maintained by the system and identify applicable state, federal and regulatory requirements;

(9) encrypt the Texas HHS Agency Sensitive Information and Confidential Information on end-user devices, on portable devices, in transit over public networks, and while stored in the cloud;

(10) ensure FIPS 140-2 validated encryption will be used for federal protected data and access to Texas HHS Confidential and Agency Sensitive Information will be controlled and monitored;

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

(12) prohibit the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside of the United States;

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

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

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

(16) ensure security will be integrated into all phases including planning, development, and implementation and will include security testing and remediation of security vulnerabilities prior to production especially for online websites, applications and mobile applications;

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

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

(20) develop and implement methods that ensure security for all components, including:

(i) environmental security;

(ii) physical site security;

(iii) computer hardware security;

(iv) computer software security;

(v) application security;

(vi) data access and storage;

(vii) client/user security;

(viii) secure processes and procedures;

(ix) telecommunications and network security; and

(x) general support systems (GSS) security;

Section 11.09 MCO's Incident and Breach Notice, Reporting and Mitigation

The MCO's obligation begins at discovery of any unauthorized disclosure of Confidential Information or any privacy or security incident that may compromise Confidential Information (collectively "Incident") and continues until all effects of the Incident are resolved to HHSC's satisfaction, hereafter referred to as the "Incident Response Period".

For each Incident, the MCO must perform a risk analysis in accordance with HIPAA requirements to determine the probability of compromise of the Confidential Information.

Section 11.09.1 Notification to HHSC.

(a) The MCO must notify HHSC within the timeframes set forth in Section (c) below unless HHSC has agreed in writing to an alternate timeframe for notification.

(b) The MCO must require that its Subcontractors and Providers take the necessary steps to assure that the MCO can comply with all of the following Incident notice requirements.

(c) Incident Notice:

1. Initial Notice.

Within 24 hours of discovery of an Incident that the MCO's risk analysis has determined has more than a low probability of compromise, the MCO must preliminarily report on the occurrence of an Incident to the HHSC Privacy Officer via email at: privacy@HHSC.state.tx.us using the Potential Privacy/Security Incident Form which is available on the HHSC website. This initial notice must, at a minimum, contain (1) all information reasonably available to MCO about the Incident, (2) confirmation that the MCO has met any applicable federal Breach notification requirements and (3) a single point of contact for the MCOs for HHSC communications both during and outside of business hours during the Incident Response Period.

2. Formal Notice.

No later than three Business Days after discovery of an Incident that the MCO's risk analysis has determined has more than a low probability of compromise, or when the MCO should have reasonably discovered such Incident, the MCO must provide written formal notification to HHSC using the Potential Privacy/Security Incident Form which is available on the HHSC website. The formal notification must include all available information about the Incident, and the MCO's investigation of the Incident.

3. Annual Notice

For an Incident that the MCO's risk analysis has determined has a low probability of compromise or only involves unauthorized disclosure of a single individual's Confidential Information to a single unauthorized recipient, the MCO must provide notice to HHSC of such Incident no later than 60 Days after the end of the calendar year in which the Incident occurred.

No later than 60 Days after the end of each calendar year, MCO's must provide the HHS Privacy Office with a comprehensive list of all incidents involving HHSC confidential information that were reported to the US Office for Civil Rights in accordance with the obligations under HIPAA.

Section 11.09.2 MCO Investigation, Response and Mitigation.

The MCO must fully investigate and mitigate, to the extent practicable and as soon as possible or as indicated below, any Incident. At a minimum, the MCO will:

1. Immediately commence a full and complete investigation;
2. Cooperate fully with HHSC in its response to the Incident;
3. Complete or participate in an initial risk analysis;

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4. Provide a final risk analysis;
5. Submit proposed corrective actions to HHSC for review and approval;
6. Commit necessary and appropriate staff and resources to expeditiously respond;
7. Report to HHSC as required by HHSC and all applicable federal and state laws for Incident response purposes and for purposes of HHSC's compliance with report and notification requirements, to the satisfaction of HHSC;
8. Fully cooperate with HHSC to respond to inquiries and/or proceedings by federal and state authorities about the Incident;
9. Fully cooperate with HHSC's efforts to seek appropriate injunctive relief or to otherwise prevent or curtail such Incidents;
10. Recover, or assure destruction of, any Confidential Information impermissibly disclosed during or as a result of the Incident; and
11. Provide HHSC with a final report on the Incident explaining the Incident's resolution.

Section 11.09.3 Breach Notification to Individuals and Reporting to Authorities.

a. MCO must provide Breach notification, in accordance with 45 C.F.R. §§164.400-414.

b. The MCO must assure that the time, manner and content of any Breach notification required by this Section meets all federal and state regulatory requirements. Breach notice letters must be in the MCO's name and on the MCO's letterhead and must contain contact information to obtain additional information, including the name and title of the MCO's representative, an email address and a toll-free telephone number.

c. The MCO must provide HHSC with copies of all distributed communications related to the Breach notification at the same time the MCO distributes the communications.

The MCO must demonstrate to the satisfaction of HHSC that any Breach notification required by applicable law was timely made. If there are delays outside of the MCO's control, the MCO must provide written documentation to HHSC of the reasons for the delay.

Article 12. Remedies & Disputes

Section 12.01 Understanding and expectations.

The remedies described in this Section are directed to MCO's timely and responsive performance of the Services and production of Deliverables, and the creation of a flexible and responsive relationship between the Parties. The MCO is expected to meet or exceed all HHSC objectives and standards set forth in the Contract. All areas of responsibility and all Contract requirements will be subject to performance evaluation by HHSC. Performance reviews may be conducted at the discretion of HHSC at any time and may relate to any responsibility and/or requirement. Any and all responsibilities and/or requirements not fulfilled may be subject to remedies set forth in the Contract.

Section 12.02 Tailored remedies.

(a) Understanding of the Parties.

MCO agrees and understands that HHSC may pursue tailored contractual remedies for noncompliance with the Contract. At any time and at its discretion, HHSC may impose or pursue one or more remedies for each item of noncompliance and will determine remedies on a case-by-case basis. HHSC's pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that HHSC may have at law or equity.

(b) Notice and opportunity to cure for non-material breach.

(1) HHSC will notify MCO in writing of specific areas of MCO performance that fail to meet performance expectations, standards, or schedules set forth in the Contract, but that, in the determination of HHSC, do not result in a material deficiency or delay in the implementation or operation of the Services.

(2) MCO will, within five (5) Business Days (or another date approved by HHSC) of receipt of written notice of a non-material deficiency, provide the HHSC Project Manager a written response that:

(i) Explains the reasons for the deficiency, MCO's plan to address or cure the deficiency, and the date and time by which the deficiency will be cured; or

(ii) 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

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other appropriate remedy HHSC may have at law or equity.

(c) Corrective Action Plan.

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

(2) The Corrective Action Plan must provide:

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

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

(iii) A specific proposal to cure or resolve the deficiency.

(3) The Corrective Action Plan must be submitted by the deadline set forth in HHSC's request for a Corrective Action Plan. The Corrective Action Plan is subject to approval by HHSC, which will not unreasonably be withheld.

(4) HHSC will notify MCO in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts MCO's proposed Corrective Action Plan, HHSC may:

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

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

(iii) Require additional or different corrective action(s).

Notwithstanding the submission and acceptance of a Corrective Action Plan, MCO remains responsible for achieving all written performance criteria.

(5) HHSC's acceptance of a Corrective Action Plan under this Section will not:

(i) Excuse MCO's prior substandard performance;

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

(iii) Prohibit HHSC from assessing additional tailored remedies or pursuing other appropriate remedies for continued substandard performance.

(d) Administrative remedies.

(1) At its discretion, HHSC may impose one or more of the following remedies for each item of material noncompliance and will determine the scope and severity of the remedy on a case-by-case basis:

(i) Assess liquidated damages in accordance with the "Deliverables/Liquidated Damages Matrix;"

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

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

(iv) Decline to renew or extend the Contract;

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

(vi) Initiate disenrollment of a Member or Members;

(vii) Suspend enrollment of Members;

(viii) Withhold or recoup payment to MCO;

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

(x) Terminate the Contract in accordance with **Section 12.03**, ("Termination by HHSC").

(2) For purposes of the Contract, an item of material noncompliance means a specific action of MCO that:

(i) Violates a material provision of the Contract;

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

(iii) Represents a failure of MCO to be reasonably responsive to a reasonable request of HHSC relating to the Services for information, assistance, or support within the timeframe specified by HHSC.

(3) HHSC will provide notice to MCO of the imposition of an administrative remedy in accordance with this Section, with the exception of accelerated monitoring, which may be unannounced. HHSC may require MCO to file a written response in accordance with this Section.

(4) The Parties agree that a State or Federal statute, rule, regulation, or Federal guideline will prevail over the provisions of this Section unless the statute, rule, regulation, or guidelines can be read together with this Section to give effect to both.

(e) Damages.

(1) HHSC will be entitled to actual and consequential damages resulting from the MCO's failure to comply with any of the terms of the Contract. In some cases, the actual damage to HHSC or State of Texas as a result of MCO's failure to meet any aspect of the responsibilities of the Contract and/or to meet specific

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performance standards set forth in the Contract are difficult or impossible to determine with precise accuracy. Therefore, liquidated damages will be assessed in writing against and paid by the MCO in accordance with and for failure to meet any aspect of the responsibilities of the Contract and/or to meet the specific performance standards identified by the HHSC "Deliverables/Liquidated Damages Matrix." Liquidated damages will be assessed if HHSC determines such failure is the fault of the MCO, including the MCO's Subcontractors and/or consultants, and is not materially caused or contributed to by HHSC or its agents. If at any time, HHSC determines the MCO has not met any aspect of the responsibilities of the Contract and/or the specific performance standards due to mitigating circumstances, HHSC reserves the right to waive all or part of the liquidated damages. All such waivers must be in writing, contain the reasons for the waiver, and be signed by the appropriate executive of HHSC.

(2) The liquidated damages prescribed in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HHSC's projected financial loss and damage resulting from the MCO's nonperformance, including financial loss as a result of project delays. Accordingly, in the event MCO fails to perform in accordance with the Contract, HHSC may assess liquidated damages as provided in this Section.

(3) If MCO fails to perform any of the Services described in the Contract, HHSC may assess liquidated damages for each occurrence of a liquidated damages event, to the extent consistent with HHSC's tailored approach to remedies and Texas law.

(4) HHSC may elect to collect liquidated damages:

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

(ii) By deduction of amounts assessed as liquidated damages as set-off against payments then due to MCO or that become due at any time after assessment of the liquidated damages. HHSC will make deductions until the full amount payable by the MCO is received by HHSC.

(f) Equitable Remedies.

(1) MCO acknowledges that, if MCO breaches (or attempts or threatens to breach) its material obligation under the Contract, HHSC may be irreparably harmed. In such a circumstance, HHSC may proceed directly to court to pursue equitable remedies.

(2) If a court of competent jurisdiction finds that MCO breached, or attempted or threatened to breach any such obligations, MCO agrees that without any additional findings of irreparable injury or other conditions to injunctive relief, it will not oppose the entry of an appropriate order compelling performance by MCO and restraining it from any further breaches, or attempted or threatened breaches.

(g) Suspension of Contract.

(1) HHSC may suspend performance of all or any part of the Contract if:

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

(ii) HHSC has reason to believe that MCO has committed, assisted in the commission of Fraud, Waste, or Abuse, malfeasance, misfeasance, or nonfeasance by any party concerning the Contract;

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

(iv) HHSC determines that suspension of the Contract in whole or in part is in the best interests of the State of Texas or the HHSC Programs.

(2) HHSC will notify MCO in writing of its intention to suspend the Contract in whole or in part. Such notice will:

(i) Be delivered in writing to MCO;

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

(iii) Unless HHSC is suspending the contract for convenience, request a Corrective Action Plan from MCO or describe actions that MCO may take to avoid the contemplated suspension of the Contract.

***Section 12.03* Termination by HHSC.**

Prior to completion of the Contract Period, all or a part of the Contract may be terminated for any of the following reasons:

(a) Termination in the best interest of HHSC.

HHSC may terminate the Contract without cause at any time when, in its sole discretion, HHSC determines that termination is in the best interests of the State of Texas. HHSC will provide reasonable advance written notice of the termination, as it deems appropriate under the circumstances. The termination will be effective on the date specified in HHSC's notice of termination.

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(b) Termination for cause.

Except as otherwise provided by the U.S. Bankruptcy Code, or any successor law, HHSC may terminate the Contract, in whole or in part, upon the following conditions:

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

HHSC may terminate the Contract at any time if MCO:

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

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

(iii) Consents to the appointment of a receiver, trustee, or liquidator of MCO or of all or any part of its property.

(2) Failure to adhere to laws, rules, ordinances, or orders.

HHSC may terminate the Contract if a court of competent jurisdiction finds MCO failed to adhere to any laws, ordinances, rules, regulations, or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of MCO's duties under the Contract. HHSC will provide at least 30 Days' advance written notice of such termination.

(3) Breach of confidentiality.

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

(4) Failure to maintain adequate personnel or resources.

HHSC may terminate the Contract if, after providing notice and an opportunity to correct, HHSC determines that MCO has failed to supply personnel or resources and such failure results in MCO's inability to fulfill its duties under the Contract. HHSC will provide at least 30 Days' advance written notice of such termination.

(5) Termination for gifts and gratuities.

(i) HHSC may terminate the Contract at any time following the determination by a competent judicial or quasi-judicial authority and MCO's exhaustion of all legal remedies that MCO, its employees, agents or representatives have either offered or given anything of value to an officer or employee of HHSC or the State of Texas in violation of state law.

(ii) MCO must include a similar provision in each of its Subcontracts and shall enforce this provision against a Subcontractor who has offered or given anything of value to any of the persons or entities described in this Section, whether or not the offer or gift was in the MCO's behalf.

(iii) Termination of a Subcontract by MCO pursuant to this provision will not be a cause for termination of the Contract unless:

(a) MCO fails to replace such terminated Subcontractor within a reasonable time; and

(b) Such failure constitutes cause, as described in this **Subsection 12.03(b)**.

(iv) For purposes of this Section, a "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to holders of public office or candidates for public office that are paid and reported in accordance with State and/or Federal law.

(6) Termination for non-appropriation of funds.

Notwithstanding any other provision of the Contract, if funds for the continued fulfillment of the Contract by HHSC are at any time not forthcoming or are insufficient, through failure of any entity to appropriate funds or otherwise, then HHSC will have the right to terminate the Contract at no additional cost and with no penalty whatsoever by giving prior written notice documenting the lack of funding. HHSC will provide at least 30 Days' advance written notice of such termination. HHSC will use reasonable efforts to ensure appropriated funds are available.

(7) Judgment and execution.

(i) HHSC may terminate the Contract at any time if judgment for the payment of money in excess of $500,000.00 that is not covered by insurance, is rendered by any court or governmental body against MCO, and MCO does not:

(a) Discharge the judgment or provide for its discharge in accordance with the terms of the judgment;

(b) Procure a stay of execution of the judgment within 30 Days from the date of entry thereof; or

(c) Perfect an appeal of such judgment and cause the execution of such judgment to be stayed during the appeal, providing such financial reserves as may be required under

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generally accepted accounting principles.

(ii) If a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the property of MCO, and such writ or warrant of attachment or any similar process is not released or bonded within 30 Days after its entry, HHSC may terminate the Contract in accordance with this Section.

(8) Termination for MCO's material breach of the Contract.

HHSC will have the right to terminate the Contract in whole or in part if HHSC determines, at its sole discretion, that MCO has materially breached the Contract. HHSC will provide at least 30 Days' advance written notice of such termination.

(9) Termination for Criminal Conviction

HHSC will have the right to terminate the Contract in whole or in part, or require the replacement of a Material Subcontractor, if the MCO or a Material Subcontractor is convicted of a criminal offense in a state or federal court:

(i) Related to the delivery of an item or service;

(ii) Related to the neglect or abuse of Members in connection with the delivery of an item or service;

(iii) Consisting of a felony related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct, or

(iv) Resulting in a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

(c) Pre-termination Process

The following process will apply when HHSC terminates the Contract for any reason set forth in Section 12.03(b), "Termination for Cause," other than Subpart 6, "Termination for Non-appropriation of Funds."

In accordance with 42 C.F.R. §438.710, before terminating the Contract, HHSC will provide the MCO with 30 Days advance written notice of its intent to terminate. The pre-termination notice will include the following information; the reason for the proposed termination; the proposed effective date of the termination; and the time and place of the pre-termination hearing. During the hearing, the MCO may present written information explaining why HHSC should not terminate the Contract. After the pre-termination hearing, the State Medicaid Director will provide the MCO with a written notice of HHSC's final affirming or reversing the proposed termination of the Contract and the effective date of termination if applicable.

HHSC's final decision to terminate the Contract is binding and is not subject to review by the State Office of Administrative Hearings under Chapter 2260, Texas Government Code.

The pre-termination process described herein will not limit or otherwise reduce the MCO's rights and the Parties' responsibilities under Section 12.13, "Dispute Resolution."

***Section 12.04* Termination by MCO.**

(a) Failure to pay.

MCO may terminate the Contract if HHSC fails to pay the MCO undisputed charges when due as required under the Contract. Retaining premium, recoupment, sanctions, or penalties that are allowed under the Contract or that result from the MCO's failure to perform or the MCO's default under the terms of the Contract is not cause for termination. Termination for failure to pay does not release HHSC from the obligation to pay undisputed charges for services provided prior to the termination date.

If HHSC fails to pay undisputed charges when due, then the MCO may submit a notice of intent to terminate for failure to pay in accordance with the requirements of **Section 12.04(e)**. If HHSC pays all undisputed amounts then due within 30 Days after receiving the notice of intent to terminate, the MCO cannot proceed with termination of the Contract under this Article.

(b) Change to HHSC Uniform Managed Care Manual.

MCO may terminate this agreement if the Parties are unable to resolve a dispute concerning a material and substantive change to the **UMCM,** a change that materially and substantively alters the MCO's ability to fulfill its obligations under the Contract. MCO must submit a notice of intent to terminate due to a material and substantive change in the **UMCM** no later than 30 Days after the effective date of the policy change. HHSC will not enforce the policy change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(c) Change to Capitation Rate.

If HHSC proposes an initial Capitation Rate or a modification to the Capitation Rate that is unacceptable to the MCO, the MCO may terminate the Contract. MCO must submit a written notice of intent to terminate due to a change in the Capitation

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Rate no later than 30 Days after HHSC's notice of the proposed change. HHSC will not enforce the rate change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(d) Expiration of Contract.

If MCO rejects, or intends to reject, an amendment extending the term of the Contract, MCO is subject to the requirements of Section 12.04(e).

(e) Notice of intent to terminate or to allow the Contract to expire.

If the MCO intends to terminate the Contract pursuant to this Section or allow the Contract to expire, MCO must give HHSC at least 90 Days' written notice of intent to terminate or intent to allow the Contract to expire. The termination date will be calculated as the last Day of the month following 90 Days from the date the notice of intent is received by HHSC.

In the event the MCO fails to comply with this notice requirement, the Contract shall be extended under the same terms, conditions, and rates, for the period of time necessary to satisfy this notice requirement.

Section 12.05 Termination by mutual agreement.

The Contract may be terminated by mutual written agreement of the Parties.

Section 12.06 Effective date of termination.

Except as otherwise provided in the Contract, termination will be effective as of the date specified in the notice of termination. The Turnover obligations of the MCO will continue to apply after the effective date of the Contract termination.

Section 12.07 Extension of termination effective date.

The Parties may extend the effective date of termination one or more times by mutual written agreement.

Section 12.08 Payment and other provisions at Contract termination.

(a) In the event of termination pursuant to this Article, HHSC will pay the Capitation Payment for Services and Deliverables rendered through the effective date of termination. All pertinent provisions of the Contract will form the basis of settlement.

(b) MCO must provide HHSC all reasonable access to records, facilities, and documentation as is required to efficiently and expeditiously close out the Services and Deliverables provided under 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 the Contract in response to the imposition of a remedy under this Article. Any modifications under this Section must be reasonable, limited to the matters causing the exercise of a remedy, in writing, and executed in accordance with **Article 8**. MCO must negotiate such proposed modifications in good faith.

Section 12.10 Turnover assistance.

Upon receipt of notice of termination of the Contract by HHSC or by the MCO, MCO will provide any turnover assistance reasonably necessary to enable HHSC or its designee to effectively close out the Contract and move the work to another vendor or to perform the work itself.

During the Turnover Phase, MCO must continue performing under the Contract, including rendering all contracted Services, until such time HHSC determines that the MCO has completed all requirements in accordance with the Turnover Plan.

Section 12.11 Rights upon termination or expiration of Contract.

In the event that the Contract is terminated for any reason, or upon its expiration, HHSC will, at HHSC's discretion, retain ownership of any and all associated work products, Deliverables, or documentation in whatever form that they exist.

Section 12.12 MCO responsibility for associated costs.

If HHSC terminates the Contract for Cause, the MCO will be responsible to HHSC for all reasonable costs incurred by HHSC, the State of Texas, or any of its administrative agencies to replace the MCO. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to MCO's failure to perform any Service in accordance with the terms of the Contract.

Section 12.13 Dispute resolution.

(a) General agreement of the Parties.

The Parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the Parties employ all reasonable and informal means to resolve any dispute under the Contract. The Parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b) Duty to negotiate in good faith.

Any dispute that in the judgment of any Party to the 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

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effort to resolve such dispute and the Parties shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by Contract between the Parties shall be reduced to writing and delivered to all Parties within 10 Business Days.

(c) Claims for breach of Contract.

(1) General requirement.

MCO's claim for breach of the Contract will be resolved in accordance with the dispute resolution process established by HHSC in accordance with Chapter 2260, Texas Government Code.

(2) Negotiation of claims.

The Parties expressly agree that the MCO's claim for breach of the Contract that the Parties cannot resolve in the ordinary course of business or through the use of all reasonable and informal means will be submitted to the negotiation process provided in Chapter 2260, Subchapter B, Texas Government Code.

(i) To initiate the process, MCO must submit written notice to HHSC that specifically states that MCO invokes the provisions of Chapter 2260, Subchapter B, Texas Government Code. The notice must comply with the requirements of Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(ii) The Parties expressly agree that the MCO's compliance with Chapter 2260, Subchapter B, Texas Government Code, will be a condition precedent to the filing of a contested case proceeding under Chapter 2260, Subchapter C of the Texas Government Code.

(3) Contested case proceedings.

The contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be MCO's sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by HHSC if the Parties are unable to resolve their disputes under Subsection (c)(2) of this Section.

The Parties expressly agree that compliance with the contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be a condition precedent to seeking consent to sue from the Texas Legislature under Chapter 107, Civil Practices & Remedies Code. Neither the execution of the Contract by HHSC nor any other conduct of any representative of HHSC relating to the Contract shall be considered a waiver of HHSC's sovereign immunity to suit.

(4) HHSC rules.

The submission, processing, and resolution of MCO's claim is governed by the rules adopted by HHSC pursuant to Chapter 2260, Texas Government Code found at Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(5) MCO's duty to perform.

Neither the occurrence of an event constituting an alleged breach of contract nor the pending status of any claim for breach of contract is grounds for the suspension of performance, in whole or in part, by MCO of any duty or obligation with respect to the performance of the 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 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 the Contract.

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.

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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, at any time after Contract Execution, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, at any time during the procurement process or in connection with the procurement process except as allowed under relevant state and federal law.

(c) Continuing duty to disclose.

(1) MCO agrees that, if after the Effective Date, MCO discovers or is made aware of an organizational conflict of interest, MCO will immediately and fully disclose such interest in writing to the HHSC project manager. In addition, MCO must promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by MCO or by HHSC as a potential conflict. HHSC reserves the right to make a final determination regarding the existence of conflicts of interest, and MCO agrees to abide by HHSC's decision.

(2) The disclosure will include a description of the action(s) that MCO has taken or proposes to take to avoid or mitigate such conflicts.

(d) Remedy.

If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the Contract 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 Texas Government 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.

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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 Texas Insurance 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, including those set forth in 42 C.F.R. § 438.116, for basic-service health maintenance organizations, including all reserve requirements, net worth standards, debt-to-equity ratios, or other debt limitations. Provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI. In the event the MCO fails to maintain such compliance, HHSC, without limiting any other rights it may have by law or under the Contract, may terminate the Contract.

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

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

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

(2) payments to unaffiliated 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.

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(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 Texas Government Code § 531.0162. This includes providing technological solutions that meet federal accessibility standards for persons with disabilities, as applicable.

Section 14.09 Electronic 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 Members 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 1 Tex. Admin. Code Chapter 213.

"Web Site Accessibility Standards/ Specifications" means standards contained in 1 Tex. Admin. Code Chapter 206.

"Product" means information resources technology that is, or is related to, EIR.

(c) Accessibility Requirements.

Under Tex. Government Code Chapter 2054, Subchapter M, and implementing rules of the Texas Department of Information Resources, HHSC must procure Products that comply with the Accessibility Standards when 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 (i) the review, testing (including acceptance testing), evaluation or monitoring of any Product, nor (ii) 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.

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(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 Member 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 Members 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. Government 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. Government Code Chapter 2054, Subchapter M, and rules of the Department of Information Resources.

(2) In the event of a breach of MCO's representations and warranties, MCO will be liable for direct, consequential, indirect, special, 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.

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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.

(b) Deliverables.

The Parties agree that any Deliverable, including without limitation the Custom Software, will be the exclusive property of HHSC.

(c) Ownership rights.

(1) HHSC will own all right, title, and interest in and to its Confidential Information, and the Deliverables provided by the MCO, including 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

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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

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this provision is not required to obtain coverage on behalf of the Network Provider.

(C) The Professional Liability Insurance requirements described in **Section 17.01(b)(1)** do not apply to Nursing Facility Providers.

(D) An MCO may waive the Professional Liability Insurance requirement described in **Section 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 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 or the date the contract terminates. MCO must obtain and maintain the annual performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee,

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securing MCO's faithful performance of the terms of this Contract. The performance bond must comply with Tex. Ins. Code Chapter 843. 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 Chapter 843 of the Texas Insurance Code. The MCO must promptly provide HHSC with copies of the bond and any amendments or renewals.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	October 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	1.1	March 1, 2016	Contract amendment did not revise Attachment B-1 Sections 1-5 "Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria."
Revision	1.2	November 1, 2016	Section 1.7 is modified to change "social security income" to "supplemental security income" Section 1.8 is modified to change "social security income" to "supplemental security income"
Revision	1.3	March 1, 2017	Contract amendment did not revise Attachment B-1 Sections 1-5 "Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria."
Revision	1.4	June 1, 2017	Contract amendment did not revise Attachment B-1 Sections 1-5 "Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria."
Revision	1.5	September 1, 2017	Contract amendment did not revise Attachment B-1 Sections 1-5 "Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria."
Revision	1.6	March 1, 2018	Contract amendment did not revise Attachment B-1 Sections 1-5 "Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria."
Revision	1.7	September 1, 2018	Contract amendment did not revise Attachment B-1 Sections 1-5 "Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria."
Revision	1.8	January 1, 2019	Contract amendment did not revise Attachment B-1 Sections 1-5 "Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria."

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Revision	1.9	March 1, 2019	Contract amendment did not revise Attachment B-1 Sections 1-5 “Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria.”
Revision	1.10	September 1, 2019	Contract amendment did not revise Attachment B-1 Sections 1-5 “Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria.”
Revision	1.11	March 1, 2020	Contract amendment did not revise Attachment B-1 Sections 1-5 “Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria.”
Revision	1.12	September 1, 2020	Contract amendment did not revise Attachment B-1 Sections 1-5 “Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria.”
Revision	1.13	March 1, 2021	Contract amendment did not revise Attachment B-1 Sections 1-5 “Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria.”

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions

[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

[3] Brief description of the changes to the document made in the revision.

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1 Introduction

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) # 529-13-0071 for establishment of the STAR Kids Medicaid managed care program.

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 North Lamar Blvd.
Austin, Texas 78756
Phone: (512) 206-5468
Fax: (512) 206-5552
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. The Respondent may not discuss cost information contained in a proposal with the HHSC point-of-contact or any other staff under any circumstances. Failure to comply with these requirements 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.

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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.

Procurement Schedule	
Draft RFP Release Date	March 19, 2014
Draft RFP Respondent Comments Due	April 18, 2014
RFP Release Date	July 18, 2014
Vendor Conference	July 31, 2014
Respondent Questions Due	August 5, 2014
Letters Claiming Mandatory Contract Status Due	September 2, 2014
HHSC Posts Responses to Respondent Questions	September 16, 2014
Proposals Due	October 30, 2014
Deadline for Proposal Withdrawal	October 30, 2014
Tentative Award Announcement	To be Announced
Anticipated Contract Effective Date	September 1, 2015
Operational Start Date	September 1, 2016

1.4 Purpose

The purpose of this procurement is to contract with multiple Managed Care Organizations (MCOs) to establish the STAR Kids Medicaid managed care program for children and young adults with disabilities.

1.5 Mission Statement

HHSC's mission is to provide individually appropriate Medicaid managed care services to children and young adults with disabilities to enable them to live and thrive in a setting that maximizes their health, safety, and overall well-being. To achieve HHSC's mission, the STAR Kids program is established to:

1. Coordinate care across service arrays;
2. Improve quality, continuity, and customization of care;
3. Improve access to care and provide person-centered Health Homes;
4. Improve ease of program participation for Members, MCOs, and Providers;
5. Improve Provider collaboration and integration of different services;
6. Improve Member outcomes to the greatest extent achievable;
7. Prepare young adults for the transition to adulthood;
8. Foster program innovation; and
9. Achieve cost efficiency and cost containment.

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1.6 Mission Objectives

To accomplish HHSC's mission, HHSC will prioritize desired outcomes and benefits for the STAR Kids population and will focus its monitoring efforts on the MCO's 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 Kids 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. HHSC will especially focus on Members' access to a Health Home, qualified Specialists, and if appropriate, Behavioral Health Services and Community-Based Services.

1.6.2 Continuity of Care

The MCO must ensure minimal impact to established Member/Provider relationships, existing treatment protocols, and ongoing care plans. Transition to the managed care model must be as seamless as possible for Members and their Providers.

1.6.3 Health Home

HHSC is committed to providing a consistent and integrated source of healthcare for the STAR Kids population through a person-centered Health Home. The MCO must develop and uphold the Health Home model through the management and coordination of Healthcare Services.

1.6.4 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 working with children and young adults with Intellectual and Developmental Disabilities.

1.6.5 Service Coordination

The integration and coordination of all Covered Services are essential features of STAR Kids. The MCO must demonstrate sufficient levels of qualified and competent personnel devoted to Service Coordination to meet the everyday and unique needs of STAR Kids Members, including Dual Eligibles.

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1.6.6 Timeliness of Initial Texas Health Steps Visit

STAR Kids MCOs must ensure timely, age-appropriate medical check-ups with Providers in accordance with the Texas Health Steps periodicity schedule.

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.

1.6.8 Quality

HHSC is accountable to Texans for ensuring that all Members receive quality services in the most efficient and effective manner possible. Accordingly, the MCO will be responsible for providing high quality services in a professional, ethical, and cost-effective manner. HHSC expects the MCO to implement new and creative approaches that ensure quality services, cost-effective service delivery, and careful stewardship of public resources.

1.6.9 Delivery of healthcare to diverse populations

Member populations in Texas are diverse. Healthcare Services must be delivered without regard to racial or ethnic factors. HHSC expects the MCO to implement intervention strategies to avoid disparities in the delivery of Healthcare Services to diverse populations and provide services in a culturally competent manner as described in **Section 8.1.5.8**.

1.6.10 Disease management requirements

The MCO must provide a comprehensive disease management program or coverage for Disease Management (DM) services for asthma, diabetes, and other chronic diseases identified by the MCO, based upon an evaluation of the prevalence of the diseases within the MCO's membership. Please refer to the **Uniform Managed Care Manual (UMCM) Chapter 9**.1 "Disease Management," for additional DM requirements.

1.6.11 Individualized Service Planning

Service Coordination strategies and services received through the MCO must be tailored to the unique needs of each Member. Through the STAR Kids Assessment Process and other strategies designed by the MCO to identify Member needs and preferences, the MCO must design and adhere to an Individual Service Plan (ISP) that is thoughtfully crafted, regularly monitored, and altered appropriately over time.

1.7 STAR Kids Overview

Senate Bill 7[1] directs the Health and Human Services Commission to establish a mandatory, capitated STAR Kids managed care program tailored to provide Medicaid benefits to children and young adults with disabilities. Through the Texas Healthcare Transformation and Quality

[1] 83rd Legislature, Regular Session, 2013

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Improvement Program (THTQIP) 1115 Waiver, STAR Kids will serve children and young adults under the age of 21 who receive supplemental security income (SSI) and SSI-related Medicaid. For eligible Members, STAR Kids will also provide the full service array for the Medically Dependent Children Program (MDCP).

Children and young adults who qualify for STAR Kids have diverse strengths and challenges. The service and support needs for the STAR Kids population varies based on broad differences in diagnoses, conditions, prior treatments, development, environment, age, family dynamics, and access to care. By working with Members and their families, STAR Kids MCOs will customize and coordinate acute, behavioral, and long-term services and supports (LTSS) through an individualized planning and service design process. Through comprehensive service coordination, STAR Kids Members will receive services and supports tailored to their individual needs.

Refer to the **Procurement Library** for enrollment information by Service Area.

1.8 Eligible Populations for STAR Kids

The following groups will be required to enroll in STAR Kids: (1) children and young adults under the age of 21 who receive Supplemental Security Income (SSI) or (2) children and young adults who receive services through Home and Community-Based Services (HCBS) Waiver programs operated by HHSC, the Department of Aging and Disability Services (DADS), and the Department of State Health Services (DSHS). These programs include the following.

1. Medically Dependent Children Program (MDCP)
2. Home and Community-based Services (HCS)
3. Community Living Assistance and Supports Services (CLASS)
4. Deaf Blind with Multiple Disabilities (DBMD)
5. Texas Home Living (TxHmL)
6. Youth Empowerment Services (YES)

Children and young adults enrolled in MDCP will receive all of their services through STAR Kids, including LTSS currently provided through MDCP. Children and young adults enrolled in the other listed HCBS Waiver programs will receive Medicaid State Plan services (sometimes known as “acute care” services) and Service Coordination through their STAR Kids MCO, but will receive LTSS specific to their HCBS Waiver through their waiver service providers.

1.9 Authorization

The Texas Legislature has designated HHSC as the single state agency to administer the Medicaid Program in the State of Texas. HHSC has authority to contract with MCOs to carry out the duties and functions of the Medicaid Managed Care Program under Title XIX of the Social Security Act; Texas Health and Safety Code §§ 12.011, 12.017, and 12.021; 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.

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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.

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 **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 **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, 2019 (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, 2016.

1.12 Development of Contracts

HHSC intends to execute one Contract per MCO, which will include all awarded MCO Service Areas.

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2. Procurement Strategy and Approach

HHSC seeks to contract with multiple MCOs to give all Members a choice of at least two MCOs. HHSC reserves the right to enter into Contracts with more than two MCOs in any Service Area based on:

- the number of managed care Eligibles in the Service Area compared to the combined capacity of qualified MCO Respondents; and
- statutory requirements.

HHSC conducts this procurement as a competitive negotiation in accordance with 1 Tex. Admin. Code Ch. 391.

Texas Government 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 **Section 5**.

2.1. Risk-Based Contract

In making the award of the Contract, HHSC will rely on the MCO's assurances of the following.

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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 and conditions 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 **Section 1.6**, "Mission Objectives" and **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** will be determined within a year of the Operational Start Date. 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 aspects of MCO performance, and include measures that, when publicly shared, will also serve to hold MCOs accountable to measurable benchmarks.

HHSC will seek to accelerate improvement efforts in areas of high priority, including those identified in **Section 1.6**. As described in **Section 8.1.1.1**, 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 each 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 each MCO's plan for its Quality Assurance and Performance Improvement (QAPI) Program, as defined in **Section 8.1.7**, "Quality Assessment and Performance Improvement," and will be incorporated by reference into the Contract.

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As described in **Section 8.1.1.3** HHSC will develop MCO report cards to help STAR Kids enrollees identify and select an MCO.

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. **Section 6.2** "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.** 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."

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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 Kids Contract Terms; and the successful Respondent's proposal.

Respondents are responsible for reviewing all parts of the Contract, including the STAR Kids 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 may affect the project. Any contract resulting from this RFP is subject to the availability of state and federal funds. As of the issuance of this RFP, HHSC anticipates that funds are available to reasonably fulfill the RFP requirements. However, if funds become unavailable, HHSC reserves the right to withdraw the 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

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HHSC. A conflict of interest would include circumstances in which a party's personal, professional, or financial interests or obligations may directly or indirectly:

- 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;
- Impair, diminish, or interfere with that party's ability to render impartial or objective assistance or advice to HHSC; or
- 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 **Attachment A**, "STAR Kids 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 two years after leaving the agency, or from contracting with the agency four years after leaving the agency. The "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

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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 ESBD 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. 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 date in **Section 1.3** (Procurement Schedule) beginning at 1:00 pm in Room K100, 1100 West 49th Street, Austin, Texas. 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 **Section 1.2**) no later 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.

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3.10. Questions and Comments

All questions and comments regarding this RFP should be sent to the HHSC Point-of-Contact (see **Section 1.2**). Questions should reference the appropriate RFP page and section number, and must be submitted by the deadline set forth in **Section 1.3**. 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 **Section 1.3**, 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 **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.

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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 **Attachment A**, "STAR Kids Contract Terms," **Article 15** 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 Responses

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.

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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 Texas Government Code Chapter 552, 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 Texas Public Information Act, with the limited exception of Social Security Numbers and certain non-public financial reports or information submitted in response to **Sections 4.2.3.3** and **4.2.3.4**.

If the Respondent asserts that financial reports or information provided in response to **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 the page. 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) 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 **Attachment A**, “STAR Kids Contract Terms,” unless the context clearly indicates otherwise. Defined terms are capitalized throughout this RFP.

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4 Submission Requirements

To be considered for award, the Respondent must address all 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 excepted 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 **Section 3.21** (Texas Public Information Act) for more information.

4.1 Part 1 – General Instructions

A Proposal must include the following two components:

- Business Proposal; and
- Programmatic Proposal.

All Proposal information must be submitted 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. Each binder must be labeled clearly 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

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Unnecessarily elaborate Proposals beyond those sufficient to provide a complete and effective response to this RFP are not desired and 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 **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 **Section 4.2** ("Business Proposal") and **Section 4.3** ("Programmatic Proposal") 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 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. The Respondent must clearly label the exterior of the shipping package with proposal number 529-13-0071. 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 GeoAccess tables, Significant Traditional Provider (STP) files, TDI filings, and other

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financial documents. The exception does not apply to the attachments referenced in **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 compatible with Microsoft Office 2007 files. PDF files 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 Enterprise Contracts and Procurement Services (ECPS) no later than **2:00 p.m**. Central Time (CT) according to the timeline in **Section 1.3** ("Procurement Schedule"). All submissions will be date and time stamped when received by ECPS. The clock in the ECPS 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 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:

1. Section 1 – Executive Summary
2. Section 2 – Respondent Identification and Information
3. Section 3 – Corporate Background and Experience

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4. Section 4 – Material Subcontractor Information
5. Section 5 – HUB Subcontracting Plan
6. 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. Please identify the Service Areas in which the Respondent proposes to operate. Respondents must indicate the intent to provide statewide coverage. (The Service Areas are described in **Attachment B-4** and **B-4.1**. A Respondent may elect to bid on some or all of the Service Areas.)

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/EPBP. If the Respondent has not received TDI approval, then submit a copy of the application filed with TDI. In accordance with **Section 7.3.9,** the Respondent must receive TDI approval no later than 60 days after HHSC executes the Contract.

3. Authorized Counties. Indicate whether the Respondent is currently authorized by TDI to operate as an MCO in each county in the proposed Service Area with a "Yes," "No," or "Partial." If the Respondent is not authorized to conduct business as an MCO in all or part of a county, it should list those areas in Column C. 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.

Table 2: TDI Authority in Proposed Service Area

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Column A	Column B	Column C
Service Area	TDI Authority/Status of Approval	Counties/Partial Counties without TDI Authority
Bexar		
Dallas		
El Paso		
Harris		
Hidalgo		
Jefferson		
Lubbock		
Medicaid RSA Central		
Medicaid RSA Northeast		
Medicaid RSA West		
Nueces		
Tarrant		
Travis		

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:
      - 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 ultimate owners);
      - stand-alone privately-owned corporation (no parents or subsidiaries); or
      - other (describe).
   b. The legal status of the Respondent and its parent (any/all that may apply):
      - Respondent is a corporation, partnership, sole proprietor, or other (describe);
      - Respondent is for-profit, or non-profit;
      - the Respondent's ultimate parent is for-profit, or non-profit;

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- 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. Section 5 of the RFP requires Respondents who believe they qualify for mandatory STAR Kids contracts under Texas Government Code § 533.004 to submit a detailed, written notice to HHSC no later than indicated in the Procurement Schedule included in **Section 1.3**. Please indicate whether the Respondent provided this notice to HHSC in the manner described in 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(s) 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 such 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 five years. In such 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, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status, and if it has or is, indicate:
    - its current NCQA or URAC accreditation status;
    - if NCQA or URAC accredited, its accreditation term effective dates; and
    - if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the Contractor.

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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 three 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, and describe if and how any noted deficiencies or non-compliance issues were resolved. 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.

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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 and how it relates to the proposed Service Area(s), including staffing and functions performed at the local level. 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 a managed care organization. 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 and how it relates to the proposed Service Area(s) including staffing and functions performed at the local level.

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 (**Chart F**) 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 such Material Subcontract. This information may be included in **Chart B**, or in a separate organizational chart.

7. Submit 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 Kids Program, including its management of any proposed Material Subcontractors.

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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 such 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 résumé of each individual expected to hold such position, if such 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 Kids:

1. Executive Director
2. Medical Director
3. Member Services Manager
4. Behavioral Health Services Manager
5. Manager of Transition Specialists
6. Vision Services Manager
7. Pharmacy Benefits Services Manager
8. Management Information Systems Manager
9. Claims Processing Manager
10. Provider Network Development and Management Manager
11. Benefit Administration and Utilization Review Manager
12. Service Coordinator Manager
13. Quality Improvement Manager
14. Financial Functions Manager
15. Reporting Manager

Service Coordinators. Please refer to **Section 8.1.38.7** for a description of Service Coordinator responsibilities. Please submit the following for each individual Service Coordinator:

1. a job description and qualifications; and

2. the anticipated maximum caseload for each Service Coordinator (number of Members per Service Coordinator) by assigned service level and the assumptions the Respondent used in developing the maximum caseload estimate.

4.2.3.3 Financial Capacity

(no page limit)

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Submit the following financial documents to demonstrate the Respondent's financial solvency, and its capacity to comply with **Section 6**, "Premium Payment, Incentives, and Disincentives," and **Section 8**, "Operations Phase Requirements," and **Attachment A**, "STAR Kids 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:

   1. a "going concern" statement was issued by any auditor in the last three years;
   2. a qualified opinion was issued by any auditor in the last three years;
   3. a change of audit firms in the last three years; and
   4. 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.

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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. 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 such 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. 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.

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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.

4.2.3.4 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 4.2.3.3**) 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, using the "Corporate Guarantee" form found in the Procurement Library, 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 from such entity, or to obtain an acceptable guarantee from another entity with sufficient financial resources to guarantee performance.

4.2.3.5 Bonding

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 Texas Department of Insurance in compliance with Texas Insurance Code § 843.402; and
2. secure and maintain throughout the life of the Contract, a performance bond in accordance with the **Attachment A**, "STAR Kids Contract Terms," of this RFP and 28 Tex. Admin. Code § 11.1805.

4.2.4 Section 4 – Material Subcontractor Information

(no page limit)

See **Attachment A**, "STAR Kids Contract Terms," for contractual definition of Material Subcontractor. Organize this information by Material Subcontractor, and list them in descending order of estimated annual payments. For *each* Material Subcontractor, the MCO must provide:

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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 (see **Attachment A**, "STAR Kids Contract Terms," for the definition of "Affiliate.")
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

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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. In such instance, 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, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation or certification status, and if it has or is, indicate:
    - its current NCQA or URAC accreditation or certification status;
    - if NCQA or URAC accredited or certified, its accreditation or certification term effective dates; and
    - if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the Material Subcontractor.
16. The website address (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

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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

In accordance with Texas Government Code § 2161.252, 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. Please see the Procurement Library for the HSP Template.

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 Historically Underutilized Businesses (HUBs) 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.

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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 Texas 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 shall 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 such services. MCO Administrative Services include Network, utilization, clinical or quality management, service authorization, claims processing, Management Information System (MIS) operation, and reporting. The Respondent must submit an HSP (see the **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 Kids). 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.

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4.2.5.5 CPA Centralized Master Bidders List

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/cmbl/cmblhub.html. For this procurement, HHSC has identified the following class and item codes for potential subcontracting opportunities.

NIGP Class/Item Code:

- 948-07: Administration Services, Health;
- 958-56: Health Care Management Services (Including Managed Care Services); and
- 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:

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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:

- Include a fully executed copy of the Mentor Protégé Agreement, which must be registered with the CPA prior to submission to HHSC; and
- Identify areas of the HSP that the protégé will perform.

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 3 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,

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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:

- 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 business 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.

- 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 description of the scope of work to be subcontracted;
  - information regarding the location to review project plans or specifications;
  - information about bonding and insurance requirements;
  - required qualifications and other contract requirements; and
  - 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 business 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.

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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 **Section 4.2.5.5**. 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.

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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.

The UMCM 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 **Section 4.2.5.6** (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.
7. Anti-Trust Certification

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 **Section 1.3**).

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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 it's 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 **Section 8** relating to a specific submission requirement for the STAR Kids 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 HHSC MCO 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.

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HHSC understands that some Respondents may not have current experience providing managed care services to STAR Kids Target Population. In responding to questions relating to experience, Respondents should clearly indicate if their experience is in Texas, and if their experience is with STAR+PLUS. STAR, STAR Health, or other comparable populations of managed care members.

The Programmatic Proposal must include a detailed description of the following program components, at a minimum:

Section 1 – Service Area and 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 Assurance and Performance Improvement
Section 8 – Utilization Management
Section 9 – Early Childhood Intervention (ECI)
Section 10 – Flexible and Tailored Services
Section 11 – Service Coordination
Section 12 – Adult Transition Planning
Section 13 – Texas Promoting Independence Initiative
Section 14 – STAR Kids Screening and Assessment Process
Section 15 – Comprehensive Care Program Community-Based Services
Section 16 – Primary Care Providers and the Health Home
Section 17 – Disease Management (DM)
Section 18 – Behavioral Health Services and Network
Section 19 – Telemedicine, Telehealth, and Telemonitoring Access
Section 20 - Pharmacy Services
Section 21 - Management Information System (MIS) Requirements
Section 22 - Fraud, Waste, and Abuse
Section 23 - MCO Transition Plan
Section 24 - Additional Requirements Regarding Dual Eligibles

4.3.1 Section 1 – Service Area and Capacity

(3 pages, excluding tables)

The Respondent must:

1. Complete the STAR Kids Service Area and Capacity table found in the **Procurement Library,** which must include for each proposed Service Area 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 Service Area and capacity projections. In developing these projections, the Respondent should consider the capacity of its Network, including its PCP Network, its Behavioral Health Services Network, its specialty care Network, its Pharmacy Network, and its

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Community-based Services Network. Respondents should specify:

a) the anticipated STAR Kids Program enrollment;

b) the expected utilization of services, taking into consideration the characteristics and healthcare needs of specific populations represented in the STAR Kids 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 Service Area capacity changes, if any, for each of the proposed Service Areas 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, including growth resulting from the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010.

4.3.2 Section 2 – Experience Providing Covered Services

(7 pages)

Covered Services are described in **Section 8.1.2, Section 8.1.36** and **Attachment B-2**.

The Respondent must briefly review the Respondent's experience providing services equivalent or comparable to STAR Kids Covered Services described in **Attachment B-2**:

1. Indicate which STAR Kids Covered Service(s) (in whole or in part) the Respondent has and 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 Covered Services, the Respondent must describe its relationship with the Material Subcontractor, as required by **Section 4.2.4**.
3. Describe the Respondent's experience in using Service Coordination for the STAR Kids population or a comparable population 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. Describe the Respondent's experience in providing Medicaid wrap-around services

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for Dual Eligibles entitled to these benefits. If the Respondent does not have experience in providing these services, indicate how the Respondent intends to meet this requirement.

5. Describe the Respondent's experience in providing Service Coordination for Dual Eligibles. Respondent should specifically describe the processes and procedures used to coordinate Medicare services with Medicaid Community-based Services and related services. If the Respondent does not have experience coordinating these services, indicate how the Respondent intends to meet this requirement.
6. Describe the Respondent's experience in providing Service Coordination for Medicaid Members with Third-Party Insurance from Medicare or a private health insurance carrier. Respondent should specifically describe the processes and procedures used to coordinate Third-Party Insurance, non-covered services and Medicaid Covered Services. If the Respondent does not have experience coordinating these services, indicate how the Respondent intends to meet this requirement.
7. Describe the Respondent's experience providing Covered Services in coordination with non-capitated HCBS waiver services.

4.3.3 Section 3 – Value-added and Case-by-Case Added Services

(1 page per Value-added Service)

Respondents may propose to offer Value-added Services as described in **Section 8.1.2.3**. 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. The Respondent may propose different Value-added Services for each Service Area bid.

For each MCO Program and Value-added Service proposed, the Respondent must:

1. define and describe the Value-added Service and how it will benefit children and young adults with special healthcare needs;
2. specify the applicable Service Areas for the proposed Value-added Services;
3. describe how a Member may obtain or access the Value-added Service;
4. 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;
5. 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;
6. note any limitations or restrictions that apply to the Value-added Services;
7. for each proposed Service Area, identify the types of Providers responsible for providing the Value-added Service, including any limitations on Provider capacity if applicable;
8. propose how and when Providers and Members will be notified about the availability of Value-added Services;

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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; and
10. describe if, and how, the Respondent will identify the Value-added Service in administrative data (Encounter Data).

4.3.3.1 Case-by-Case Added Services

(1 page per Service)

Respondents must briefly describe any Case-by-Case Added Services which the Respondent proposes satisfy requirements described in **Section 8.1.2.4**. Describe an example in which such a service might be offered to the Member.

4.3.4 Section 4 – Access to Care

Access to Care standards are described in **Section 8.1.3**.

4.3.4.1 Travel Distances

(No page limit, should only submit applicable tables)

For each proposed Service Area, submit tables created using **UMCM Chapter 5.14.2** "STAR Kids Geo-Mapping Report" found in the Procurement Library 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 in each proposed Service Area. For purposes of Geo Mapping, the distribution method will be to place all members at the center of the county. If the software used does not support this methodology, describe the assumptions and approach used to determine the information reported in the "STAR Kids Geo-Mapping Report".

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 a 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 1 set of the above tables and maps for each Service Area bid.

4.3.4.2 Assessing Access to Care

(10 pages)

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1. Identify the processes by which the Respondent must measure and regularly verify:
    a. Network compliance, including pharmacy, regarding travel distance access in **Section 8.1.3.2**;
    b. Provider compliance regarding appointment access standards in **Section 8.1.3.1**, and
    c. Compliance with after-hours coverage standards in **Section 8.1.3**.
2. Describe actions the Respondent will take if they are notified or become aware of inappropriate wait times before a Member is seen by a Provider.
3. 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 Behavioral Health Services within the required travel distance;
    c. The lack of outpatient Behavioral Health Services from Providers, including child psychiatrists, within the required travel distance;
    d. The lack of appropriate specialist with sufficient knowledge and training to treat the Member's diagnosis;
    e. For 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.
4. Describe the steps the Respondent has taken in the past when it identified a deficiency in its compliance with:
    a. A Provider that 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 3 and 4 above with regularity, describe how it proposes to take those steps in the future.

5. 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;
6. Describe how the Respondent will provide training to ensure the Providers understand and respond to the STAR Kids population’s physical and Behavioral Health needs;
7. Describe how the Respondent plans to provide Behavioral Health Emergency Services described in **Section 8.1.16.8** 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; and

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8. Describe how the Respondent plans to address deficiencies in the availability of appropriately credentialed providers to provide Community-Based Services.

4.3.5 Section 5 – Provider Network Provisions

(3 pages)

Provider Network requirements are primarily described in **Section 8.1.4**. In addition, the Significant Traditional Provider (STP) requirements applicable to Medicaid MCOs are described in **Sections 8.1.25.** 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 needs of the STAR Kids 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.
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 letter of intent (LOI) or a letter of agreement (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 **Section 8.1.4** 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 **Procurement Library**.

1. For each Service Area in which the Respondent proposes to participate, the Respondent must submit a complete list of proposed Network Providers for each of the following provider types that would be responsible for providing Covered

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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 list must include separate lists of each provider type in the order listed below and a separate worksheet for each proposed Service Area.

Acute Care Services

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 mental health services;
i. Hospitals providing substance abuse services, inpatient and outpatient; and
j. Other facilities or clinics providing outpatient substance abuse services.

2. For each Service Area in which the Respondent proposes to participate, identify a list of Community-based Service Providers with whom the Respondent has a signed contract, LOI, or LOA. These Providers should be listed by type, name, address, and Department of Aging and Disability Services (DADS) contract number where applicable. Respondent should also list the array of Community-based Services each of these entities provides.

Community-based Services

a. Personal Care Services (PCS);
b. Private Duty Nursing (PDN);
c. In-home skilled nursing care;
d. Adaptive aids
e. Durable medical equipment (DME) and medical supplies;
f. Assisted living and residential care services;
g. Emergency response services;
h. Supported Employment and Employment Assistance;
i. Minor home modifications;
j. Respite care;
k. Therapy – occupational;
l. Therapy – physical;
m. Therapy – speech or language pathology services;
n. Consumer-directed services;
o. Community Living Supports;
p. Family Supports;

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q. Supportive Family-based Alternatives; and
r. Transition assistance services.

3. Identify the types of Providers the Respondent allows as PCPs for adults, PCPs for children, and outpatient Behavioral Health Service Providers. The Respondent must 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 serve as a PCP for children.

4.3.5.2 Significant Traditional Providers

(No page limit for STP tables, 1 page for narrative)

The STP requirements applicable to Medicaid MCOs are described in **Section 8.1.25.** HHSC-designated Medicaid Significant Traditional Providers (STPs) can be found in the Procurement Library. STPs also include Community-based Service Providers. For each STP provider type in the Respondent's proposed Service Area(s) complete the “STP Network Percentage Table” charts provided in the **Procurement Library**. The total number of STPs in each Service Area can be found in the Procurement Library by type of STP.

Respondent may provide a one-page narrative to explain STP status.

4.3.5.3 Provider Network Capacity

(5 pages)

HHSC has targeted continued access to existing Providers, improved Network capacity, and improved Member access to Covered Services as priorities for the Initial Contract Period.

1. Identify short-term and long-term strategies the Respondent will adopt to encourage participation among existing and new Providers;
2. Indicate which, if any, Covered Services are not available from a qualified Provider in the Respondent’s proposed Network in each applicable Service Area and how the Respondent proposes to provide such Covered Services to Members in each proposed Service Area; and
3. 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 **Section 8.1.3.2**. The description should include how the Respondent will address deficiencies in the Network related to:
   a. the lack of a PCP with an Open-Panel within the required travel distance of the Member’s residence;
   b. the lack of a pediatric specialists and subspecialists within the travel distance of the Member’s residence;
   c. the lack of an OB/GYN within the travel distance of the Member’s residence;

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d. the lack of Hospitals with specialized children's services, Children's Hospitals or Special Hospitals within the travel distance of the Member's residence;
e. the lack of Psychiatric Hospitals within the travel distance of the Member's residence;
f. the lack of pediatric psychiatrists and Qualified Mental Health Professionals (QMHP) within the travel distance of the Member's residence; and
g. 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 **Section 8.1.4.2.** For all of the following submission requirements the Respondent must provide a brief summary of its policies and procedures. Do not attach copies of the MCO's policies and procedures.

1. Describe the Respondent's minimum credentialing and licensure requirements and procedures for Providers of Acute Care by type of Provider, and demonstrate how the Respondent ensures, or proposes to ensure, that any Provider rendering Covered Services meets the minimum credentialing requirements. The description must demonstrate compliance with **Section 8.1.4.2**. The Respondent should not attach relevant policies and procedures, but must summarize its policies and procedures within the page limit requirements.

2. Describe the re-credentialing process or process between re-credentialing cycles for Providers and 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. utilization management information; and
    d. information from licensing and accreditation agencies.

3. Describe the Respondent's minimum credentialing and licensure requirements and procedures for Providers of Community-based Services by type of Provider, and how Respondent will ensure that any Provider rendering Covered Services meets the minimum credentialing and licensing requirements. Describe how the Respondent's credentialing process will ensure that Providers will meet the needs of a pediatric population. The Respondent should not attach relevant policies and procedures, but must summarize its policies and procedures within the page limit requirements.

4. A Respondent currently operating in Texas must separately report the following information. A Respondent <u>not</u> currently operating in Texas must separately report the same information for a managed care program it operates in another state

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similar to the STAR Kids Program or a similar program serving individuals under the age of 21 or with disabilities:

a. the percentage of providers in its Texas network re-credentialed in the past three years, for the following provider types: primary care physician, specialty care physician, and masters-level outpatient Behavioral Health Service 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.

4.3.5.5 Provider Manual, Materials, and Training

(4 pages)

Provider training requirements are described in **Section 8.1.4.4** and **Section 8.1.40.1**.

1. Outline the contents the Respondent intends to include in the Provider Manual.

2. Provide a brief description of proposed Provider training programs. Please distinguish between training programs for PCPs, other Acute Care, Behavioral Health and Community-based Services Providers. 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, health home, telemedicine and telehealth services);
   c. how the Respondent will specifically train Providers on the requirements of the Contract and the unique needs of the STAR Kids population;
   d. which Providers will be invited to attend in-person trainings;
   e. how Provider training programs will be evaluated;
   f. the frequency of Provider training;
   g. how the Respondent proposes to maximize Provider participation in training programs, including how the Respondent proposes to use Internet and televideo capabilities to provide 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 Kids population.

3. Briefly describe two examples of recent Provider training programs conducted by the Respondent that may be relevant to the STAR Kids 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.

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A Respondent currently participating in any of HHSC's Medicaid MCO Programs must submit the above Provider training examples for each such 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 in another state. 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 **Section 8.1.4.5**. 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 Kids 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 HHSC Provider Hotline calls (e.g., responding to non-Network provider calls or HHSC 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. the monthly 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; and
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 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 Kids Program.

A Respondent not currently participating in any of HHSC's Medicaid MCO Programs must submit the information in Section 4.3.5.6(7) for a similar managed care program that it operates in another state. If such 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.

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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 **Section 8.1.4.6.2**, "MCO Value-Based Contracting (Expansion of Alternative Payment Structures for Providers)."

The Respondent must submit a plan with alternative payment structures to increase quality and efficiency through collaboration and innovation to improve access to comprehensive Health Homes. The plan should address methods for addressing the following goals:

1. Identified opportunities for shared savings;
2. Reductions in inappropriate utilization of services including inappropriate admissions and readmissions;
3. Mechanics by which the MCO will provide incentive payments to providers to improve quality of care;
4. Quality metrics that would be required for provider recruitment strategies, incentives, and shared savings; and
5. Strategies to increase availability of comprehensive Health Homes.

4.3.5.8 Clinical and Administrative Advisory Committees

(2 pages)

For requirements described in **Section 8.1.7.7**, the Respondent must:

1. Describe the role of the Clinical and Administrative Advisory Committee in establishing and monitoring clinical policies and procedures, and in developing and updating clinical practice guidelines.
2. Describe how the Respondent will outreach to a broad variety of Providers for the goal of including Acute Care, Community-based, Behavioral Health, therapies, DME and supplies, and pharmacy Providers in Clinical and Administrative Advisory Committee meetings.
3. 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 and Behavioral Health staff.

4.3.6 Section 6 – Member Services

4.3.6.1 Member Services Staffing

(5 pages; excluding organizational charts)

The MCO must maintain a Member Services Department to assist Members and Member's LAR in obtaining Covered Services as described in **Section 8.1.2**

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. Include a description for how

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Member services staff will interact with other departments or units within the Respondent's organization.

2. Explain the functions of the Member Services staff, including brief job descriptions and qualifications.

3. Describe the curriculum for training the MCO will provide to Member Services representatives, including when the training is conducted and how the training addresses:
   a. Eligibility policy;
   b. Access to Covered Services, including access to Texas Health Steps (THSteps) medical checkups and Behavioral Health Services and Community-based Services;
   c. The STAR Kids Assessment Instrument and coordinating additional assessments and evaluations;
   d. Understanding STAR Kids Program requirements;
   e. Cultural Competency;
   f. Trauma-Informed Care;
   g. Person-centered practices;
   h. 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;
   i. The purpose and information included in the Individual Service Plan (ISP); and
   j. Educating Members about Non-capitated Services and providing referrals to these services.

4. 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 in another state and identify the managed care program.

5. Identify the percentage of Member Services staff that will be physically located in the Service Area.

6. Identify situations in which the Respondent will provide eligibility assistance to a Member.

7. Explain plans to establish a STAR Kids Member website or mobile device application. Include example content that will be available on the website or application.

4.3.6.2 Nurse and Member Hotline

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The Nurse and Member Hotline requirements are described in **Section 8.1.5.6**.

4.3.6.3 Nurse Hotline

(5 pages; excluding hotline telephone reports)

Describe the proposed Nurse Hotline function and how its purpose differs from the Member Hotline. Provide the following information on the Nurse Hotline:

1. normal hours of operation;
2. number of nurses designated to the STAR Kids Nurse Hotline, 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 to Nurse Hotline nurses, to ensure timely and accurate response to Member inquiries;
4. responsibilities of Nurse Hotline staff;
5. training for Nurse Hotline staff including responding to a behavioral health crisis;
6. after-hours procedures and available services, including those provided to non-English speaking Members and Members who are deaf or hard-of-hearing;
7. the number and percentage of FTE Nurse Hotline staff who are bilingual in English and Spanish;
8. the number and percentage of FTE Nurse Hotline staff who are multi-lingual for any additional language, by language spoken;
9. 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
10. whether the Nurse 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 in items 1 through 9 above for each Nurse Hotline operated, and identify any proposed changes to hotline functions for the STAR Kids 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 **Section 8.1.5.6.1**. The description must include the information listed in items 1 to 9 above.

If a Respondent is proposes a single point of access, i.e., toll-free number, for multiple hotlines, e.g., Member Services, Behavioral Health, Nurse Hotline, and Provider Hotline, the Respondent must note in its proposal the differences in its staffing for each of these Hotlines, and must describe how calls to the Hotline(s) are triaged.

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4.3.6.4 Nurse Hotline Scenarios

(6 pages)

Describe the procedures a Nurse Hotline representative will follow to deal with the following situations:

1. a Member or Member's LAR calls requesting advice regarding a missed medication dose;
2. a Member or Member's LAR is unable to reach her PCP after normal business hours;
3. a Member or Member's LAR is having difficulty filling a needed prescription after hours;
4. a Member or Member's LAR calls requesting an evaluation of whether or not to go to an Emergency Room for immediate care;
5. a Member is experiencing a Behavioral Health crisis;
6. a caregiver other than the Member's LAR calls to seek advice about a Member's medical situation; and
7. a Member or Member's LAR calls to report a problem or malfunction with critical adaptive equipment.

4.3.6.5 Member Hotline

(4 pages; excluding hotline telephone reports)

The Member Hotline requirements are described in **Section 8.1.5.6.2**.

Describe the proposed Member Hotline function, including:

1. Training for Member Services representatives to assure proficiency in the knowledge requirements established in **Section 8.1.5.6.2**;
2. Oversight of Member Services representatives including monitoring calls and customer satisfaction;
3. normal hours of operation;
4. number of Member Hotline staff dedicated to the STAR Kids 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;
5. routing of calls among Member Hotline staff to ensure timely and accurate response to Member inquiries;
6. responsibilities of Member Hotline staff, if any, in addition to responding to STAR Kids Member Hotline calls, (e.g., responding to non-STAR Kids Member calls or Provider Hotline or Behavioral Health Hotline calls);
7. after-hours procedures and available services, including those provided to non-English speaking Members and Members who are deaf or hard-of-hearing;
8. the number and percentage of FTE Member Hotline staff who are bilingual in English and Spanish;

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9. the number and percentage of FTE Member Hotline staff who are multi-lingual for any additional language, by language spoken;
10. If applicable, 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
    d. whether the Member 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 items one through ten above for each Member Hotline operated, and identify any proposed changes to hotline functions for the STAR Kids 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 **Section 8.1.5.6.2** The description must include the information listed in items one to ten above.

If a Respondent is proposing to use a single point of access, i.e., toll-free number, for multiple hotlines, e.g., Member Services, Behavioral Health, 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.

4.3.6.6 Member Service Scenarios

(10 pages)

Describe the procedures a Member Services representative will follow to handle these situations:

1. a Member or Member's LAR has received a bill for payment of Covered Services from a Network Provider and an Out-of-Network Provider;
2. a Member or Member's LAR is unable to reach her PCP after normal business hours;
3. a Member or Member's LAR is having difficulty scheduling an appointment for preventive care with her PCP;
4. a Member becomes ill while traveling outside of the state;
5. a Member or Member's LAR 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 Member is experiencing a behavioral health crisis;
8. a Caregiver or the Member's LAR calls after hours asking for assistance in managing the Member's acting out behavior;

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9. a Member or the Member's LAR believes the Member is not receiving needed home and community-based services;
10. a Member or Member's LAR with a hearing impairment or another communicative disorder calls the Member Hotline and needs assistance;
11. a Member's PCP calls to report a suspicion that he/she is treating an adolescent with a substance abuse problem;
12. a Member or Member's LAR calls stating that the Member's current specialist is not meeting their needs;
13. a Member or Member's LAR requests a specialist Out-of-Network;
14. a request is made for a Member to receive applied behavior analysis therapy;
15. a Member or Member's LAR calls to complain that their Service Coordinator is not meeting their needs;
16. a Member or Member's LAR calls to complain that it is taking too long to be seen by a Specialist; and
17. a Member or Member's LAR calls requesting a review of their ISP or for a re-assessment.

4.3.6.7 Member Education

(5 pages)

Member education requirements are described in **Section 8.1.5.7**. Provide a description of Member education materials and other methods the Respondent will use to disseminate information to Members. The description must explain how the materials and methods will inform and educate Members and Member's LAR on each of the following topics:

1. How the STAR Kids MCO system operates including the role of the PCP, Health Home, ISP and Service Coordination;
2. The Member complaint, appeals and fair hearings process;
3. Covered Services, and limitations and any Value-added Services offered by the MCO; and
4. How to obtain Covered Services; and
5. Access to services delivered through the consumer directed services model.

The Respondent must also describe how Member Education will be personalized based on the different types of needs of Members.

4.3.6.8 Cultural Competency

(3 pages)

Provide a high-level description of the processes the Respondent will adopt to the meet the requirements of the cultural competency requirements as described in **Section 8.1.5.8**, “Cultural Competency Plan.”

1. Describe how the Respondent will ensure culturally competent services to people of all cultures, education levels, family composition, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes

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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 healthcare to diverse populations.

4.3.6.9 Member Advisory Groups
(2 pages)

Provide a high-level description of the processes the Respondent will put in place to the meet the requirements as described in **Section 8.1.5.10**, “Member Advisory Groups.”

The Respondent must describe the process for implementing and maintaining the Member Advisory Groups including the identification and selection of participants and how the Respondent will ensure participation. The response must also include a description for how the Respondent will elevate concerns raised through the Member Advisory Group meetings to executive level staff and other decision-makers.

4.3.6.10 Continuity of Care
(4 pages)

Continuity of Care transition requirements for certain new Members with Out-of-Network providers are described **Section 8.1.23**. Requirements related to Conversation Plans for new STAR Kids Members are described in **Section 8.1.38.11**.

1. Describe the proposed Conversion Planning process for newly enrolled Members.
2. Describe how the Respondent will ensure continuity of prior authorized services when a Member transfers from the Fee-for-Service program to the STAR Kids program or from another Medicaid or CHIP MCO to the STAR Kids 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 Kids program. The Respondent’s description should include how the STAR Kids MCO will authorize the Member’s Out-of-Network providers to finish the treatment plan authorized by the Fee-for-Service program or another Medicaid or CHIP managed care organization.
3. Describe the proposed Conversion Plan for new Members whose current PCP, OB/GYN, specialty care, Behavioral Health, and Community-based Providers are not participants in the Respondent’s Provider Network.
4. Describe the MCO’s Provider recruitment process and timeframes (especially for recruiting STP providers) for outreaching to and enrolling Out-of-Network providers who have existing relationships with Members.
5. Describe the protocol the Respondent will follow to ensure services are not disrupted for Member's receiving specialty services that were prior authorized previous to the Member's enrollment with the MCO.
6. Describe how the Respondent will evaluate and make certain a change in Provider is appropriate for the Member's unique healthcare needs.
7. Describe how the Respondent will identify and track new Members with high physical or behavioral health needs to assure continuity of care.

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8. Describe how the Respondent will coordinate with other MCOs when a Member changes MCOs in order to ensure continuity of care. Include a description for how authorizations and data will be exchanged.
9. Describe how the Respondent will develop a plan to identify and reach out to Members with the most immediate service needs leading up and immediately after the Operational Start Date.

4.3.6.11 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 **Section 8.1.24.7**. 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.

The Respondent must 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.

4.3.6.12 Member Complaint and Appeal Processes

(4 pages, excluding flow chart)

Medicaid Member Complaint and Appeal Processes are described in **Section 8.1.5.9 and Section 8.1.29**. A Respondent's submission must reflect how it will meet the applicable Member Complaint and Appeal requirements. The submission must include details about automation that will be used to document, track and report on Complaints and Appeals. 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 follow to review Member Complaints and Appeals, including which staff will be involved;
2. provide a flowchart that depicts the process the Respondent will follow to resolve Member complains, questions and appeals. The process must start from the receipt of a request and describe each phase of the review including notification of disposition. Include information on providing notice of access to HHSC Fair Hearings;
3. document the MCO's average time for resolution over the past twelve 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;

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5. describe how and if named Service Coordinators will be involved in the complaint resolution process; and
6. describe any additional measures that will be used to assure transparency for all Complaints and Appeals.

4.3.6.13 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 commit any practices prohibited by CMS or HHSC in its Marketing activities.

The Respondent must 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.

4.3.6.14 This Section Intentionally Left Blank

4.3.7 Section 7 – Quality Assurance and Performance Improvement

The Quality Assurance and Performance Improvement (QAPI) requirements of the RFP are described in **Section 8.1.7.1**.

4.3.7.1 Clinical Initiatives

(4 pages, excluding QA 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 Kids population.
2. Document two statistically significant improvements generated by the Respondent's clinical initiatives.
3. Describe challenges associated with establishing quality metrics and measuring outcomes for children and young adults with Complex Conditions and how the Respondent will tailor their QAPI Plan based on the individual traits of the STAR Kids population.
4. 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.
5. 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

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HHSC MCO Program, provide a copy of a 2013 quality assurance 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 assurance plan for a program operated by the Respondent and serving a population with similarities to the STAR Kids population, such as a CHIP plan.

4.3.7.2 Healthcare Effectiveness Data and Information Set (HEDIS) and Other Quality Data

(4 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 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. describe the challenges associated with using traditional measures like HEDIS for children and adolescents with special healthcare needs and what other types of measures the Respondent will use to gauge and measure quality for STAR Kids;
3. document examples of statistical clinical indicator measures previously generated by the Respondent within the last two years for the STAR Kids population or a managed care population comparable to the STAR Kids population;
4. describe efforts that the Respondent has made to assess Member satisfaction within the last two years for a managed care population comparable to the STAR Kids population and Member satisfaction methodologies the Respondent will collect for STAR Kids; and
5. describe management interventions implemented within the last two years based on member satisfaction measurement findings for the STAR Kids population or a managed care population comparable to the STAR Kids population, and whether these interventions resulted in measurable improvements in later member satisfaction findings.

4.3.7.3 Clinical Practice Guidelines

(2 pages)

Through strategic partnerships between HHSC, STAR Kids MCOs, and medical professionals, HHSC encourages increased adoption of evidence-based clinical practice guidelines.

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1. Describe a clinical guideline that is relevant to the STAR Kids populations and that the Respondent believes requires improved adherence.
2. Describe what steps the Respondent will take to increase compliance with the clinical guideline noted in its response to number 1, including the roles of HHSC, the Respondent, and medical professionals.
3. Provide a general description of the Respondent's process for developing and updating clinical guidelines, and for disseminating them to participating Providers and Members.
4. Describe at least two tactics the Respondent will implement to assure Provider compliance with clinical practice guidelines.
5. Describe what steps the MCO will take to align clinical practice guidelines with other MCOs for the purpose of requiring Providers to adopt conflicting guidelines from different Medicaid MCOs.

4.3.7.4 Provider Profiling

(2 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).
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.

4.3.7.5 Network Management and Pay-for-Quality

(5 pages)

1. 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:

    a. the 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;
    b. the process and timeline the Respondent proposes for periodically assessing Provider progress on its implementation of strategies to attain improvement goals;

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c. 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;
d. how the Respondent will share “best practice” methods or programs with Providers of similar programs in its Network;
e. how the Respondent will take action with Providers who demonstrate continued unacceptable performance and performance that does not improve over time;
f. the steps the Respondent will take with a Provider that specifically is not meeting HHSC contractual access standards; and
g. the extent to which the Respondent currently operates a Network management program consistent with HHSC requirements in **Section 8.1.7.8**, and measurable results it has achieved from those Network management efforts.
h. strategies the MCO will adopt to simplify administrative procedures for Providers.

2. Based on pay-for-quality requirements in **Section 8.1.7.11** identify the Respondent's strategy for reducing potentially preventable events (PPEs); rewarding evidence-based practices; and promoting healthcare coordination in compliance with the P4Q program.

4.3.8 Section 8 – Utilization Management
(6 pages)

Utilization Management (UM) requirements are described generally in **Section 8.1.9** and specifically for Behavioral Health Services in **Section 8.1.9**. A Respondent’s response to this submission requirement should address UM for all Covered Services, including Behavioral Health 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 **Section 8.1.9**.
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.

4.3.9 Section 9 – Early Childhood Intervention (ECI)
(2 pages)

ECI Services are described in **Section 8.1.10**.

1. Describe the Respondent’s experience with, and general approach to, providing ECI services, including how the Respondent will identify such individuals.

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2. Describe procedures and protocols for using the IFSP information in the development of the Member ISP and to 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 information and other necessary information to the PCP.

4.3.10 Section 10 – Flexible and Tailored Services
(3 pages)

All STAR Kids Members are considered Members with Special Health Care Needs (MSHCN) as defined in the STAR Kids Contract Terms. Children and young adults with special healthcare needs vary greatly in terms of strengths, challenges and needs. STAR Kids MCOs are expected to provide services and supports that are tailored to the needs of individual Members as described in **Section 8.1.13** and **8.1.38.2**.

1. Describe the Respondent's experience with, and general approach to, providing services for children and young adults with special healthcare needs.
2. Describe procedures and protocols for including the Member or Member's LAR and key Providers in the care planning process.
3. Describe the process by which the Respondent will allow Members to have:
    a. direct, timely access to a Specialist as appropriate for the Member's condition and identified needs, such as a standing referral to a specialty physician; and
    b. timely access to non-primary care physician specialists as PCPs, as required by 28 Tex. Admin. Code § 11.900 and **Section 8.1.4.10.1**.

4.3.11 Section 11 – Service Coordination
(18 pages)

Service Coordination is described in **Section 8.1.38**.

1. Describe the duties and responsibilities of the Service Coordinator to authorize Community-based Services. The Respondent must describe in detail how the Service Coordinator will function in relation to the Member's PCP for:
    a. Dual Eligible STAR Kids Members receiving both Medicaid and Medicare services from the MCO:
    b. Dual Eligible STAR Kids Members receiving Medicare services through either fee-for-service Medicare or another Medicare MCO; and
    c. Members with third-party insurance from a private health insurance carrier.

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2. Submit detailed information, including protocols and procedures, for identifying Members requiring Service Coordination at Levels 1, 2, and 3 (as described in **Section 8.1.38.6**).
3. Describe the methods the MCO will use to determine Service Coordinator qualifications for all three Service Coordination levels.
4. Provide a description of the appropriate case mix and staffing ratio of Service Coordinators to Members and the Respondent's target ratio of Service Coordinators to Members for each Service Coordination level.
5. Describe the actions the MCO will take to establish relationships with community organizations and engage them in providing non-Covered Services to Members.
6. Describe the process for creating an ISP including parties to be consulted, what information will be incorporated, and how the Member and the Member's LAR will be involved in the process.
7. Describe procedures and protocols for using the information from the STAR Kids Assessment to inform and update the Member ISP and authorize services.
8. Describe under what types of circumstances the MCO will allow Members to receive Service Coordination through an integrated Health Home and how the MCO will compensate Health Home Providers who are designated to provide a Member's Service Coordination.
9. Describe how the Respondent will arrange to include clinical information and options for Medically Necessary Covered Services in the Member's ISP, and share this information with the PCP or Medical Home, as appropriate.
10. Describe how the MCO will evaluate and report Members' clinical progress in meeting goals identified in the ISP.
11. Describe how the ISP development process may be tailored to the specific needs of Members with the following health considerations:
    a. Autism Spectrum Disorder (ASD);
    b. Intellectual or Developmental Disability (IDD);
    c. Cancer; and
    d. Severe mental illness or behavioral health concerns.
12. Describe procedures and protocols for including the Member or Member's LAR in the care planning and ISP development process. Include a description of how the Member and the Member LAR will be educated about the Service Coordination process and how the Member and the Member's LAR will be informed of the name and contact information for his or her Service Coordinator.
13. Describe the criteria and processes for advising Members and Member's LARs about how to access the most appropriate, least restrictive home and community-based services as alternatives to institutional care. Additionally, describe how the Respondent will ensure that the Member or the Member's LAR is receives the opportunity to make an informed choice about care options.
14. Describe the MCO's plan for a dedicated toll-free Service Coordination phone number or call option through the Member Services phone number.
15. Describe the MCO's plan for tracking Service Coordination provided to its Members, including numbers and types of contact, timeliness of contacts, and the qualifications of individuals making the contact.

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16. Submit criteria for identifying and training certain Members and those in their immediate Support Network to coordinate and direct the Member's own care, to the extent reasonable and supported by the Member and the Member's LAR. Criteria should include those used to enable the Member and family to select, train, and supervise providers of Community-based Services.
17. Submit a list of the relevant community organizations in each proposed STAR Kids Service Area with which the Respondent will coordinate services for Members and to which it will refer Members for services.
18. Describe how the Respondent will identify Members who are at risk of an institutional placement and how the Service Coordination process will address those identified at risk.
19. Describe in detail the training provided to Service Coordinators, both initially and ongoing, to ensure they are knowledgeable about the STAR Kids 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.
20. Describe how the MCO will reach Members for whom the MCO has lost contact.
21. Describe the Service Coordination process for STAR Kids Members who also receive non-capitated services through the following programs:
    a. Intermediate Care Facility for Individuals with an Intellectual or Developmental Disability or Related Condition (ICF/IID);
    b. Nursing Facility;
    c. Community Living and Assistance Support Services (CLASS);
    d. Home and Community-based Services (HCS);
    e. Deaf Blind with Multiple Disabilities (DBMD);
    f. Texas Home Living (TxHmL); and
    g. Youth Empowerment Services (YES)

4.3.12 Section 12 – Adult Transition Planning
(3 pages)

Adult Transition planning requirements are included in **Section 8.1.38.8**.

1. Describe the process for hiring and training Transition Specialists, including qualifications for the position and a job description.
2. Describe how the Respondent proposes to help Member's transition to adulthood including the role of Service Coordination, use of Transition Specialists, and additional resources for transition planning.
3. Describe how Transition Specialists will work with Members, individuals in the Member's Support System, and other individuals employed by the MCO to help prepare Members for the transition to adulthood.

4.3.13 Section 13 – Texas Promoting Independence Initiative
(1 page)

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Requirements for the Texas Promoting Independence Initiative are provided in **Section 8.1.38.13**. Describe the steps the Respondent will take on behalf of a STAR Kids Member who moves from the community to an institutional setting. Explain the MCO's objective in this situation and who the MCO will work with to meet established goals.

4.3.14 Section 14 – STAR Kids Screening and Assessment Process
(5 pages)

Screening and assessment requirements for STAR Kids are described in **Section 8.1.39**

1. Leading up to and immediately after the Operational Start Date describe the process the MCO will use to identify which Members need to be assessed most quickly.
2. Describe strategies the MCO will adopt to assess all Members in a timely and thorough manner following the Operational Start Date.
3. Describe who will administer the STAR Kids Screening and Assessment Instrument (SAI) and what training they will receive.
4. Describe the process for initially and periodically screening and assessing Members' needs for services, including how the STAR Kids SAI will be incorporated into the process.
5. Submit any proposed functional assessment instruments to be used in addition to the STAR Kids SAI and describe how the assessment instruments will be employed to help inform the Member's service needs. Identify who will perform each assessment and specify his or her credentials.
6. Describe how the Respondent will engage Providers in the STAR Kids Screening and Assessment Process and how the MCO will attempt to resolve different plan of care recommendations between Provider orders and STAR Kids Screening and Assessment Process findings.
7. Describe the HIPAA-compliant process for sharing information between the individual that administers the STAR Kids Assessment Instrument and a subsequently named Service Coordinator.
8. Describe the process the Respondent will follow to determine which Members will be considered Priority 1, Priority 2, or Priority 3 after the Operational Start Date. and
9. Describe the steps the Respondent will take to ensure annual MDCP assessments to not lapse.

4.3.15 Section 15 – Comprehensive Care Program Community-Based Services
(3 pages)

Personal Care Services and Nursing Services are Covered Services available to Members when Medically Necessary or Functionally Necessary.

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Describe the Respondent's experience providing Personal Care Services (PCS) and PDN or any similar services. In the description, include strategies the MCO will employ to connect Members who receive PCS and PDN with appropriate Providers. Describe the processes and protocols for ensuring the continuity and provision of prior authorized PCS or PDN hours for Members who are new to the STAR Kids program. The description should include how the MCO will authorize the Member's providers to finish a previously authorized treatment plan.

4.3.16 Section 16 – Primary Care Providers and the Health Home

(5 pages)

Primary Care Providers and the Health Home is described in **Section 8.1.4.10**

1. Describe the methods the Respondent will train Network PCPs on requirements described in **Section 8.1.4.10.1** and how the Respondent will monitor PCPs to ensure ongoing compliance.
2. Describe the Respondent's experience in implementing Health Home programs for populations comparable to the STAR Kids Program.
3. Identify the process by which the Respondent proposes to provide Members with Health Home services. Describe how the Respondent will work with medical practices to establish qualified Health Homes, the proposed outreach approach, and how services will be differentiated 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.
5. Identify innovative strategies the Respondent will implement to expand the number of Network Health Home Providers and to improve Health Home offerings for children and young adults with Complex Needs.
6. Describe how the MCO will work with PCPs and Health Homes to improve access to care for Members in rural or underserved areas including through the use of telemedicine or mobile clinics.
7. Describe proposed incentive programs to establish Network Providers that meet nationally recognized levels of accreditation, recognition, and certification for the development of a medical or Health Home model.

4.3.17 Section 17 – Disease Management (DM)

(5 pages)

Disease Management is described in **Section 8.1.14**.

1. Describe the Respondent's experience in implementing Disease Management programs for the STAR Kids population or populations comparable to the STAR Kids population.
2. Identify any measurable results in terms of clinical outcomes and program savings that have resulted from the Respondent's Disease Management

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initiatives, and briefly describe the analyses used to identify such outcomes and savings.
3. Identify the process by which the Respondent proposes to provide Members with Disease Management. Describe how the Respondent will identify Members in need of such Disease Management program, the proposed outreach approach, and the Disease Management program components for Members of different risk levels.

4.3.18 Section 18 – Behavioral Health Services and Network

The Behavioral Health Services and Network requirements are described in **Section 8.1.16**.

4.3.18.1 Behavioral Health Services Hotline

(3 pages; excluding telephone reports)

The Behavioral Health Services Hotline requirements are described in **Section 8.1.16.2**.

Describe the proposed Behavioral Health Services Hotline function, including:

1. verification that it is, or will be, staffed 24 hours per day, 365 days per year;
2. staffing of Behavioral Health Services Hotline staff, including clinical credentials;
3. routing of calls among Behavioral Health Services Hotline staff to ensure timely and accurate response to Member inquiries;
4. the curriculum for training to be provided to Behavioral Health Services Hotline representatives, including when the training will be conducted and how the training will address a) Covered Services; b) STAR Kids Program requirements; c) Cultural Competency; and d) providing assistance to Members with limited English proficiency.
5. responsibilities of Behavioral Health Services Hotline staff, if any, in addition to responding to STAR Kids Member Hotline calls, (e.g., responding to non-STAR Kids member calls or STAR Kids Provider Hotline or Member Hotline calls);
6. the number and percentage of FTE Behavioral Health Services Hotline staff who are bilingual in English and Spanish;
7. the number and percentage of FTE Behavioral Health Services Hotline staff who are multi-lingual for any additional language, by language spoken;
8. Behavioral Health 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 Behavioral Health Services Hotline has the capability to administer automated surveys to callers at the end of calls.

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A Respondent currently participating in any of the HHSC MCO Programs bid must submit the information above for each Behavioral Health Services Hotline it operates, and should provide the monthly call volume for each Service Area by MCO Program. Such a Respondent should also indicate any changes it proposes to its Behavioral Health Services Hotline.

If the Respondent is not currently participating in a HHSC MCO Program, describe its experience and proposed approach in establishing and maintaining an accessible call center for Members that is comparable to the Behavioral Health Services Hotline described in **Section 8.1.16.2**, such a description must include the information listed in items 1 to 9 above**.**

4.3.18.2 Behavioral Health Provider Network Expertise

(no page limit)

1. For each proposed Service Area, identify Behavioral Health Service Providers with expertise in providing services to each of the following populations, as applicable to the Respondent's Proposal:
    a. Individuals with IDD;
    b. Children and adolescents with Complex Needs;
    c. Children and adolescents with Severe Emotional Disturbance (SED);
    d. persons with a dual diagnosis of mental health and substance abuse; and
    e. services for linguistic and cultural minorities.
2. Indicate the criteria the Respondent will use to determine that the Behavioral Health Providers have the requisite expertise.

4.3.18.3 Coordination of Behavioral Health Care

(2 pages)

1. Describe the Respondent's approach to coordinating Behavioral Health Service delivery with other healthcare 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/Behavioral Health Service delivery models. Describe the program model services, treatment approach, special considerations, and expected outcomes for the special populations.
3. Describe the process the Respondent will use to ensure the delivery of outpatient Behavioral Health Services within seven days of inpatient discharge for Behavioral Health Services. Describe additional monitoring or coordination techniques the MCO will use following an inpatient Behavioral Health stay to prevent re-admission.

4.3.18.4 Behavioral Health Quality Management

(2 pages)

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1. Identify the areas Respondent believes to be the greatest opportunities for clinical quality improvement in Behavioral Health in the STAR Kids Program and provide supporting information.
2. Discuss the approaches the Respondent will pursue to improve clinical Behavioral Health outcomes.
3. Describe how the Respondent proposes to integrate behavioral health into its quality assurance program, as described in **Section 8.1.7.5**.

4.3.18.5 Utilization Management for Behavioral Health Services

(2 pages)

1. Identify the source of the Respondent's Behavioral Health Services UM guidelines and include a copy of internally developed Behavioral Health Services UM guidelines, if any.
2. Describe how the Utilization Management guidelines, whether internally or externally developed, will generally be applied to authorize or retrospectively review inpatient, residential, and outpatient Behavioral Health Services.
3. Discuss any special issues in applying the Behavioral Health Services UM guidelines for:
   a. substance abuse services;
   b. Inpatient Behavioral Health Services.

4.3.18.6 Behavioral Health Emergency Services

(2 pages)

Describe the Respondent's experience with, and plans for, providing Behavioral Health Emergency Services, including:

1. Use of Mobile Crisis Teams;
2. Emergency screening services;
3. Training for Members and individuals in the Member's support network to help prevent and effectively respond to a behavioral health emergency; and
4. Short-term crisis stabilization for STAR Kids populations or for a comparable population.

4.3.19 Section 19 – Telemedicine, Telehealth, and Telemonitoring Access

(2 pages)

Describe the Respondent's vision for the use of Telemedicine, Telehealth, and Telemonitoring services including opportunities to use video conferencing to improve quality or access to care. The Respondent must describe the Respondent's Telemedicine, Telehealth, and Telemonitoring capabilities, how the Respondent will recruit providers with Telemedicine, Telehealth, and Telemonitoring capabilities, and how the Respondent will structure its Provider Network to use Telemedicine, Telehealth, and Telemonitoring to connect providers throughout Texas. The Respondent must describe how it will meet the Telemedicine, Telehealth, and Telemonitoring requirements in **Section 8.1.3.4**, including how it will determine the number and placement of telemedicine and telehealth endpoints.

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4.3.20 Section 20 – Pharmacy Services

(8 pages)

The Pharmacy Services requirements are described in **Section 8.1.17**. For all of the following submission requirements, instead of attaching copies of the Respondent's policies and procedures, the Respondent should provide a brief summary of its policies and procedures.

1. The Respondent must describe the processes it will use to manage the pharmacy benefit under both of the following scenarios:
    a. HHSC requires the MCO to implement the Medicaid formulary and preferred drug lists (PDLs); and
    b. the MCO is allowed to establish its own formularies and PDLs.
2. The Respondent must describe the policies and procedures for how mail-order pharmacies will be available to Members.
3. The Respondent must identify 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. The Respondent must describe how rebates will be negotiated (if HHSC determines that the MCO will perform this service), identified, and reported.
5. The Respondent must describe the policies and procedures for drug utilization reviews, including ensuring prospective reviews take place at the dispensing pharmacy's point of sale (POS).
6. The Respondent must describe its policies and procedures for targeted interventions for Network Providers over-utilizing certain drugs.
7. The Respondent must describe monitoring policies and procedures to ensure prescriptions for psychotropic medications remain within established parameters.

4.3.21 Section 21 – Management Information System (MIS) Requirements

(10 pages – Page limit excludes system diagrams and process flow charts.)

The Respondent must:

1. Describe the Management Information System (MIS) the Respondent will implement, including how the MIS will comply with HIPAA as amended or modified. The response must address the requirements of **Section 8.1.20**. At a minimum, the description should address:
    a. hardware and system architecture specifications;
    b. data and process flows for all key business processes in **Section 8.1.20.3**; and
    c. attest to the availability of the data elements required to produce required management reports.

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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 for the MCO's proposed STAR Kids Program.
4. Describe the Respondent's ability and experience in performing coordination of benefits and 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 processing claims electronically, generally describe the type and volume of provider claims received electronically in the previous year versus paper claims for each claim type; and
    b. if currently making claims payments to providers electronically, generally describe the type and volume of provider claims payment processed electronically.
6. Describe the Respondent's experience and capability to comply with the Internet website requirements and mobile application requirements of **Section 8.1.5.5**, and briefly describe any additional website and mobile application capabilities that the Respondent proposes to offer to Members or Providers.
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 Kids Program.

4.3.22 Section 22 – Fraud, Waste, and Abuse
(3 pages)

The Fraud, Waste, and Abuse requirements of the RFP are described in **Section 8.1.21**. The Respondent must describe how it 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.

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4.3.23 Section 23 – MCO Transition Plan

(4 pages)

The Transition Plan Requirements for MCOs are described in **Section 7**.

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 similar contractors.
2. Respondent must answer either (a) or (b) as it applies to Respondent.
    a. A Respondent that is proposing to participate in STAR Kids 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 **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 Kids 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 **Section 7**.

4.3.24 Section 24 – MCO Turnover Plan

(4 pages)

The Turnover Plan Requirements for MCOs are described in **Section 9**.

The Respondent must describe a high-level overview of how it will implement a Turnover Plan that will comply with this RFP, including how it will transfer data to HHSC or a successor contractor and how it will ensure the least disruptive delivery of services to Members.

In addition, 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 Turnover Plan.

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2. Identify the officer or director of the Respondent organization who will have overall responsibility and authority for carrying out the Turnover Plan provisions.

4.3.25 Section 25 – Additional Requirements Regarding Dual Eligibles

(4 pages)

The additional requirements regarding certain categories of Dual Eligibles are described in **Section 8.2**.

1. Briefly describe the Respondent's experience in managing the cost sharing obligations of Dual Eligibles, or, if the Respondent has no experience, describe the Respondent's proposed process for meeting this requirement. Include a description of the Respondent's methods to inform providers regarding the balance billing requirements of federal law with respect to Dual Eligible cost-sharing obligations.
2. Describe how the Respondent intends to coordinate care for Dual Eligible Members, including:
   a. How the Respondent will identify Long-Term Services and Supports (LTSS) providers in the relevant Service Areas.
   b. The processes and procedures Respondent will use to coordinate the delivery of Community-based Long-Term Care Services with Medicare benefits for Dual Eligible Members.
   c. The training Respondent will provide to staff and providers regarding Community-based Long-Term Care Services and the coordination of those services with Medicare benefits.
3. Describe the Respondent's process for providing Medicaid outpatient pharmacy services for Dual Eligibles.
4. Describe how the Respondent will work with HHSC to share information regarding Medicare and Medicaid participating providers, Member complaints, and HEDIS data.

4.4 Part 4 – Additional Requirements Regarding MDCP STAR Kids

(8 pages)

1. Describe the process the Respondent will use to create an ISP for a Member receiving MDCP STAR Kids services. Include a description of the role of the named Service Coordinator in the process.
2. Describe how the Respondent will identify needs for home modifications and adaptive aides, determine the appropriate amount of services, and ensure the services are sufficiently provided.

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3. Describe how the Respondent will work with Members, the Members' LARs, and Providers to create a plan of care for MDCP services that is within the MDCP Member's cost limit. Include a description of how the MCO will document and communicate service fluctuations that occur from month to month.
4. Describe the process the Respondent will use to coordinate services for Members who receive respite, flexible family supports, PCS, and Nursing Services. Describe how the Member and the Member's LAR will be involved in this process.
5. Provide a list of qualifications and training requirements for staff members who will help provide services to Members who receive MDCP STAR Kids services. Include specific requirements for named Service Coordinators working with MDCP Members.
6. Describe immediate steps the Respondent will take for Members who fail to meet Medical Necessity criteria upon annual reassessment.
7. Describe how the Respondent will work with families, HHSC, and the HHSC Administrative Services Contractor (ASC) to prevent gaps in service resulting from the annual redetermination process.

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5. Evaluation Process and Criteria

5.1. Overview of Evaluation Process

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 and conditions of the RFP, including **Attachment A**, "STAR Kids Contract Terms."

5.2. MCO Service Areas

MCOs may bid to serve one or multiple Medicaid Managed Care Service Areas. See the maps in **Attachment B-4 and B-4.1**.

5.3. Evaluation Criteria

HHSC will evaluate each proposal using the following criteria, in descending order of priority, developed from the best value factors listed in Section 2.

	Evaluation Criteria
1	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: a. The extent to which the proposal addresses HHSC's priority objectives for the initial Contract Period, as defined in Section 1.6 ("Mission Objectives"); b. The extent to which the Respondent accepts without reservation or exception the RFP's terms, including Attachment A, "STAR Kids Contract Terms"; c. The extent to which the proposal exhibits expertise in providing services to populations comparable to STAR Kids Members and ability to comply with the requirements of this RFP—particularly the requirements outlined in Section 4 and 8; d. The quality and reliability of the goods and services, including the ability to retain, recruit, and maintain Providers in Respondent's network and to respond timely and adequately to Member questions and complaints; e. The degree to which the proposal demonstrates flexibility based on

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	Evaluation Criteria
	individual Members' needs, the MCO's adaptability to the unique needs of this population, and exceptional customer service; f. The identification of a methodology to identify positive outcomes and a proposal to structure payments to incentivize and reward desired outcomes; and g. The extent to which the proposal ensures appropriate access to care in rural and medical shortage areas;
2	Indicators of probable vendor performance, including: a. Respondent's past performance in Texas or comparable experience in other states, including proven ability to integrate physical and behavioral health services and acute and long-term services and supports; b. Current financial solvency and the ability to remain financially solvent during the Initial Contract Period; c. Ability to deliver Community-Based Services and coordinate with HCBS Waiver programs; d. Capacity for Respondent's organizational structure to support operations; e. Ability to obtain and maintain TDI approval to operate and a status of Good Standing with the Comptroller; and f. The qualifications and experience of Respondent's key personnel to achieve program goals.
3	Effect of the acquisition on agency productivity, including: a. The level of effort and resources required by HHSC to monitor the Respondent's performance under the Contract; and b. The level of effort required by HHSC to maintain a good working relationship with Respondent.
4	Delivery Terms, including: a. The Respondent's ability to complete transition phase requirements in Section 7 and to fully implement services by the Operational Start Date; b. The Respondent's ability to maintain full service operations throughout the Initial Contract Period; c. The Respondent's ability to comply with turnover requirements in Section 9 upon termination of the Contract.

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 (STP). HHSC defines "substantial participation"

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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; and

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 the date provided in **Section 1.3**. 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.

5.4. 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 **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.

5.5. 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.

5.6. 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.

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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.

5.7. Best and Final Offer

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 **Attachment A,** "STAR Kids Contract Terms," **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.

5.8. 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:

- obtaining clarification of proposal ambiguities;
- requesting modifications to a proposal; or
- 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.

5.9. Contract Awards

Respondents are allowed to select which Services Areas to include in their Proposals. It is possible that a Respondent submitting a Proposal for more than one Service Area could be awarded a Contract for some of its proposed Service Areas, but not necessarily all Service Areas. HHSC reserves the right to change the boundaries for, or otherwise modify, the Service Areas if it determines that doing so is in the best interest of the State.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	October 1, 2015	Initial version of Attachment B-1, RFP Section 6, "Incentives & Disincentives" that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2016	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.2	November 1, 2016	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.3	March 1, 2017	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.4	June 1, 2017	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.5	September 1, 2017	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.6	March 1, 2018	Section 6.2.2 is modified to reflect the new chapter for the redesigned medical P4Q.
Revision	1.7	September 1, 2018	Section 6.2.2 is modified to reflect the new chapter for the redesigned medical P4Q.
Revision	1.8	January 1, 2019	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.9	March 1, 2019	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.10	September 1, 2019	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.11	March 1, 2020	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.12	September 1, 2020	Global Change to correct the reference to UMCM Chapter 6.
Revision	1.13	March 1, 2021	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."

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[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

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6 Premium Payments and Performance 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**, "STAR Kids Contract Terms," under Article 10, "Terms of Payment," and **UMCM Chapter 6** 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 contracting MCOs 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 **Section 8.1.7.11** and **Uniform Managed Care Manual (UMCM) Chapter 6**.

6.2.1 Performance Profiling

HHSC intends to distribute information on key performance indicators to MCOs on a regular basis, identifying an 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 or MCO peer group performance comparisons on its website.

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6.2.2 Medical Pay-for-Quality (P4Q) Program

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

HHSC will pay the MCO the full monthly Capitation Payments as described in **Section 6.2**. Then, at the end of the medical P4Q data collection period, HHSC will evaluate the MCO's performance and assign points and dollar amounts using the methodology set out in **UMCM Chapter 6**. Failure to timely provide HHSC with necessary data related to the calculation of the P4Q performance indicators will result in HHSC's assignment of a zero percent (0%) performance rate for each related performance indicator.

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

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

6.3 Auto-assignment Methodology for Medicaid MCOs

HHSC may revise its auto-assignment methodology during the Contract Period for enrollees who do not select an MCO. The new assignment methodology may reward those MCOs that demonstrate superior performance or improvement on one or more key dimensions of performance (see 1 Tex. Admin. Code § 353.403(d)(3)(B)).

6.4 Frew Incentives and Disincentives

This Contract includes a system of incentives and disincentives required by the *Frew v. Traylor* "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**.

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6.5 This Section Intentionally Left Blank

6.6 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 Kids Contract Terms," and **Attachment B-3 ~~2~~,** "Deliverables/Liquidated Damages Matrix," for performance standards that carry liquidated damage values.

6.7 Additional Incentives and Disincentives

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.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	October 1, 2015	Initial version of Attachment B-1, RFP Section 7, "Transition Phase Requirements" that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2016	Section 7.3.7 is modified to require the MCOs to submit all provider education materials and presentations for HHSC approval prior to use.
Revision	1.2	November 1, 2016	Section 7.3.7.1 Value-Added Services is added.
Revision	1.3	March 1, 2017	Contract amendment did not revise Attachment B-1, RFP Section 7, "Transition Phase Requirements."
Revision	1.4	June 1, 2017	Contract amendment did not revise Attachment B-1, RFP Section 7, "Transition Phase Requirements."
Revision	1.5	September 1, 2017	Contract amendment did not revise Attachment B-1, RFP Section 7, "Transition Phase Requirements."
Revision	1.6	March 1, 2018	Section 7.3.7 is modified to align the timeframe requirement for uploading files.
Revision	1.7	September 1, 2018	Section 7.3.7.1 is modified to update UMCM Chapter reference.
Revision	1.8	January 1, 2019	Contract amendment did not revise Attachment B-1, RFP Section 7, "Transition Phase Requirements."
Revision	1.9	March 1, 2019	Contract amendment did not revise Attachment B-1, RFP Section 7, "Transition Phase Requirements."
Revision	1.10	September 1, 2019	Contract amendment did not revise Attachment B-1, RFP Section 7, "Transition Phase Requirements."
Revision	1.11	March 1, 2020	Contract amendment did not revise Attachment B-1, RFP Section 7, "Transition Phase Requirements."
Revision	1.12	September 1, 2020	Global Change to correct the references to UMCM Section 7.1 is modified to clarify language to include expectations required of contracted MCO' should they terminate, merge, or acquire new business.

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			Section 7.2 is deleted. “Intentionally Left Blank” Section 7.3 is modified to clarify language to include expectations required of contracted MCO’ should they terminate, merge, or acquire new business. Section 7.3.1 is modified to clarify language to include expectations required of contracted MCO’ should they terminate, merge, or acquire new business. Section 7.3.2 is modified to clarify language to include expectations required of contracted MCO’ should they terminate, merge, or acquire new business.
Revision	1.13	March 1, 2021	Contract amendment did not revise Attachment B-1, RFP Section 7, “Transition Phase Requirements.”

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions

[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

[3] Brief description of the changes to the document made in the revision.

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7 Transition Phase Requirements

7.1 Introduction

This Section presents the scope of work for the Transition Phase of the Contract. The Transition Phase includes all activities the MCO is required to perform between the Effective Date and the Operational Start Date of a Contract resulting from award through procurement or an assignment and assumption due to termination, expiration, merger, or acquisition.

The Transition Phase includes a timeline for Readiness Review, which must be completed to HHSC's satisfaction prior to the MCO's Operational Start Date for each Service Area. Readiness Review includes but is not limited to the following areas, which are further explained in this Article7:

- Administration of Key MCO Personnel
- Organizational Readiness Review
- Financial Readiness Review
- System Testing and Transfer of Data
- System Readiness Review
- Demonstration and Assessment of System Readiness
- Operations Readiness
- Assurance of System and Operational Readiness

Upon the identification by the MCO or HHSC of any deficiencies during or as a result of Readiness Review, MCO will correct the deficiencies within 10 Days of identification and written notification to the Parties or provide a Corrective Action Plan or risk mitigation plan as directed by HHSC if the deficiency requires more than 10 Days to correct.

HHSC may, at its discretion, postpone the MCO's Operational Start Date, or assess contractual remedies, including termination of the Contract, if the MCO fails to timely correct all Readiness Review deficiencies within a reasonable cure period determined by HHSC.

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.

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7.2 Intentionally Left Blank

7.3 Transition Phase Schedule and Tasks

The MCO has overall responsibility for the timely and successful completion of each of the Transition Phase tasks. The MCO is responsible for clearly specifying and requesting information needed from HHSC, other HHSC contractors, and Providers in a manner that does not delay the schedule or work to be performed.

7.3.1 Transition Phase Planning

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

1. define 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 must update the Transition Plan provided with its Proposal to HHSC no later than 30 Days after the Effective Date, then provide monthly implementation progress reports through the sixth month of MCO Program operations. In the case of the assignment and assumption of a Contract due to termination, expiration, merger, or acquisition, the incoming or transitioning MCO must provide a Transition Plan no later than 30 Days after the MCO notifies HHSC or upon notification from HHSC of the termination, expiration, merger, or acquisition. The exiting MCO must comply with the requirements as described in Attachment B-1, Section 9, Turnover Requirements.

The Transition Plan must include:

(1) specific staffing patterns by function for all operations, including enrollment, information systems, member services, quality improvement, claims management, case management, and provider and recipient training;

(2) specific time frames for demonstrating preparedness for implementation before the Operational Start Date; and

(3) Other elements identified by HHSC.

The MCO's Transition/ Plan must include a detailed description of the process it will use to ensure continued authorization of Community-based Services at the time of implementation. HHSC will provide a file identifying Members who receive Community-based Services, including those enrolled in MDCP to the MCO for this purpose. The

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MCO's Transition Plan must identify a designated MCO staff member responsible for the facilitation and oversight of this process. These requirements are further described in **Section 8.1.23,** "Continuity of Care and Out-of-Network Providers" and Section 8.1.40.1, "Training".

7.3.2 Administration and Key MCO Personnel

No later than the Effective Date, the MCO must designate and identify Key MCO Personnel that meet the requirements in **Attachment A**, "STAR Kids Contract Terms." The MCO will supply HHSC with the current resume of each Key MCO Personnel. The MCO must also provide HHSC with any organizational information that has changed since the MCO's Proposal, such as job descriptions and organizational charts, if applicable. For Service Coordinators, the MCO must also provide information on the anticipated maximum caseload per Service Coordinator (i.e., number of Members per Service Coordinator). If the MCO is using Material Subcontractors, the MCO must also provide the organizational chart for these Material Subcontractors.

In the case of assignment and assumption of a Contract, the incoming or transitioning MCO must provide HHSC with the Key MCO Personnel who will facilitate ongoing activities and requirements described in the Transition Plan. The MCO will also provide HHSC with the Material Subcontractor's functions and responsibilities as identified in UMCM Chapter 5.21.

7.3.2.1 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

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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.

7.3.3 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") of the RFP for a list of Financial Statements, Corporate Background and Status, Corporate Experience, and Material Subcontractor Information the MCO must update for Readiness Review.

7.3.4 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 8.1.20**. For example, the MCO's MIS system must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as indicated in **Section 8.1.20.4**.

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.

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.

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7.3.5 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 health care claims and data as required under the Contract.

The MCO must submit descriptions of interface and data and process flow for each key business processes described in **Section 8.1.20.3** "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 State review and approval, the following information no later than 120 Days prior to the Operational Start Date:

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.

7.3.6 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 that have been 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 Kids 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

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documentation to support the provision of STAR Kids 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 ten Days after notification of any deficiency by HHSC. If the MCO documents to HHSC's satisfaction that the deficiency has been corrected within ten Days of the deficiency notification by HHSC, no Corrective Action Plan is required.

7.3.7 Operations Readiness

The MCO must clearly define and document the policies and procedures that will be followed to support day-to-day business activities related to the provision of STAR Kids 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 other costs as damages in accordance with **Attachment A**, "STAR Kids Contract Terms," **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. The list must include a specific section on home health providers. The section must also include estimates of STAR Kids Members who may require Private Duty Nursing and attendant services and evidence of provider adequacy to serve the eligible population.
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.) All provider training and education materials and associated presentations specific

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to Medicaid benefits, services and programs must be submitted to HHSC for approval prior to use.

4. Prepare a Coordination Plan documenting how the MCO will coordinate its business activities with those activities performed by the Department of Aging and Disability Services (DADS), HHSC contractors, 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 the draft Member Handbook, draft Provider Manual, draft Provider Directory, and draft Member Identification Card to HHSC for review and approval. The materials must at a minimum meet the requirements specified in **Section 8.1.5.1** and include the Critical Elements as defined in the **Uniform Managed Care Manual (UMCM) Chapter 3.**
6. 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**.**
7. Develop and submit the MCO's proposed Member complaint and appeals processes to HHSC.
8. Provide sufficient copies of the final Provider Directory to the HHSC Administrative Services Contractor in sufficient time to meet the enrollment schedule.
9. Demonstrate toll-free telephone systems and reporting capabilities for the Nurse Hotline, Member hotline, the Behavioral Health hotline, and the Provider hotline.
10. Submit a Service Coordination plan that addresses requirements provided in **Section 8.1.38.6**.
11. 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 8.1.21**, 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 and abuse detection, prevention and reporting. Executive and essential fraud and abuse personnel means MCO staff persons who supervise staff in the following areas: data collection, Provider enrollment or disenrollment, Encounter Data, claims processing, Utilization Review, appeals or grievances, quality assurance and marketing, and who are directly involved in the decision-making and administration of the Fraud, Abuse, and Waste detection program within the MCO. The training will be conducted by the Office of Inspector General, HHSC, and will be provided free of charge. The MCO must schedule and complete training no later than 90 Days after the Effective Date.

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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 as stated in **Section 8.1.21**.

d. Complete hiring and training of STAR Kids Service Coordination staff no later than 45 Days prior to the STAR Kids Operational Start Date.

12. 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 (within two Business Days and off-cycle upon HHSC's request);

    b. prior authorization of drugs, including how HHSC's preferred drug lists (PDLs) will be incorporated into prior authorization systems and processes. The MCO must adopt HHSC's prior authorization processes, criteria, and edits unless HHSC grants a written exception, and HHSC's approval is required for all Clinical Edit policies;

    c. implementing drug utilization review;

    d. monitoring the use of psychotropic medications;

    e. overriding standard drug utilization review criteria and clinical edits when Medically Necessary based on the individual Member's circumstances (e.g., overriding quantity limitations, drug-drug interactions, refill too soon);

    f. call center operations, including how the MCO will ensure that staff for all appropriate hotlines are trained to respond to prior authorization inquiries and other inquiries regarding pharmacy services; and

    g. monitoring the PBM Subcontractor.

The plan must also include a written description of the assurances and procedures that must be put in place under the proposed PBM Subcontract, such as an independent audit, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information.

Additionally, the MCO must include a written attestation by the PBM Subcontractor in the plan stating, in the three 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.

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During the Readiness Review, HHSC may request from the MCO certain operating procedures and updates to documentation to support the provision of STAR Kids 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 promptly provide a Corrective Action Plan or Risk Mitigation Plan as requested by HHSC in response to Operational Readiness Review deficiencies identified by the MCO or by HHSC or its agent. The MCO must promptly alert HHSC of deficiencies, and must correct a deficiency or provide a Corrective Action Plan or Risk Mitigation Plan no later than ten Days after HHSC's notification of deficiencies. If the Contractor documents to HHSC's satisfaction that the deficiency has been corrected within ten Days of such deficiency notification by HHSC, no Corrective Action Plan is required.

7.3.7.1 Value-Added Services

The MCO must use HHSC's template for submitting proposed Value-added Services which is included in **UMCM Chapter 4.**

During the Transition Phase (as defined in **Attachment A**), HHSC will offer a one-time opportunity for the MCO to propose two additional Value-added Services to its list of current, approved Value-added Services HHSC will establish the requirements and the timeframes for submitting the two additional proposed Value-added Services.

During this HHSC-designated opportunity, the MCO may propose either to add two new Value-added Services or to enhance its approved Value-added Services, which will be effective on the Operational Start Date. The services do not have to be the same for each Program. The Contract will be amended to include any additional Value-added Services approved by HHSC.

The MCO does not have to add Value-added Services during the HHSC-designated opportunity, but this will be the only time during the Transition Phase for the MCO to add Value-added Services. At no time during the Transition Phase will the MCO be allowed to delete, limit or restrict any of its approved Value-added Services.

7.3.8 Assurance of System and Operational Readiness

In addition to successfully providing the Deliverables described in **Section 7.3** (Transition Phase Schedule and Tasks), the MCO must assure HHSC that all processes, MIS systems, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Operational Start Date. In particular, the MCO must assure that Key MCO Personnel, Member Services staff, Provider Services staff, and MIS staff are hired and trained, MIS systems and interfaces are in place and functioning properly, communications procedures are in place, Provider Manuals have been distributed, and that Provider training sessions have occurred according to the schedule approved by HHSC.

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7.3.9 TDI and Centers for Medicare and Medicaid Services Licensure, Certification, or Approval

The MCO must receive TDI licensure, certification, or approval (as applicable) for all zip codes in the awarded Service Areas no later than 60 Days after the Contract's Effective Date.

7.3.10 Post-Transition

The MCO will work with HHSC, Providers, and Members to promptly identify and resolve problems identified after the Operational Start Date and to communicate to HHSC, Providers, and Members, as applicable, the steps the MCO is taking to resolve the problems.

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, Members, Members' families, and other stakeholders.
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 under 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 8.1.1.2** and **8.1.17** for additional information regarding MCO Readiness Reviews during the Operations Phase.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	October 1, 2015	Initial version of Attachment B-1, RFP Section 8, "Operations Phase Requirements" that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2016	Section 8.1.1.1 is modified to remove the reference to the NorthSTAR behavioral health organization. Section 8.1.1.2 is modified to require the MCO to allow HHSC access for remote monitoring. Section 8.1.2 is modified to require MCOs to monitor claims data for delivery of prior authorized acute and long-term care services and to require the MCOs to utilize evidence based medical policies. Section 8.1.3.1 is modified to remove "non-HCBS STAR+PLUS Waiver" from item 5. Section 8.1.3.4.1 "School-based Telemedicine Services" is added. Section 8.1.4.2.2 is modified to remove "Abuse or Neglect (CPS)" and "(APS)" from items 4 and 5. Section 8.1.4.7 is modified to the timeframe. Section 8.1.5.11 is modified to require MCOs to adhere to the minimum requirements set in the UMCM. Section 8.1.6 is modified to correct the UMCM reference. Section 8.1.16 is modified to remove the reference to NorthSTAR. Section 8.1.16.9 "Data Sharing with NorthSTAR" is deleted in its entirety. Section 8.1.17.1 is modified to change "Clinical Edits" to "Clinical PAs." Section 8.1.17.2 is modified to add language regarding VDP's Clinical PA process and dispensing or refilling a prescription without a prior authorization during a Governor-declared disaster. Section 8.1.17.6 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

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.17.15 is modified to prohibit the use of extrapolation in pharmacy audits and to remove the requirement to comply with Texas Insurance Code § 843.3401. Section 8.1.17.18 "Second Generation Direct Acting Antivirals for Hepatitis C" is deleted in its entirety. Section 8.1.22.2 is modified to add "Critical Incidents and Abuse, Neglect, and Exploitation Report" and "MSHCN Quarterly Report." Section 8.1.24.8 is modified to remove the reference to NorthSTAR. Section 8.1.29.4 is modified to require MCOs to ensure appropriate staff attends all Fair Hearings as scheduled. Section 8.1.38.6.1 is modified to add SED and remove "Members with psychosocial needs that present significant challenges to the Member's health and wellbeing." Section 8.1.38.4 is modified to clarify that an integrated Health Home may perform Service Coordination functions, and serve as an identified Service Coordinator. Section 8.1.38.6.2 is modified to remove "non-SPMI behavioral health issues" and add "without SED or SPMI, but who have another behavioral health condition that significantly impairs functioning." Section 8.1.47 "Reporting Abuse, Neglect, or Exploitation" is renamed "Abuse, Neglect, or Exploitation" and the text is deleted. In addition, Section 8.1.47.1 "Member Education on Abuse, Neglect, or Exploitation" is added. Section 8.1.47.2 "Abuse, Neglect, and Exploitation Email Notifications" is added.
Revision	1.2	November 1, 2016	Section 8.1.2.3 is modified to delete references to the transition phase. The language has been moved to Section 7.3.7.1. The September 1, 2016, request to change VAS is deleted as redundant. Section 8.1.4 is modified to modify Children's Hospitals/Hospitals with specialized pediatric services and to add Prescribed Pediatric Extended Care Centers (PPECC) as a provider type.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.4.1 is modified to require the MCOs to provide each provider with a copy of the executed provider contract within 45 days of execution. Section 8.1.4.2.1 is modified to add provider types for which the MCOs must expedite credentialing. Section 8.1.4.4 is modified to clarify item 10; and to remove item 21 "requirements of the *Frew v. Traylor* Consent Decree and Corrective Action Orders". Section 8.1.4.6 is modified to align the contract language with the Texas Government Code. Section 8.1.4.6.2 Safety-net Hospital Incentives is added. Section 8.1.4.7 is modified to clarify the reporting requirement. Section 8.1.5.4 is modified to clarify the requirements and to add Subsections 8.1.5.4.1 Hard Copy Provider Directory and 8.1.5.4.2 Online Provider Directory. Section 8.1.5.5 is modified to add a reference to the Online Provider Directory and to add requirements for mobile device use. Section 8.1.5.7 is modified to add item (6)(v) Prescribed Pediatric Extended Care Services. Section 8.1.5.11 is modified to change "is encouraged to" to "must, if possible" and to update the UMCM reference. Section 8.1.12 Coordination with Texas Department of Family and Protective Services is added. Section 8.1.15 is modified to add THSteps to the section name and to include PPECC services in the description of CCP Community-Based Services. Section 8.1.16.2 is modified to add UMCM chapter reference. Section 8.1.21 is modified to clarify MCO level of cooperation and assistance. Section 8.1.21.2 is modified to clarify and provide support to the Deliverables/Liquidated Damages Matrix. Section 8.1.22.2 is modified to update the requirements for items (d) (e) and (f) to reflect current

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			UMCM reporting; to delete items (f), (l), (m), and (p); and to add item (v) Network and Capacity Report. Section 8.1.23 is modified to add subsection headings and to update the requirements for individuals who become Members on the Operational Start Date. Section 8.1.24.3.2 is modified to require the MCOs to educate providers on OEFV documentation. Section 8.1.24.3.4 is modified to add item 6 Prescribed Pediatric Extended Care Center services to the list of Covered Services. Section 8.1.24.3.5 is modified to clarify items 3 and 4 and to remove the requirement for the MCO to educate and train Providers regarding the requirements of the *Frew v. Traylor* Consent Decree and Corrective Action Orders. Section 8.1.24.8 is modified to update item 3 to ECI targeted case management; to remove the words service coordination; and to add item 14 "Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members." Section 8.1.24.13 is modified to require the MCOs to educate providers on documentation for immunizations. Section 8.1.24.15 Prescribed Pediatric Extended Care Centers is added. Section 8.1.24.15.1 Prior Authorization for PPECC Services is added. Section 8.1.29.10 Member Pre-Appeal Process is deleted in its entirety. Section 8.1.30.1 is modified to add clinic/group practices to the list of qualified Network entities. Section 8.1.36.1 is modified to remove private duty nursing. Section 8.1.36.2 is modified to add TAC reference. Section 8.1.37.1 is modified to remove the requirement to hold a DADS FMSA contract. Section 8.1.38.2 is modified to add the caveat that the Member or Member's LAR can decline the STAR Kids Screening and Assessment Process.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.38.3 is modified to add timeframes for the completion of the ISP. Section 8.1.38.6 is modified to add notification requirements. Section 8.1.38.6.2 is modified to qualify Nursing Services as including PDN and PPECC. Section 8.1.38.6.3 is modified to require the MCO to provide a named Service Coordinator to Level 3 Members who are in CLASS, DBMD, HCS, or TxHml. Section 8.1.38.7 is modified to require the Service Coordinator to have expertise in pediatric developmental challenges; to attend at least 75% of face-to-face visits; to provide Members with service options for ongoing skilled nursing; and to complete any HHSC-required training. In addition, THSteps CCP services is added to the list of extended service network services. Section 8.1.38.11 is modified to change the title from "Conversion Plan for New STAR Kids Members" to "Documentation for New STAR Kids Members" and to update the language. Section 8.1.38.16.5 is modified to remove the reference to the MDCP module. Section 8.1.39 is modified to clarify timeframes, clarify requirements for staff completing the NCAM, to clarify that the NCAM module in the STAR Kids SAI is used to establish the need for nursing services for either PDN or PPECC, or a combination of both; to change the title of the section to include the term "Initial"; to change the timeframe for initial telephonic screening for members who enroll 6 months after the Operational Start Date from 5 business days to 10; to require MCO documentation if a Member declines the SAI process; to clarify Priority 2 and 3 Members and the timeframes for scheduling the SAI; to remove references to the MDCP module; to expand the list of those who can administer the SAI; to require that the MCO submit data to HHSC; to require that the MCO provide the Member, upon request, a copy of the results of the SAI; to require that the MCO provide a summary on significant findings to the Member's PCP if requested; and to require that the MCO provide the Member's CFC provider (as applicable) with a copy of the SAI and the ISP.

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			Section 8.1.39.1 is modified to clarify the timeframes. Section 8.1.40.3 Rate Enhancement Payments for Agencies Providing Attendant Care is modified to apply only to DAHS Providers. Section 8.1.44 is modified to remove the reference to Frew requirements. Section 8.1.45 is modified to remove redundant language. Section 8.1.47.3 MCO Training on Abuse, Neglect, and Exploitation is added. Section 8.1.48 Carve-in Readiness is added. Section 8.2 is modified to delete the introductory paragraph. Section 8.3.1 is modified to clarify the STAR Kids SAI transmission process between the MCO and the HHSC ASC.
Revision	1.3	March 1, 2017	All references to OIG or IG will be changed to HHSC OIG. Section 8.1.1.1 is modified to align to the UMCM and the UMCC. Section 8.1.3.1 is modified to change the section name from "Waiting Times for Appointments" to "Appointment Accessibility" and the requirements are updated. Senate Bill 760, 84th Legislature, requires HHSC to start several network adequacy initiatives in Medicaid managed care. This contract language clarifies requirements for appointment wait times. Section 8.1.3.2 is modified to clarify time and mileage standards for network providers. Senate Bill 760, 84th Legislature, requires HHSC to start several network adequacy initiatives in Medicaid managed care. CMS also requires states to implement network adequacy requirements with time and distance standards by Sept. 2018. See CFR 438.68 (b). Section 8.1.3.3 is modified to change the mandatory challenge survey to a Provider Directory Verification Survey and to update the requirements. Section 8.1.4 is modified to clarify that qualified PPECCs include those with a temporary, initial, or renewal license.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.4.2.1 is modified to add Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Psychologists to the list of providers allowed to provide services to members on a provisional basis while in the credentialing process. Section 8.1.5.1 is modified to remove review timeframe. Review timeframes can be found in UMCM Chapter 4.6 MCO Materials Submission Process, and to update the reference to UMCM Chapter 4. Section 8.1.5.5 is modified to update the reference to UMCM Chapter 4. Section 8.1.5.6.2 is modified to add requirements that Member Service representatives be knowledgeable about service management and service plans and trained to assist with scheduling an appointment. Section 8.1.5.8 is modified to add CLAS requirements. Section 8.1.5.12 Member Service Email Address is added to comply with SB 760, 84th Legislature which requires MCOs to have an email address for assistance with appointments. Section 8.1.16.6 is modified to obligate MCOs to pay for court ordered services when they are a Medicaid benefit (outside the IMD exclusions age range of 21-64); to remove a provision that specifically prohibits MCOs paying for court ordered commitments; and to require MCOs to cover SUD treatment as a condition of probation. Section 8.1.16.10 is modified to conform to CMS clarifying guidance regarding mental health parity. Section 8.1.20.2 is modified to remove the phrase "at the beginning of each State Fiscal Year" from the first and second paragraph. Section 8.1.21 is modified to add a reference to Texas Government Code § 531.1131. Section 8.1.21.3 is modified to add item 2 and all subsequent items are renumbered. Section 8.1.22.2 is modified to remove (n) and add items (v) and (w). Section 8.1.23.2 is modified to add requirements for newly enrolled Members who were receiving a

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			service that did not require a prior authorization in FFS, but does require one by the new MCO. Section 8.1.24.8 is modified to remove item 12 "Court-Ordered Commitments to inpatient mental health facilities as a condition of probation" and all subsequent items are renumbered. Section 8.1.26 is modified to clarify the payment requirements. Section 8.1.38.7 is modified to change the date for required comprehensive training on Person-Centered Practices and Person-Centered Plan Facilitation. Section 8.1.38.15 is modified to clarify the requirement. Section 8.1.40.2 is modified to remove the reference to a UMCM chapter that has been withdrawn. Section 8.1.44 "Medical Transportation" is deleted in its entirety as being not necessary. Section 8.2.1 is modified to change "will" to "may be required to" to align with the other managed care contracts.
Revision	1.4	June 1, 2017	Contract amendment did not revise Attachment B-1, Section 8, “Operations Phase Requirements.”
Revision	1.5	September 1, 2017	Section 8.1.1.4 is added. Section 8.1.1.2 is modified to add material subcontractor site visit language and to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.2 is modified to comply with 42 CFR §438.210. Section 8.1.2.3 is modified to reduce the opportunity for changes to Value-added Services from biannual to annual. Section 8.1.3 is modified to comply with a court order requiring FQHC non-emergency unauthorized out-of-network services to be fully reimbursed. Section 8.1.4 is modified to comply with 42 CFR §457.990 regarding enrollment of CHIP providers. In

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			addition the reference to the DSHS website is changed to HHSC. Section 8.1.4.10.1 is modified to add Indian Health Care Providers to comply with 42 CFR §438.14 and to align the age requirements for PCPs with the American Academy of Pediatrics. Section 8.1.4.2 is modified to reference compliance with all of 42 CFR §438.214. Section 8.1.4.5 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.4.6.4 is added to comply with a new CMS managed care requirement in 438.602(d)(2). Section 8.1.4.7 is modified to comply with 42 CFR §438.10(f)(1), which relates to written notice of termination of a contracted provider. Section 8.1.5.1 is modified to comply with 42 CFR §438.10. Section 8.1.5.4.2 is modified to comply with 42 CFR §438.10, which relates to provider directories, member handbooks, and formularies. Section 8.1.5.6 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.5.9 is modified to change the performance standard for applying liquidated damages on Member appeals to be applicable to standard and expedited appeal is. Section 8.1.5.10 is modified to comply with 42 CFR §438.110. Section 8.1.7.1 is modified to comply with 42 CFR §438.332. Section 8.1.7.9.2 "MCO Value-Based Contracting" is renamed "MCO Alternative Payment Models with Providers" and the requirements are updated to establish targets for MCOs regarding levels of payments tied to APMs with Providers.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.7.12 is modified to clarify that MCOs using HEDIS hybrid measures are responsible for conducting chart reviews and submitting results to the EQRO. Section 8.1.9.1 is modified to add Member Handbook to the list of policies and procedures and substituting HHSC for DARS. Section 8.1.14.1 is modified to change the submission of the Plan for Special Populations from an annual report to an ad hoc report. Section 8.1.16.2 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.16.10 is modified to add specificity to the requirement. Section 8.1.19 is modified to clarify reasonable costs. Section 8.1.19.2 is modified to add item (n) "Medical Loss Ratio (MLR) Report" to comply with 42 CFR §438.8. Section 8.1.20 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.20.5 is modified to require the STAR+PLUS MCOs to display member eligibility verification data on their MCO portals; and to upload that data within 24 hours of receiving the file from HHSC; to keep online automated NF claims payment history for the most current 24 months; and to require MCOs to notify Providers regarding reprocessing of adjudicated claims. Section 8.1.20.5.1 is added. Section 8.1.21.2 is modified to add a five business day timeframe for requests submitted to the MCO/DMO for policy guidance, interpretations or clarifications. Section 8.1.21.4 (7) clarifies how settlements under the False Claims Act will be handled.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.22.2 is modified to change the reporting requirements for "Claims Summary Report" to by Program only, to delete "Children of Migrant Farmworkers Annual Plan" and to change the report title "Children of Migrant Farmworkers Annual Report (FWC Annual Report)" to "Migrant Farmworker Child Annual Report (FWC Annual Report) and Annual FWC Report Log" and update the requirements. Section 8.1.17 is modified to comply with 42 C.F.R. §438.3(s) and the Mental Health Parity and Addiction Equality Act (MHPAEA) of 2008. Section 8.1.17.1 is modified to comply with 42 C.F.R. §438.10, which relates to provider directories, member handbooks, and formulary information. Section 8.1.17 is modified to comply with 42 C.F.R. §438.3(s). Section 8.1.26 is modified to comply with a court order related to the Legacy lawsuit requiring FQHC non-emergency unauthorized out-of-network services be fully reimbursed. Section 8.1.23.3 "Residential and HCBS LTSS Continuity of Care" is added to comply with 42 CFR §438.56(d)(2)(iv). Section 8.1.24.1 is modified to update the citation to 42 C.F.R. §438. 113. Section 8.1.24.3.4 is modified to clarify requirements as a result of the Frew settlement agreement. Section 8.1.24.3.5 is modified to clarify requirements as a result of the Frew settlement agreement. Section 8.1.24.7 is modified to comply with 42 CFR §438.102. Section 8.1.24.12 is modified to provide consistency with contract definitions and implement administrative efficiencies for MCOs and HHSC staff. Section 8.1.25 is modified to add STPs for AA/PCA and MBCC and to remove Pharmacy providers and all other provider types in the table as the dates have passed. Section 8.1.27 “Provider Complaints and Appeals” is renamed “Provider Complaints and Internal MCO Appeals”; Section 8.1.27.1 Provider Complaints is amended to provide greater clarification regarding

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			proper and timely dissemination of information to the noted parties. Section 8.1.27.2 "Appeal of Provider Claims" is renamed " Provider Appeal of MCO Claims Determinations" and to comply with 42 CFR §438.406 Section 8.1.29.1 "Member Complaint Process" is renamed "MCO Member Complaint Process". Section 8.1.29.2 "Medicaid Standard Appeal Process" is renamed "Medicaid MCO Appeal Process" modified to change the performance standard for applying liquidated damages on member appeals to be applicable to standard and expedited appeals, to clarify that MCOs must not recover costs from Members without written permission from HHSC, and to comply with 42 CFR §§438.402, 438.406, and 438.420(b)(5). Section 8.1.29.7 is modified to clarify that both Members and any entity acting on behalf of the Member must receive appeal resolutions in writing. Section 8.1.31 is modified to clarify the requirements. Section 8.1.36.2 is modified to comply with 42 CFR §438.3(o). Section 8.1.38.7 is modified to include additional education requirements based on deficits verbalized by Service Coordinators and seen in UR reviews.
Revision	1.6	March 1, 2018	The following changes were made throughout the attachment: Updates to citations Removal of hyperlinks Change “patient” to “Member” Change “shall” to “must” Change “Network Provider Agreement” and “Provider Agreement” to “Provider Contract” Change “day(s)” and “calendar day(s)” to “Day” Remove numeric number for those numbers under 10 Capitalized defined terms Changed order of terms Fraud, Waste and/or Abuse to consistent use of phrase

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Changed “Expedited Appeal” to “Expedited MCO Internal Appeal” Changed “Fair Hearing System” to “State Fair Hearing System” Section 8.1.1.4 is modified to remove statement regarding STAR+PLUS. Section 8.1.2 is modified to clarify MCOs are responsible for providing and reimbursing out-of-home respite services provided in a nursing facility. Section 8.1.2.4 is modified to accommodate 42 C.F.R. § 438.3(e). Section 8.1.3 is modified to comply with a court order requiring FQHC non-emergency unauthorized out-of-network services to be fully reimbursed. Section 8.1.3.1 is modified to include MDCP services. Section 8.1.3.4 is modified to combined deleted Section 8.1.46. Section 8.1.4 “Optometrists and Ophthalmologists” is added to comply with implementation of HB 3675, 85r. Section 8.1.4.6.1 is modified to comply with the new CMS managed care rule 438.3(g) and added a paragraph to clarify “reporting” information. Section 8.1.4.9 is modified to withdraw MCO geo-mapping and to state expectations related to retaliation. Section 8.1.5.1 is modified to remove references to potential members from requirements. Section 8.1.5.4.1 is modified to comply with 42 C.F.R. § 438.10(h)(3) and to comply with FTP submission from beginning of each state fiscal quarter to as often as needed. Section 8.1.5.4.2 is modified to add “at least” weekly updates to online provider directories. Section 8.1.5.6.2 is modified to clarify the refusal is of a member and not MCO or provider. Section 8.1.5.8 is modified to add standardized requirements for cultural competency plans. Section 8.1.7.11 is removed because Pay-for-Quality is redundant to Section 6.2.2 .

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.9 is modified to clarify reauthorizations. Section 8.1.9.2 is modified to include "Provider portal" Section 8.1.17 is modified to remove requirements for in-state claims only due to new federal direction. Section 8.1.17.2 is modified to give more flexibility to the MCOs by no longer requiring a provider to submit a 72-hour claim. Section 8.1.17.3 is modified to add flexibility to deny certain claims for compound medications and to add clarity to the automatic approval of compounded medications. Section 8.1.17.4 "Compounded Medications" is added. Section 8.1.17.6 is modified to provide a clear set of expectations for compliance with UMCC requirements for PMUR. Section 8.1.17.13 is modified to give the MCOs the ability to deny retail claims. Section 8.1.20.1 is modified to comply with 42 C.F.R. §§ 438.242 and 438.818. Section 8.1.20.3 is modified to align language with other contracts. Section 8.1.21.6 is modified to convert the timing from ad hoc to annual. Section 8.1.22.2 is modified to require documentation accompany a FWA referral, to remove items (m) and (n), and to add MDCP PDN PPECC Authorization Report. Section 8.1.23 is modified to make certain MCOs ensure continuity of care of newly enrolled Members. Section 8.1.23.3 is modified to clarify Provider requirements to notify Members of their option to change MCOs. Section 8.1.24.3.4 is modified to replace the term "must" with "should" when informing Members of available Texas Health Steps services. Section 8.1.24.3.5 is modified to remove reference to MCOs encouraging Network pharmacies to become Medicaid enrolled DME providers.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.24.13 is modified to clarify who can administer Immunizations. Section 8.1.26 is modified to comply with a court order requiring FQHC non-emergency unauthorized out-of-network services be fully reimbursed. Sections 8.1.29 and 8.1.29.1 are modified to move the definition of authorized representative from 8.1.29.1 to 8.1.29. Section 8.1.29.3 is modified to comply with 42 C.F.R. § 438.410. Section 8.1.29.4 is modified to comply with new CMS Managed Care Regulation 438.408. Section 8.1.31 is modified to require MCOs to submit a yearly plan/TPL process and clarify deadlines for billing & collection of TPL recoveries and to clarify to MCOs they should not require EOB for services which would not be approved by a primary insurance plan. Section 8.1.35 is modified to a 6th grade reading comprehensive level Section 8.1.36 is modified to comply with new managed care regulation 438.3(o) - LTSS Contracts. Section 8.1.38.4 is modified to ensure service coordination teams receive messages within 24 hours. Section 8.1.38.7 is modified to ensure service coordination teams receive messages within 24 hours. Section 8.1.39 is modified to clarify refusal is of a member and not MCO or provider and clarify MCOs requirement to provide Members with the Screening and Assessment Instrument within 7 Days. Section 8.1.39.1 is modified to provide additional guidance to MCOs about HHSC expectations related to assessment, authorization and initiation of LTSS. Section 8.1.46 is deleted in its entirety and combined with Section 8.1.3.4. Section 8.2.1 is modified to clarify MCOs must cover LTSS for dual-eligible members. Section 8.2.1.2 Long-term Services and Supports is added.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.3.1 is modified to identify the MCO service coordinator responsibilities. Section 8.3.3 is modified to remove requirements to collect MDCP Member's individual budget.
Revision	1.7	September 1, 2018	The following changes were made throughout the attachment: Capitalize defined terms and un-capitalize terms which are note defined. Spell out the full name of acronyms and remove acronyms in some instances. Remove duplicative language. Section 8.1.1.1 is modified to allow health plans to collaborate with community organizations. Section 8.1.2.3 is modified to update UMCM Chapter reference. Section 8.1.2.4 is modified to provide clarity for Case-by-case Services. Section 8.1.3 is modified to be in full compliance with 42 C.F.R. § 438.14. Section 8.1.3.2 is modified to comply with requirements of 42 C.F.R. §438.3(l), 438.68, and §457.1201(j). It is also modified to comply with S.B. 760 of the 84th Legislative Session, and managed care rules related to network adequacy. Lastly, it is modified to allow Geo mapping for audiology providers, and to bring contract language into alignment with current practice. Section 8.1.3.5 is added to outline requirements permitting Members to see out-of-network Indian Health Care Providers in order to comply with 42 C.F.R. 438.14. Section 8.1.4 is modified to clarify pharmacy services are included in the requirements supported by the CDC. Section 8.1.4.4 is modified to clarify the responsibility of the MCO to coordinate substance use disorder services. Section 8.1.4.6 is modified to reflect the new program area name.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.4.10.1 is modified to comply with S.B. 654 of the 85th Legislative Session, to allow MCOs to include advanced practice registered nurses as network primary care providers. Section 8.1.5.5 is modified to allow families to monitor the Member's documents in an electronic manner. Section 8.1.5.5.1 is added to allow families to monitor the Member's documents in an electronic manner. Section 8.1.9 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity. Section 8.1.15 is modified to update T.A.C. citation and to remove unrelated language regarding PDN services. Section 8.1.16 is modified to comply with S.B. 1107 of the 85th Legislature Session which updates the definitions of Telemedicine and Telehealth services in Texas Government Code § 531.001(7) and (8). Section 8.1.16.3 is modified to comply with S.B. 1107 of the 85th Legislature Session which updates the definitions of Telemedicine and Telehealth services in Texas Government Code § 531.001(7) and (8). Section 8.1.17.1 is modified to comply with H.B. 1296 of the 85th Legislative Session. Section 8.1.20 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity. Section 8.1.20.5 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity. Section 8.1.21.3 is modified to clarify language on operational processes. Section 8.1.21.4 is modified to comply with Texas Government Code § 531.102(g). Section 8.1.21.5 is modified to comply with 42 C.F.R. 438.608(d)(1)(i) and CMS MCE Checklist 1.1.6. Section 8.1.22.2 (q) is modified to update the reference to the UMCM chapter, (s) is modified to comply with 1915 (c) requirements, (x) is added to

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			comply with 1915 (c) waiver requirements, and (y) is added to create a new deliverable which captures utilization data for clinician-administered drugs paid through the non-risk based model. Section 8.1.26 is modified to be in full compliance with 42 C.F.R. § 438.14. Section 8.1.36.1 is modified to streamline and improve the EVV process/system. Section 8.1.37.1 is modified to clarify the requirements of the MCO to calculate a Member's budget through the CDS option. Section 8.1.38.6.1 is modified to comply with guidance for MDCP. Section 8.1.38.7 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity. Section 8.1.38.10 is modified to clarify the responsibility of the MCO to coordinate substance use disorder services. Section 8.1.38.13 is modified to clarify the responsibility of the MCO to coordinate substance use disorder services. Section 8.1.39 is modified to update T.A.C. citation and to remove unrelated language regarding NCAM services. In addition, this section is modified to require the MCOs to post the SAI to the Member Portal. Section 8.1.39.1 is modified to update T.A.C. citation and to remove unrelated language regarding NCAM services. In addition, this section is modified to require the MCOs to offer Members an opportunity to review the results of the SAI prior to TMHP submission. Section 8.1.43 is modified to emphasize the MDCP waiver requirements. Section 8.1.49 is added to ensure plans are in place for future disasters
Revision	1.8	January 1, 2019	Section 8.1.16.6 is modified to identify types of court orders that are Medicaid-payable.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.16.6.1 is added to identify types of court orders that are Medicaid-payable. Section 8.1.16.6.2 is added to identify types of court orders that are Medicaid-payable. Section 8.1.16.8 is modified to clarify court orders that are Medicaid-payable. Section 8.1.24.1 is modified to clarify court orders that are Medicaid-payable. Section 8.1.31 is modified to comply with The Bipartisan Budget Act of 2018.
Revision	1.9	March 1, 2019	Contract amendment did not revise Attachment B-1, Section 8, "Operations Phase Requirements."
Revision	1.10	September 1, 2019	Global change for the term "substance abuse" is changed to "substance use disorder" to align with the language in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Transferred Title 40 & 25 Texas. Admin. Code to Title 26 Global change for the term "Action" to "Adverse Benefit Determination" Section 8.1 is modified to remove & update language. Section 8.1.3.1 is modified to clarify required appointment wait time standards for Specialty Therapy Services. Section 8.1.3.3 is modified to comply with managed care Network Adequacy initiatives. Section 8.1.4 is modified to ensure Providers are not being paid for claims after a sanction or exclusion; clarify pharmacy contract arrangements; and correct the terminology regarding licensing, certification and Medicaid contracting per guidance from HHSC Licensing. Section 8.1.4.2.1 is modified to clarify language. Section 8.1.4.6 is modified to change timeframes for fee schedule changes. Section 8.1.5.4 is modified to comply with managed care Network Adequacy initiatives. Section 8.1.5.4.1 is modified to comply with managed care Network Adequacy initiatives.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.5.4.2 is modified to comply with managed care Network Adequacy initiatives. Section 8.1.5.6.2 is modified to comply with managed care Network Adequacy initiatives. Section 8.1.5.8 is modified to clarify the interpreter service requirements available to MCOs, including advance notice. Section 8.1.7.9.2 is modified to meet the APM requirement. Section 8.1.9 Modified to comply with CFR. Section 8.1.17.10 is modified to clarify MCOs requirement to adhere to the Specialty Drug List. 8.1.18 is modified to align the TPL language across all MCO contracts. Section 8.1.20 is modified to add language for verification. Section 8.1.20.5 is modified to add a sentence which was removed from the definition of “Clean Claim” Section 8.1.21 is modified to comply with nursing facility utilization. Section 8.1.21.1 is modified to comply with Rider 152, Article II, 85th Texas Legislature Section 8.1.21.2 is modified to add a requirement to retain certain documents for review by the OAG. Section 8.1.22.2 is add or modify reports. Section 8.1.29.1 is modified to align with MCO appeal standards. Section 8.1.29.2 is modified to comply with CFR and to ensure managed care Members have a full 10 Business days to request continued benefits. Section 8.1.31 is modified to clarify current language and alignment of the TPL language across all MCO contracts and to implement updated Section 1902(a)(25)(E) of the Social Security Act (42 U.S.C. §1396a(a)(25)(E)) as amended by the Bipartisan Budget Act of 2018 (Pub. L. 115-123) effective February 9, 2018. Removed September 1, 2017 language.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.36.1 is modified to comply with the requirement to streamline and standardize the EVV process per the OIG audit findings and the 21st CURES Act and Texas Govt. Code §531.024172 Section 8.1.38.3 is modified to align with similar Service Coordinator requirements in the STAR Kids contract. Section 8.1.38.4 is modified to ensure access to care for Members. Section 8.1.38.7 is modified to follow 2014 federal guidance from CMS. Section 8.1.38.7 is modified to align Critical Incident and Abuse, Neglect, and Exploitation efforts 2014 federal guidance from CMS. Section 8.1.39.3 is added to ensure contract language matches and aligns. Section 8.1.41.2 is modified to clarify narcotic/opiate treatment programs must be included the network. Also updated references to DSHS to HHSC and STP requirements consistent across contracts. Section 8.1.41.3 is modified to clarify narcotic/opiate treatment programs must be included the network. Also updated references to DSHS to HHSC and STP requirements consistent across contracts. Section 8.1.43 is modified to ensure the contract language matches and aligns. Section 8.1.49 is modified to align with the UMCM Chapter 16.1.13.
Revision	1.11	March 1, 2020	Section 8.1.3.4 is modified to comply with Senate Bill 670, and allows Members to utilize Telemedicine services from a provider other than their PCP Section 8.1.9 is modified to require MCOs to review and issue prior authorization determinations within specific timeframes for members who are hospitalized. The changes are necessary to comply with SB 1096.
Revision	1.12	September 1, 2020	Global change to correct the program name from “ImmTrac” to “ImmTrac2,” the new program name. Global Change to correct the references to UMCM.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.1.2 is modified to align review requirements across all contracts Section 8.1.2.4 is modified to specify what information is required for each authorized case-by-case service. Section 8.1.3.2 is modified to align all contract to ensure consistency in performance requirements. Section 8.1.4 is modified to align with all contracts and to remove a reference due to a policy change. Section 8.1.4.5 is modified to remove language that is no longer required by CMS. Section 8.1.5.6 is modified to remove measures that are no longer required by CMS. Section 8.1.5.8 is modified to remove reference to UMCM Chapter that do not exist. Section 8.1.7.9.1 is modified to correct citation. Section 8.1.7.9.2 is modified facilitate in advance to approval of MCOs APMs involving the outpatient drug benefit. Section 8.1.9 is modified to include requirement from SB 1207 related to prior authorizations and to comply with Legislative direction-HB 3041. Section 8.1.9.1 is modified to clarify language when providing new information to providers. Section 8.1.16.2 is modified to remove measures that Is no longer required by CMS. Section 8.1.17.1 is modified to align with TDI. Section 8.1.17.5 is modified to be consistent with current contract language. Section 8.1.17.11 is modified to requirement. The corresponding resolution and percentage language also aligns with UMCC contract requirements for the complaints and appeals processes. Section 8.1.18 is modified to add language to reflect the order when Medicaid is obligated pay. Section 8.1.19.2 (i) is removed from contract Section 8.1.19.2 (n) is modified to make language consistent across all contracts.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.19.2 (o) is modified to update Chapter reference. Section 8.1.20.5 is modified to comply with SB 749. Section 8.1.20.5.1 is modified to include Nursing Facility Daily/Unit as part of a Claims Project. Section 8.1.21.1 Is modified delete the language that allows MCOs to submit a letter in lieu of a full Fraud, Waste and Abuse compliance plan. Section 8.1.21.3 is modified to remove a report that is no longer required. Section 8.1.22.2 is modified to update UMCM references and report descriptions. Section 8.1.22.2(x) is modified to remove MCO self-reported service plan measures Section 8.1.24 is modified to be in alignment with other schedule for immunization. Section 8.1.24.3.4 is modified to be consistent throughout the contracts Section 8.1.24.13 is modified to be in alignment with other schedule for immunization. Section 8.1.25 is modified to be consistent throughout the contracts. Section 8.1.29.2 is modified to comply with S.B. 1207, 86TH Legislature, Regular Session, 2019, and in compliance with 42 C.F.R 438.402. Section 8.1.29.3 is modified to comply with S.B. 1207, 86TH Legislature, Regular Session, 2019, and in compliance with 42 C.F.R 438.402. Section 8.1.29.4 is modified to comply with S.B. 1207, 86TH Legislature, Regular Session, 2019, and in compliance with 42 C.F.R 438.402. Section 8.1.29.6 is modified to comply with the updates to SB 1207. Section 8.1.31 is modified to be consistent across all contracts. Section 8.1.33 is modified to be consistent throughout the contracts. Section 8.1.37 is modified to comply with HB4533

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.37.1 is modified to be consistent across all contracts. Section 8.1.37.2 is modified to comply with HB4533 Section 8.1.37.3 is modified to be consistent across all contracts. Section 8.1.40.2 is modified to comply with Audit recommendations. Section 8.1.41.2 is modified language moved to provider network section. Section 8.1.41.5 is Added to comply with SB 1564 86th Legislature requirements. Section 8.3.1 modified to clarify MDCP reassessment requirement Section 8.3.2 is modified to comply with HB4533 Section 8.3.3 is modified to comply with SB 1207
Revision	1.13	March 01, 2021	Section 8.1.3.2 is modified to comply with Rider 157 from the 86TH Legislature, Regular Session, 2019requirements. Section 8.1.4.6.5 is added to comply with SB 1621, 86TH Legislature, Regular Session, 2019. Section 8.1.16 is modified to comply with SB 1177, 86TH Legislature, Regular Session, 2019, amended Government Code § 533.005 updating contract requirements to include the provisions of this bill. Section 8.1.23 Added to comply with SB1207, Section 533.038(g), 86th Regular Legislative Session Section 8.1.50 is added to comply with federal law and CMS requirements. Section 8.1.50.1 is added to comply with federal law and CMS requirements.

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

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8. OPERATIONS PHASE REQUIREMENTS

HHSC will select multiple MCOs to provide Healthcare Services and Medically Dependent Children Program (MDCP) services to Members in every STAR Kids Service Area.

Section 8.1 describes the general administrative and operational requirements for serving all STAR Kids Members.

Section 8.2 includes additional requirements for serving qualified Dual Eligible Members.

Section 8.3 includes additional requirements for serving Members participating in MDCP STAR Kids.

This Section does not include all of the STAR Kids Program requirements, such as the time frames and formats for all reporting requirements. HHSC has included this information in the **Attachment A**, "STAR Kids Contract Terms," and the **Uniform Managed Care Manual (UMCM)**. HHSC reserves the right to modify these documents using the procedures set forth in the **STAR Kids Contract Terms**.

8.1 General Scope of Work

The MCO must provide Covered Services to all Members who are enrolled in the MCO STAR Kids Program.

The MCO must be licensed by the Texas Department of Insurance (TDI) as an HMO or an ANHC, or approved as an EPO, in all zip codes in the MCO's Service Area(s).

8.1.1 Administration and Contract Management

The MCO must comply, to the satisfaction of HHSC, with all provisions set forth in this Contract, including all applicable provisions of state and federal laws, rules, regulations, and waiver agreements with CMS.

8.1.1.1 Performance Evaluation

HHSC will provide the MCO with two Performance Improvement Project (PIP) topics. The MCO must develop one PIP per topic. The MCO must conduct one PIP in collaboration with other MCOs, Dental Contractors, participants in Delivery System Reform Incentive Payment (DSRIP) projects established under the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, or community organizations in the Service Area. HHSC will determine the PIP topics, and the MCO must complete each PIP template in accordance with **UMCM Chapter 10**. Each MCO must also complete progress reports as outlined in the **UMCM Chapter 10**.

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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 ten 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;
8. analyze data and interpret study results;
9. plan for "real" improvement; and
10. achieve sustained improvement.

(See **UMCM Chapter 10**.)

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 in accordance with **UMCM Chapter 10**. 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 measures with high and minimum performance standards established using the methodology set forth in **UMCM Chapter 10** with the MCO on an annual basis.

8.1.1.2 Operations Phase Readiness, Operations, and Targeted Reviews

HHSC may conduct desk or onsite reviews related to Contract performance. HHSC may also require Contractors to submit detailed policies and procedure that document day-to-day business activities related to Contract requirements for HHSC review and approval.

The MCO may be subject to additional Readiness Reviews if it makes changes deemed by HHSC to require such Readiness Reviews. Changes made during the Operational Phase that may lead to additional Readiness Reviews include, but are not limited to:

1. Location change;
2. Processing system changes, including changes in Material Subcontractors performing MIS or claims Processing Functions;
3. Carve-ins of new membership; and
4. Carve-ins of new Services.

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HHSC will determine whether the proposed changes will require a desk review or an onsite review. The MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent for onsite reviews conducted as part of Readiness Review or HHSC's normal Contract monitoring efforts. For purposes of this section, "authorized reimbursable travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

Unless the MCO receives HHSC approval for an exception in writing, the MCO must provide HHSC with secure access rights as an authorized guest user to all Member and Provider portals and call center services for remote monitoring capability. To qualify for an exception to this requirement, the MCO must demonstrate to HHSC the required functionality for Member and Provider portals via WebEx or onsite reviews. Portal demonstrations must be conducted in the MCO or Subcontractor's production environment or an environment that mirrors the production environment functionality.

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

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

For MIS Changes Only: The MCO must provide HHSC updates to the MCO's organizational charts and descriptions of MIS responsibilities at least 30 days prior to the effective date of an MIS change. The MCO must provide up-to-date official points of contract to HHSC for MIS issues on an ongoing basis.

The MCO or its designee must be able to demonstrate, upon HHSC's request, oversight of each Material Subcontractor based on MCO's assessed risk of Material Subcontractor's performance.

Refer to **Section 7.3.7** and **Section 8.1.20** for additional information regarding MCO Readiness Reviews. Refer to **Attachment A, Section 4.08(c)** for information regarding Readiness Reviews of the MCO's Material Subcontractors.

8.1.1.3 MCO Report Cards

Texas Government Code § 536.051 requires HHSC to provide information to Medicaid and CHIP Members regarding MCO performance on outcome and process measures during the enrollment process. To comply with this requirement, HHSC will provide annual MCO report cards. HHSC will also provide a separate report card for each Program Service Area to allow enrollees to easily compare the MCOs on specific quality

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measures. HHSC may publish the report cards on its website, and include them in the enrollment packets. HHSC will provide a copy of the report card to the MCO before publication and the MCO will have the opportunity to review and provide comments. However, HHSC reserves the right to publish the results while awaiting MCO feedback.

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

8.1.1.4 HHSC Performance Review and Evaluation

In accordance with **Section 12.01** of Attachment A, STAR Kids Contract Terms, HHSC, at its discretion, will review, evaluate and assess the development and implementation of the Medicaid MCO's policies and procedures related to the timely and appropriate delivery of services as required under this Contract. Reviews, evaluations and assessments may include the following: MCO corrective actions taken; MCO internal policies; MCO internal procedures; MCO workflows; MCO use of prior authorizations; MCO utilization review process; assessment of the MCO service planning package; the potential for underutilization of services; assessments; delivery of services; and case notes.

Upon notice and at no charge to HHSC, the MCO and its Subcontractors must cooperate with HHSC and provide any assistance required to complete the review, evaluation or assessment including prompt and adequate access to related documents, internal systems containing Member information and records, and appropriate staff, as well as utilization management documentation, case notes, and service locations or facilities that are related to the scope of services provided under this Contract.

HHSC shall monitor the Medicaid MCO to confirm the MCO is using prior authorization and utilization review processes that ensure appropriate utilization and prevent overutilization or underutilization of services.

8.1.2 Covered Services

The MCO is responsible for assessing, authorizing, arranging, coordinating, and providing Covered Services, including Community-based Long Term Services and Supports and Nursing Facility services, in accordance with the requirements of the Contract.

MCOs must authorize Community-based Long-term Services and Supports, including private duty nursing and services provided in a Prescribed Pediatric Extended Care Center, and Nursing Facility services based on the Member's current required needs assessment and consistent with the Member's SP or ISP. The services supporting Members with ongoing or chronic conditions or who require long-term services and supports must be authorized in a manner that reflects the Member's ongoing need for such services and supports. Members receiving Community-based Long-term Services and Supports must have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

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The MCO must provide full coverage for necessary Covered Services beginning on the date of the Member's enrollment and without regard to the Member's:

1. Previous coverage, if any, or the reason for termination of that coverage;
2. Pre-existing conditions;
3. Prior diagnoses;
4. Receipt of any prior healthcare services;
5. Health status;
6. Confinement in a healthcare facility; or
7. For any other reason.

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 is not responsible for providing payments to a Nursing Facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities or other related condition (ICF/IID) but must provide Acute Care and Service Coordination to a Member residing in a Nursing Facility or an ICF/IID if the services are not provided through the Nursing Facility or ICF/IID as part of the daily rate. This provision excludes out-of-home respite services provided in a Nursing Facility. To align with **Section 8.1.37** STAR Kids Service Delivery Option and **Section 8.3.2** MDCP STAR Kids Covered Services, the MCO is responsible for contracting with out-of-home respite Providers and providing MDCP covered services, including respite. The MCO must adjudicate within 30 Days of receiving a Clean Claim.

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

Covered Services for all Members are listed in **Attachment B-2** (STAR Kids Covered Services). As noted in **Attachment B-2,** the MCO must provide Covered Services described in the **Texas Medicaid Provider Procedures Man**ual (TMPPM), and as required by 42 C.F.R. § 440.230 for Members 21 and older and by 42 C.F.R. Subpart B of Part 441 for Members under the age of 21, and in accordance with 42 C.F.R. § 438.210, except for those services identified in **Section 8.1.24.8** as Medicaid Non-capitated Services. Medicaid MCOs must provide the services and benefits described in the most recent TMPPM and any updates thereto Covered Services are subject to change due to changes in federal and state law; changes in Medicaid Program policy; and changes in medical practice, clinical protocols, or technology.

The MCO must have a process in place to monitor a Member's claims history for acute and long-term care services that receive a prior authorization to ensure that these services are being delivered. On an ongoing basis, the MCO must monitor claims data for all approved prior authorizations for delivery of the services. The MCO must research and resolve any services not received as a result of the lack of claims data.

In the development of medical policies and medical necessity determinations, the MCO must adopt practice guidelines that:

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(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 Medicaid Covered Services for Recipients of Facility-Based Care and Certain HCBS Waiver Services

Members who receive services through a Nursing Facility, the ICF-IID Program, or an HCBS Waiver not integrated into STAR Kids must receive Medicaid Covered Services and Service Coordination through their STAR Kids MCO. The MCO will not pay the Nursing Facility or ICF-IID daily rate. The MCO will not provide HCBS Waiver services for the following programs: Home and Community-Based Services (HCS), Community Living Assistance and Support Services (CLASS), Texas Home Living (TxHmL), Deaf Blind with Multiple Disabilities (DBMD), and Youth Empowerment Services (YES).

Except as provided in **Section 8.1.2.2**, the STAR Kids MCO must help to coordinate all services for Members enrolled these HCBS Waivers, but will not contract with HCBS Waiver service providers for services provided through those HCBS Waivers. For STAR Kids Members who reside in a Nursing Facility or ICF-IID, the MCO is responsible for coordinating the Member's care with facility-based LTSS providers providing Non-capitated Services to the Member.

8.1.2.2 Additional STAR Kids Services Available to Qualified Members

The MCO must provide all Covered Services, including MDCP STAR Kids Covered Services, to Members that are eligible for and enrolled in MDCP STAR Kids, as described in **Section 8.3.1**, Program Eligibility. MDCP STAR Kids services include Home and Community-Based LTSS and the services listed in **Section 8.3.2,** MDCP STAR Kids Covered Services. The MCO must contract with Providers that can provide MDCP STAR Kids Covered Services, including Providers listed in **Section 8.3.2**, MDCP STAR Kids Covered Services.

At a future date following the STAR Kids Operational Start Date, to be determined by HHSC, the YES waiver will be included in STAR Kids. At that future date, the MCO must provide YES STAR Kids services to Members who are eligible for and enrolled in YES STAR Kids.

8.1.2.3 Value-added Services

The MCO may propose additional services for coverage. These are referred to as "Value-added Services." Value-added Services may be actual Healthcare Services, health-related benefits, Family Support Services, or positive incentives that HHSC agrees will promote wellness and improved health outcomes among Members. Value-

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added Services that promote wellness may include nutritional support services, home modifications, enhancements or additions to adaptive aids, improved access to telemedicine and telehealth services, exercise programs, or other programs approved by HHSC. Family and community support services may include respite care or trainings on managing challenging behaviors or care for a child with complex health needs. Value-added Services may also include services such as applied behavior analysis (ABA) or specialized therapies such as hippo therapy. Temporary phones, cell phones, additional transportation benefits, and extra home health services may also be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

The MCO must offer approved Value-added Services for Acute Care or Behavioral Health services to all Members in a Service Area, but the MCO may offer additional Value-added Services to Members receiving MDCP STAR Kids services. 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 costs of Value-added Services are not reportable as allowable medical or administrative expenses, and therefore are not factored into the rate-setting process. In addition, the MCO must not pass on the cost of the Value-added Services to Members or Providers.

The MCO may offer discounts on non-covered benefits to Members as Value-added Services, provided that the MCO complies with Texas Insurance Code § 1451.155 and § 1451.2065. The MCO must ensure that Providers do not charge Members for any other cost-sharing for a Value-added Service, including copayments or deductibles.

The MCO must 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 4.16** "Value-added Services, Flexible Benefits, and Rewards and Incentives Template and Instructions.") Once approved by HHSC, this document is incorporated by reference into the Contract.

During the Operations Phase, Value-added Services can be added or removed only by written amendment of the Contract. MCOs will be given the opportunity to add, enhance, delete or reduce Value-added Services once per State Fiscal Year (SFY), with changes to be effective September 1. HHSC may allow additional modifications to Value-added Services if Covered Services are amended by HHSC during a SFY. This approach allows HHSC to coordinate annual revisions to HHSC's MCO Comparison Charts for Members. An MCO's request to add, enhance, delete, or reduce a Value-added Service must be submitted to HHSC by April 1 of each year to be effective September 1 for the following Contract Period. The MCOs cannot reduce or delete any Value-added Services

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until September 1 of the next SFY. When the MCO requests deletion of a Value-added Service, the MCO must include information regarding the processes by which the MCO will notify Members and revise materials. (See **UMCM Chapter 4**.)

An MCO's request to add a Value-added Service must:

1. Define and describe the proposed Value-added Service;
2. Specify the Service Areas for the proposed Value-added Service;
3. Identify the category or group of mandatory Members eligible to receive the Value-added Service if it is a type of service that is not appropriate for all mandatory Members;
4. If the Value-added Service is not a Healthcare Service or benefit, describe how the MCO will determine whether a Member is eligible to receive the Value-added Service and what criteria were used to arrive at that decision;
5. Note any limitations or restrictions that apply to the Value-added Service;
6. Identify the Providers or other entities responsible for providing the Value-added Service, including any limitation on Provider or other persons' capacity, if applicable.
7. 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.;
8. Propose how and when the MCO will notify Providers and mandatory Members about the availability of the Value-added Service;
9. Describe the process by which a Member may obtain or access the Value-added Service, including any action required by the Member, as appropriate; and
10. Include a statement that the MCO will provide the Value-added Service for at least 12 months from 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 each Member that the service is no longer available through the MCO. The MCO must also revise all materials distributed to prospective Members to reflect the change in Value-added Services. Materials are subject to review and approval by HHSC.

8.1.2.4 Case-by-Case Services

Except as provided below, the MCO may offer additional benefits to individual Members on a case-by-case basis. Case-by-case Services may be based on Medical Necessity, cost-effectiveness, the wishes of the Member or the Member's Legally Authorized Representative (LAR), the potential for improved health status of the Member, or Functional Necessity. The MCO does not have to receive HHSC approval for Case-by-case Services and does not have to provide such services to all MCO Members. MCO has the discretion to offer Case-by-case Services, which are not included in the capitation rate. The MCO must maintain documentation of each authorized Case-by-case Service provided to each Member. At a minimum, this documentation must include the reason for providing the service. Case-by-case Services are not included in the rate setting process.

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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 the Contract's requirements and medically appropriate guidelines generally accepted practice parameters. The MCO must comply with the access requirements as established by the Texas Department of Insurance (TDI) for all MCOs doing business in Texas, except as otherwise required by this Contract.

The MCO must provide coverage for Emergency Services in compliance with 42 C.F.R. § 438.114, and as described in more detail in **Section 8.1.24.1**. The MCO must provide coverage for Emergency Services to Members 24 hours a Day and seven Days a week, without regard to prior authorization or the Emergency Service Provider's contractual relationship with the MCO. The MCO's policy and procedures, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must comply with all applicable state and federal laws and regulations, whether the Provider is in the MCO's Network or Out-of-Network.

A Medicaid MCO is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network providers, except when that provider is an Indian Health Care Provider (IHCP) enrolled as a Federally Qualified Health Center (FQHC), as provided in **Section 8.1.26**.

The MCO must also have an emergency and crisis Behavioral Health Services Hotline available 24 hours a Day, 7 Days a week, toll-free throughout the Service Area(s). The Behavioral Health Services Hotline must meet the requirements described in **Section 8.1.16.2**. The MCO may arrange Emergency Services and Crisis Behavioral Health Services through Mobile Crisis Teams.

The MCO must require, and make best efforts to ensure, that PCPs are accessible to Members 24 hours a Day, 7 Days a week and that Network Primary Care Providers (PCPs) have after-hours telephone availability consistent with **Section 8.1.5.6.2**. 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 Members.

If Medically Necessary Covered Services are not available through Network physicians or other Providers, the MCO must allow referral to an Out-of-Network physician or provider upon request of a Network Provider. The referral must occur within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but in no event to exceed five Business Days after receipt of reasonably requested documentation. The MCO must fully reimburse the Out-of-Network Provider in accordance with the Out-of-Network methodology for Medicaid as defined by HHSC in 1 Tex. Admin. Code § 353.4. The MCO must provide these services within the timeframes specified in **Section 8.1.4.6** and within the time appropriate to the circumstances and Member's need.

The MCO must ensure the provision of Covered Services meet the specific preventive, Acute Care, Community-Based Services, Long-Term Services and Supports, and

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specialty healthcare needs appropriate for treatment of the individual Member's condition(s).

The MCO must provide access to PCPs and specialist physicians with experience serving children and adolescents with special healthcare needs, including behavioral health needs. The MCO must make best efforts to recruit and contract with PCPs and specialist physicians who are board-certified in their specialty. As described in **Section 8.1.38.2**, the MCO is responsible for working with Members, their LAR, and their Providers to develop a seamless package of care in which primary care, community-based care, behavioral health, and specialty care needs are met through an Individual Service Plan (ISP) that is culturally competent and understandable to the Member.

The MCO may not require the Member to pay for any Medically Necessary or Functionally Necessary Covered Services other than HHSC-specified copayments and applied income for Medicaid Members, where applicable, if HHSC implements Medicaid cost sharing after the Effective Date of the Contract.

8.1.3.1 Appointment Accessibility

Through its Provider Network composition and management, the MCO must ensure that the following standards for appointment accessibility are met. The standards are measured from the date of presentation or request, whichever occurs first.

Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;

1. An Urgent Condition, including urgent specialty care and behavioral health services, must be provided within 24 hours; treatment for behavioral health services may be provided by a licensed behavioral health clinician;

Primary Routine Care must be provided within 14 Days;

Specialty Routine Care must be provided within 21 Days;

Specialty Therapy evaluations must be provided within 21 Days of submission of a signed referral. If an additional evaluation or assessment is required as a condition for authorization of therapy evaluation, the additional required evaluation or assessment should be scheduled to allow the Specialty Therapy services to occur within 21 Days from date of submission of a signed referral;

Initial outpatient behavioral health visits must be provided within 14 Days;

Initial outpatient behavioral health visits must be provided within 7 Days upon discharge from an inpatient psychiatric setting;

Community-Based Services for Members must be initiated within 7 Days from the authorization;

For members receiving MDCP services, services must be initiated by the start date of the ISP Tracker;

Prenatal care must be provided within 14 Days of request for initial appointments, except for high-risk pregnancies or new Members in the third trimester, for whom an initial appointment must be offered within 5 Days, or immediately, if an emergency exists. Appointments for ongoing care must be available in accordance to the treatment plan as developed by the provider;

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Preventive health services for Members less than 6 months of age must be provided within 14 Days. Preventive health services for Members 6 months through age 20 must be provided within 60 Days. Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule. MCOs must encourage new Members 20 years of age or younger to receive a Texas Health Steps checkup within 90 Days of enrollment. For purposes of this requirement, the term "New Member" is defined in **UMCM Chapter 12.4**.

8.1.3.2 Access to Network Providers

The MCO's Network must include all of the provider types described in this section and in UMCM Chapter 5. Access to Network Providers Performance Standards and Specifications in sufficient numbers, and with sufficient capacity, to provide timely access to all Covered Services in accordance with the appointment accessibility standards in **Section 8.1.3.1**. To the extent possible, Providers must have experience working with children or young adult populations. The MCO's PCP Network must provide timely access to regular and preventive care to all Members, and Texas Health Steps services to all child Members. The MCO must allow each Member to choose his or her Network Provider to the extent possible and appropriate, in accordance with federal and state law and policy, including 42 C.F.R. § 438.3(l) and § 457.1201(j). The MCO must ensure that access is consistent with Tex. Admin. Code §353.411.

For each Provider type, the MCO must provide access to at least 90 percent of Members in each Service Area within the prescribed distance or travel time standard. This 90 percent benchmark does not apply to pharmacy providers (refer to the "Pharmacy Access" heading for applicable benchmarks). Counties will be designated as metro, micro, or rural. The county designation is based on population and density parameters. A map of counties by designation and parameters is available in **Attachment B-5**. Members' residence in eligibility files with HHSC will be used to assess distance and travel times. The MCO must comply with the requirements set forth in UMCM Chapter 5, Access to Network Providers Performance Standards and Specifications.

HHSC will track MCO performance. HHSC will use the MCO Provider Files to run the Geo-Mapping Report which will measure provider choice, distance, and travel time. HHSC will compile the reports based on each MCOs network. HHSC will share identified deficiencies with the MCO. The MCO may be subject to liquidated damages specified in **Attachment B-3**.

Community Attendant Care Services: MCOs must ensure that a minimum of 90% of Members who are authorized to receive community attendant care services have timely access to such services. For purposes of this paragraph, timely access is within seven Days from the authorization as stated in section 8.1.3.1. Reference UMCM 10.1.12 for reporting information and templates.

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

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An internist who provides primary care to adults only is not considered an age-appropriate PCP choice STAR Kids Members birth through age 17, and a pediatrician is not considered an age-appropriate choice for a Member age 18 and over.

Obstetrician/Gynecologist (OB/GYN): At a minimum, the MCO must ensure that all female Members have access to an OB/GYN in the Provider Network.

If the OB/GYN is acting as the Member's PCP, the MCO must follow the access requirements for the PCP.

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

The MCO must allow a pregnant Member past the 24th week of pregnancy to remain under the Member's current OB/GYN's care through the Member's post-partum checkup, even if the OB/GYN Provider is, or becomes, Out-of-Network.

Mental Health - Outpatient: At a minimum, the MCO must ensure that all Members have access to an outpatient mental health Service Provider in the Network. The outpatient mental health Service Provider should be the appropriate Provider type to meet each individual Member's needs, including child psychiatrists, and outpatient mental health Service Providers who serve children and adolescents.

Outpatient mental health Service Providers must include Masters and Doctorate-level trained practitioners practicing independently or at clinics/group practices, or at outpatient Hospital departments as detailed in the UMCM Chapter 5, Access to Network Providers Performance Standards and Specifications, Outpatient Mental Health.

Outpatient Substance Use Disorder Treatment: The MCO must ensure all Members have access to a choice of outpatient substance use disorder service providers in the Network.

Mental Health Targeted Case Management and Mental Health Rehabilitative Services (TCM/MHR): The MCO must ensure the Member has access to a Network Provider of Mental Health Targeted Case Management and Mental Health Rehabilitative Services.

Specialist Physician Access: At a minimum, the MCO must ensure that all Members have access to a Network specialist physician. PCPs must make referrals for the following providers on a timely basis, based on the urgency of the Member's medical condition, but no later than five Days:

Audiologist, Cardiovascular Disease, Otolaryngologist (ENT), General Surgeon, Ophthalmologist, Orthopedist, Pediatric Sub-specialty, Psychiatrist, Urologist, and all other specialties not listed above.

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In addition, all Members must be allowed to: 1) select a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery, and 2) have access without a PCP referral to eye Health Care Services from a Network specialist who is an ophthalmologist or therapeutic optometrist for non-surgical services.

Therapies – Occupational, Physical, and Speech Therapy Provided in an Outpatient Clinic or Facility: The MCO must ensure the Member has access to a Network Provider for occupational therapy, physical therapy, and speech therapy.

Acute Care Hospital The MCO must ensure that all Members have access to an Acute Care Hospital with a staff or on-call pediatrician in the Provider Network. MCOs may request exceptions on a case-by-case basis. The MCO also must ensure that Members have access by transfer to an appropriate Network or Out-of-Network Hospital providing the needed level of care.

Pharmacy: At the minimum, the MCO must ensure that all Members have Pharmacy access. The MCO must ensure that access is consistent with 1 Tex. Admin. Code § 353.915.

Long Term Services & Support (LTSS) Providers: At a minimum, the MCO must ensure that all Members have access to the following LTSS providers for all covered services: Assisted Living Facility; Attendant Care; CFC Habilitation Services; Consumer Directed Services (CDS); In-Home Therapies – OT, PT, and ST, In-Home Skilled Nursing; and Private Duty Nursing.

All other Covered Services, except for services provided in the Member's residence: At a minimum, the MCO must ensure that all Members have access to a Network Provider for all other Covered Services. This access requirement includes: specialists not previously referenced in this section, oncology including surgical and radiation, hospitals with specialist children's services, children's hospitals and special Hospitals, psychiatric Hospitals, diagnostic services, and single or limited service healthcare physicians or Providers, as applicable to the Program.

The MCO may make arrangements with physicians or providers outside the state for Members to receive a higher level of skill or specialty than the level available within the state, including treatment of cancer, burns, and cardiac diseases.

The MCO must make arrangements with physicians or Providers outside the MCO's Service Area if necessary for a Member to receive a higher level of skill or specialty than the level available within the Service Area.

Exception Process: HHSC will consider requests for exceptions to the access standards for all provider types under limited circumstances. Each exception request must be supported by information and documentation as specified in the template provided by HHSC's Managed Care Compliance and Operations Network Adequacy. Exceptions may be granted on a case-by-case basis for an area does not meet the performance standards as outlined in UMCM Chapter 5, Access to Network Providers

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Performance Standards and Specifications. The MCO must establish, through applicable supporting documentation, a normal pattern for securing Health Care Services or that the MCO is providing care of a higher skill level or specialty than the level available within the Service Area.

8.1.3.3 Monitoring Access

The MCO must verify that Covered Services are available and accessible to Members in compliance with the standards described in **Sections 8.1.3 and 8.1.3.2.** For Covered Services furnished by PCPs, the MCO must also comply with the standards described in **Section 8.1.2**.

The MCO must develop and implement a Provider directory verification survey to verify that the Provider information maintained by the MCO is correct and in alignment with the Provider information maintained by the HHSC Administrative Services Contractor.

The survey must be conducted each fiscal year. At a minimum, the survey must include verification of Provider directory critical elements in accordance with **UMCM Chapter 5.**

The MCO may conduct the survey through its online Provider portal, telephone calls, onsite visits, email, or other method that collects and verifies information. For each Service Area, the MCO must conduct a statistically-valid random sample (95 percent confidence level with a margin of error +/- 5 percent) of Network PCPs and specialists. The MCO must collect, analyze, and submit survey results and supporting documentation as specified in UMCM Chapter 5.

The MCO must enforce access and other Network standards required by the Contract and take appropriate action with Providers whose performance is determined by the MCO to be out of compliance.

8.1.3.4 Telemedicine, Telehealth, Telepharmacy, and Telemonitoring Access

Telemedicine, Telehealth, Telepharmacy, and Telemonitoring are Covered Services and are benefits of Texas Medicaid. MCOs are encouraged to contract with Providers offering these services to provide better access to healthcare for its Members. In addition, a Medicaid MCO must be able to accept and process Provider claims for these services in conformity with the Texas Medicaid benefit. The MCO must contract with Providers with Telemedicine, Telehealth, and Telemonitoring capabilities to increase access to specialty and behavioral healthcare. The MCO must include information in its Provider Directory on Providers with Telemedicine, Telehealth, and Telemonitoring capabilities. **Section 8.1.16**, Behavioral Health (BH) Services and Network, provides additional information regarding Telemedicine, Telehealth, and Telemonitoring.

The MCO must determine the exact number and locations of all Telemedicine, Telehealth, and Telemonitoring end points and the number of Providers who will commit to working with the MCO's Telemedicine, Telehealth, and Telemonitoring contractors. The MCO must outreach to its Telemedicine, Telehealth, and Telemonitoring Providers

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to encourage the increase and availability of end points in rural and medically underserved areas. The MCO must also outreach to pediatric specialty and behavioral health providers to assure engagement of qualified Telemedicine, Telehealth, and Telemonitoring contractors. In the outreach process the MCO must offer trainings and supports to help establish Telemedicine, Telehealth, and Telemonitoring literacy and capabilities. In addition, the MCO must actively recruit additional rural providers in order to increase Member access to the services that Telemedicine, Telehealth, and Telemonitoring can provide.

MCOs are required to comply with Texas Government Code §531.0216

MCOs may not limit a physician's choice of platform for providing Telemedicine or Telehealth services by requiring the physician to use a particular platform to receive reimbursement for the services. MCOs must allow Members to receive Telemedicine or Telehealth services from providers other than the Member's PCP.

8.1.3.4.1 School-based Telemedicine Services

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 Member'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.

8.1.3.5 Indian Health Care Providers

The MCO must demonstrate a sufficient number of Indian Health Care Providers (IHCP) are participating in its Provider Network to ensure that Indian Members who are eligible to receive services have timely access to services available from a Network IHCP. The MCO must allow an Indian Member to designate a Network IHCP as a Primary Care Provider (PCP), as long as that provider has capacity to provide the services. The MCO must allow an Indian Member to receive Covered Services from an Out-of-Network (OON) IHCP from whom the Indian Member is otherwise eligible to receive such services.

If the MCO cannot ensure timely access to Covered Services because of few or no Network IHCPs, the MCO will be considered as compliant with this Contract in accordance with 42 C.F.R. § 438.14(b)(1) if Indian Members are allowed to access IHCPs out-of-state or if the circumstance is deemed good cause for disenrollment from managed care in accordance with 42 C.F.R. § 438.56(c). The MCO must permit an OON IHCP to refer an Indian Member to a Network Provider.

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The MCO must pay for Covered Services provided by an IHCP to an Indian Member, regardless of whether the IHCP is a Network Provider. The MCO must (1) pay the IHCP an agreed to negotiated rate, or (2) in the absence of a negotiated rate, pay a rate not less than the level and amount that would be paid to a Network Provider that is not an IHCP; and (3) make payment to all IHCPs in its Network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. § 447.45 and § 447.46.

If an IHCP is not enrolled in Medicaid as an FQHC and regardless of whether an IHCP is a Network Provider, the IHCP must be paid the applicable encounter rate published annually in the Federal Register by the Indian Health Service, or, in the absence of a published encounter rate, the amount the IHCP would be paid if services were provided under the State Plan in Medicaid FFS. If an IHCP is enrolled in Medicaid as an FQHC, the IHCP must be reimbursed as described in **Section 8.1.26**

8.1.4 Provider Network

The MCO must enter into written contracts with properly credentialed Providers as described in this Section. The Provider contracts must comply with the **UMCM**'s requirements, and include reasonable administrative and professional terms.

The MCO must maintain a Provider Network sufficient to provide all Members with access to the full range of Covered Services required under the Contract. The MCO must also develop short- and long-term strategies to improve access to qualified providers.

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 Provider Network must be responsive to the linguistic, cultural, and other unique needs of the population in the Service Area(s) served by the MCO, including 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 Medicaid Members in the MCO's proposed Service Area(s). MCOs utilizing Out-of-Network 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 1 Tex. Admin. Code § 353.4(e)(3) (see **UMCM Chapter 5**).

The MCO must seek participation in the Provider Network from the following types of entities that may serve American Indian and Alaskan Native children:

1. Health clinics operated by a federally-recognized tribe in the Service Area;
2. Federally Qualified Health Centers (FQHC) operated by a federally-recognized tribe in the Service Area; and

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3. Urban Indian organizations in the Service Area.

All Providers: Except as provided in **Section 8.1.2**, all Providers must comply with State of Texas licensure requirements and all state and federal laws governing the provision of Covered Services. Network Providers cannot be under sanction or exclusion from the Medicaid program. All Providers serving Medicaid Members 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. Long-Term Services and Supports (LTSS) Providers are not required to have a TPIN but must have an LTSS Provider number. All Providers must also have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D. This also includes Atypical Provider Identification Numbers (APIs).

The MCO is prohibited from employing, contracting with, or entering into a Provider agreement with providers whose license is expired or cancelled or who are excluded, suspended, or terminated from participation in the Texas Medicaid and CHIP programs. The MCO must reconcile the MCO Provider file to the master Provider list as often as HHSC makes it available.

Inpatient hospital and medical services: The MCO must ensure that Acute Care Hospitals and specialty Hospitals are available and accessible 24 hours per Day, 7 Days per week, within the MCO's Network to provide Covered Services to Members throughout the Service Area(s). The MCO must enter into a Provider Contract with any willing State Hospital that meets the MCO's credentialing requirements and agrees to the MCO's contract rates and terms.

Children's Hospitals/Hospitals with specialized pediatric services: The MCO must ensure Member access to Hospitals designated as Children's Hospitals by Medicare and Hospitals with specialized pediatric services, such as teaching Hospitals and Hospitals with designated children's wings, so that these services are available and accessible 24 hours per day, 7 Days per week, to provide Covered Services to Members throughout the Service Area. The MCO must enter into written arrangements with Out-of-Network designated Children's Hospitals or hospital with specialized pediatric services in proximity to the Member's residence if the MCO does not include these hospitals in its Provider Network. 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 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 MCO's Service Area, or in close proximity to the Service Area. The MCO must make a written reimbursement arrangement with an Out-of-Network 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 Provider Network. The DSHS website provides additional information on the EMS Trauma System in Texas.

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Transplant centers: The MCO must ensure Member access to HHSC-designated transplant centers meeting equivalent levels of care. HHSC utilizes the CMS list for the HHSC-designated transplant centers list, which may be found on the CMS website. HHSC-designated transplant centers also include members of the United Network for Organ Sharing (UNOS), which can be found on the Organ Procurement and Transplantation Network website. 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 Out-of-Network providers for such care.

Hemophilia centers: The MCO must ensure Member access to hemophilia centers supported by the Centers for Disease Control (CDC), which include pharmacy services provided by the centers. A list of these hemophilia centers is maintained by the CDC. The MCO must make written reimbursement arrangements with an Out-of-Network CDC-supported hemophilia center if the MCO does not include such a center in its Provider Network.

Outpatient Behavioral Health Service Providers: The MCO must ensure Member access to outpatient Behavioral Health 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; licensed social workers (LCSWs); licensed marriage and family therapists (LMFTs); licensed professional counselors; licensed adolescent Chemical Dependency Treatment facilities; licensed chemical dependency counselors (LCDCs) with experience treating adults and adolescents; and entities employing Qualified Mental Health Professionals for Community Services (QMHPs-CS). QMHPs-CS include Licensed Practitioners of the Healing Arts (LPHAs). QMHPs can also include Community Services Specialists Provider (CSSP), Peer Providers, or Family Partners if acting under the supervision of an LPHA. The Provider Network can include both 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.

Physician services: The MCO must ensure that Primary Care Providers 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 each Service Area to comply with the access requirements throughout **Section 8.1.3** and meet the needs of Members for all Covered Services.

The MCO must ensure that an adequate number of participating physicians have admitting privileges at one or more participating Acute Care Hospitals in the Provider Network to ensure that necessary admissions are made. In no case may there be less than one Network PCP with admitting privileges available and accessible 24 hours per Day, 7 Days per week for each Acute Care Hospital in the Provider Network.

The MCO must ensure that an adequate number of participating specialist physicians have admitting privileges at one or more participating Hospitals in the MCO's Provider Network to ensure necessary admissions are made. The MCO must require that all

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physicians who admit to Hospitals maintain Hospital access for their Member 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 in each Service Area, strategically located specimen collection areas in each Service Area, 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; and total hemoglobin tests that are processed at the Austin Laboratory. Providers may submit specimens for glucose, cholesterol, HDL, lipid profile, HIV, and 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. The MCO must refer Providers to the Texas Health Steps Online Provider Training Modules referencing specimen collection on the Texas Health Steps website and to the Texas Medicaid Provider Procedures Manual, and the Children's Services Handbook on the TMHP website Children Services Handbook for the most current information and any updates. The Children's Services Handbook is located within the Texas Medicaid Provider Procedures Manual

Pharmacy Providers: The MCO must ensure that all pharmacy Network Providers are licensed with the Texas State Board of Pharmacy and meet all other requirements under 1 Tex. Admin. Code § 353.909. Providers must not be under sanction or exclusion from the Medicaid, Medicare, or CHIP Programs. The MCO must enter into a Provider contract with any willing pharmacy provider that meets the MCO's credentialing requirements and agrees to the MCO's contract rates and terms for participation in the MCO's retail pharmacy Network. The MCO may also enter into selective contracts for drugs listed on the HHSC Specialty Drug List (published on the Medicaid Vendor Drug Program website in accordance with 1 Tex. Admin. Code § 354.1853) with one or more pharmacy providers, but any selective arrangement must comply with Texas Government Code § 533.005(a)(23)(G) and 1 Tex. Admin. Code §§ 353.905(e) and 370.701.

MCOs may have only retail pharmacy Networks and specialty pharmacy Networks. Except for selective arrangements for drugs on the HHSC Specialty Drug List, MCOs may not have preferred pharmacy or selective pharmacy Networks. MCOs must allow pharmacies in the retail pharmacy network to dispense any drug listed on the VDP formulary, with the exception of drugs listed on the HHSC Specialty Drug List. MCOs may limit the dispensing of drugs on the HHSC Specialty Drug List to pharmacies enrolled in the MCOs specialty pharmacy network.

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Diagnostic imaging: The MCO must ensure that diagnostic imaging services are available and accessible to all Members in each Service Area 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 STAR Kids 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 noted in this Section.

MDCP STAR Kids: The MCO must have a sufficient number of contracts with MDCP STAR Kids service Providers so that all Members who receive MDCP STAR Kids have access to Medically Necessary and Functionally Necessary Covered Services.

Ambulance providers: The MCO must enter into a Provider Contract with any willing ambulance provider that meets the MCO's credentialing requirements and agrees to the MCO's contract terms and rates.

Optometrists and Ophthalmologists: The MCO must enter into a Provider Contract with any willing optometrists, ophthalmologists, therapeutic optometrists, and enrolled providers within institutions of higher education that provides an accredited program for training as a Doctor of Optometry or an optometrist residency or training as an ophthalmologist or an ophthalmologist residency that meets the MCO's credentialing requirements and agrees to the MCO's contract terms and rates.

Mental Health Rehabilitative Services: The MCO must ensure Members have access to Mental Health Rehabilitative Services.

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. Qualified PPECCs include those with a temporary, initial or renewal license.

LMHAs and LBHAs: The MCO must enter into a Provider Contract with any willing LMHA or LBHA that meets the MCO's credentialing requirements and agrees to the MCO's contract rates and terms.

Outpatient Substance Use Disorder Service Providers:

The MCO must make reasonable effort to contract with outpatient substance use disorder (SUD) service providers. The MCO's network for outpatient SUD service providers must include chemical dependency treatment facilities, including facilities licensed by HHSC to serve adolescents. The network must also include the following for

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medication assisted treatment: licensed narcotic (opioid) treatment programs, chemical dependency treatment facilities licensed by HHSC, and appropriately trained physicians and other qualified prescribers as specified in the Texas Medicaid Provider Procedures Manual.

The MCO must include Significant Traditional Providers (STPs) of this benefit in its Network and provide such STPs with expedited credentialing. Medicaid MCOs must enter into Provider Contracts with any willing STP of these benefits that meets the Medicaid enrollment requirements, MCO 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 HHSC to receive funding for treatment under the Federal Substance Abuse Prevention and Treatment block grant. The STP requirements described herein apply to all SAs, and unlike other STP requirements are not limited to the first three years of operation.

Residential Substance Use Disorder Service Providers:

The MCO must make reasonable effort to contract with residential SUD service providers. The MCO's network for residential outpatient SUD service providers must include chemical dependency treatment facilities licensed by HHSC to provide residential services, including those licensed to serve adolescents in a residential setting. The MCO must ensure access to providers who offer residential treatment services, and providers who offer residential withdrawal management services.

The MCO must include STPs of this benefit in its Network and provide such STPs with expedited credentialing. Medicaid MCOs must enter into Provider Contracts with any willing STP of these benefits that meets the Medicaid enrollment requirements, MCO 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 HHSC to receive funding for treatment under the Federal Substance Abuse Prevention and Treatment block grant. The STP requirements described herein apply to all SAs, and unlike other STP requirements are not limited to the first three years of operation.

8.1.4.1 Provider Contract Requirements

The MCO is prohibited from requiring a Provider or Provider group to enter into an exclusive contracting arrangement with the MCO as a condition for participation in its Provider Network.

The MCO's contract with Providers must be in writing, must be in compliance with applicable federal and state laws and regulations, and must include the minimum requirements specified in the **Attachment A**, "STAR Kids Contract Terms," and **UMCM Chapter 8**. 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.

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As described in **Section 7**, 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 the STAR Kids Contract or Program requirements.

8.1.4.2 Provider Credentialing and Re-credentialing

All Medicaid MCOs must utilize the Texas Association of Health Plans' (TAHP's) contracted Credentialing Verification Organization (CVO) as part of its credentialing and recredentialing process regardless of membership in the TAHP. The CVO is responsible for receiving completed applications, attestations and primary source verification documents.

At least once every three years, the MCO must review and approve the credentials of all participating licensed and unlicensed Providers who participate in the MCO's Provider Network.

The MCO may subcontract with another entity to which it delegates credentialing activities if the delegated credentialing is maintained in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and any comparable requirements defined by HHSC.

At a minimum, the scope and structure of an MCO's credentialing and re-credentialing processes must be consistent with recognized 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, and, as an additional requirement for Medicaid MCOs, 42 C.F.R. §§ 438.12 and 438.214. The re-credentialing process must take into consideration Provider performance data including Member Complaints and Appeals, quality of care, and utilization management.

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

If an application does not include required information, the MCO must provide the provider written notice of all missing information no later than five Business Days after receipt.

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 Days after receiving a complete application requiring expedited credentialing, and no later than 90 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 Provider Contract. The re-credentialing process must occur at least every three years.

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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.

8.1.4.2.1 Expedited Credentialing Process

MCOs 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,
2) dental specialists (including dentists and physicians providing dental specialty care),
3) licensed clinical social workers,
4) licensed professional counselors,
5) licensed marriage and family therapists, and
6) psychologists.

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.

The MCO must also establish and implement an expedited credentialing process for nursing facilities that successfully underwent a change of ownership (CHOW). The requirements for applicant providers to qualify for expedited credentialing listed above apply to CHOWs with the exception of (1) and (3). An applicant provider must also agree to comply with the terms of the contract between the MCO and the Nursing Facility.

If a Provider qualifies for expedited credentialing, the MCO must treat the Provider as a Network Provider upon submission of a complete application. This includes paying the in-network rate for claims with a date of service on or after the submission date of a complete application, even if the MCO has not yet completed the credentialing process. The MCO's claims system must be able to process claims from the Provider no later than 30 Days after receipt of a complete application.

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8.1.4.2.2 Minimum Credentialing Requirements for Unlicensed or Uncertified LTSS Providers

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:
    a. HHS-OIG Exclusion; and
    b. 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, legally responsible person 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.

8.1.4.3 Board Certification Status

The MCO must maintain a policy with respect to board certification for PCPs and specialist physicians that encourages participation of board-certified PCPs and specialist 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 specialist physicians, by specialty, available to HHSC upon request.

8.1.4.4 Provider Relations Including Manual, Materials, and Training

The MCO must maintain a provider relations presence in each Service Area. MCO provider relations staff must have a physical address in each Service Area so that to the staff can meet face-to-face with providers as necessary.

The MCO must maintain a Provider Manual, including any necessary specialty manuals (e.g., behavioral health) 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** including sections relating to the special requirements of the STAR Kids Program and Members.

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

The MCO must provide training to all Providers and their staff regarding the requirements of the Contract and unique 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 on-going training to new and existing Providers as required by the MCO or HHSC to comply with the Contract. The MCO must maintain and make available upon request enrollment or attendance rosters dated and signed by each attendee or other written evidence of training of each Provider and their staff.

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, Severe Emotional Disturbance (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 SED or another type of mental illness. The MCO must also ensure that Members who may need access to IDD supports and HCBS Waiver services receive the appropriate evaluation and psychometric testing required for approval of services.

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) Special emphasis must be placed on areas that vary from commercial coverage rules (e.g., Early Childhood Intervention services, Private Duty Nursing, Personal Care Services, MDCP STAR Kids services, therapies and DME/Medical Supplies, pharmacy services and processes, including information regarding outpatient drug benefits, HHSC's drug formulary, preferred drugs, prior authorization processes, and 72-hour emergency supplies of prescription drugs);
    b) The MCO should also place special emphasis on Behavioral Health Services including: substance use disorder (SUD) treatment options, including opioid use disorder treatment; screening, brief intervention, and referral to treatment (SBIRT) (TMPPM, Behavioral Health and Case Management Services Handbook, Chapter 7); mental health treatment; Mental Health Rehabilitative Services and the availability of Mental Health Targeted Case Management for qualified Members; and the process for making referrals for and coordination with the provision of Non-capitated Services;
2. Relevant requirements of the Contract;

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3. Specific training related to Utilization Management reviews, Fraud, Waste, and Abuse, including oversight activities such as pre-payment reviews, audits, and monitoring;
4. Information regarding Service Coordination including how and when to contact the Member's Service Coordinator;
5. The MCO's policy and procedures for prior authorization;
6. The MCO's quality assurance and performance improvement 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. Member cost-sharing obligations, benefit limitations, Value-added Services, and prohibitions on balance-billing Members for Covered Services;
9. Cultural Competency Training based on National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS);
10. Texas Health Steps benefits, periodicity, 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;
11. Medical Transportation 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;
12. The importance of updating contact information to ensure accurate Provider Directories and the Medicaid Online Provider Lookup;
13. Information about the MCO's process for acceleration of Texas Health Steps services for Children of Migrant Farmworkers;
14. Partial settlement agreements in *Alberto N., et al. v. Traylor, et al.*;
15. Missed appointment referrals and assistance provided by the Texas Health Steps Outreach and Informing Unit;
16. The role of the MCO Service Coordinators;
17. Information on discharge planning and transitional care related to long-term care settings;
18. Administrative issues such as detailed claims filing (including the processes regarding claims appeals and recoupments) and how to receive assistance with claims;
19. Services available to Members;
20. Information about maintaining and developing a Health Home, including best practices, as referenced in **Section 8.1.4.10.2**, Health Home;
21. 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; and
22. 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 Kids program.

Provider Materials must comply with state and federal laws governing the STAR Kids Program and requirements of the **Attachment A**, "STAR Kids Contract Terms and Conditions," and **UMCM Chapter 3**.

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As described above, HHSC must approve the MCO's Provider Manual and all substantive revisions. Additionally, the MCO must submit, for HHSC's review, all other Provider Materials relating to STAR Kids 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, that are not in compliance with state and federal laws or the Contract's requirements.

8.1.4.5 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 the Service Area(s), Monday through Friday, except for state-approved holidays. The State-approved holiday schedule is updated annually and can be found on the Texas State Auditor's Office Website. The Provider Hotline must be staffed with personnel who are knowledgeable about the STAR Kids Program, Covered Services, and Non-capitated Services.

The MCO must ensure that, after regular business hours, the Provider Hotline 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.

The MCO must ensure that the Provider Hotline meets the following minimum performance requirements for the MCO Program:

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

The MCO must conduct ongoing call quality assurance to ensure these standards are met. The Provider Hotline may serve multiple MCO Programs or Service Areas if Hotline staff is knowledgeable about all of the MCO's Programs and Service Areas, including the Provider Network in each Service Area.

The MCO must monitor its Provider Hotline performance and submit performance reports summarizing call center performance for the Hotline as indicated in **Section 8.1.22.2**. If the MCO subcontracts with a Behavioral Health Organization (BHO) that is responsible for Provider Hotline functions related to Behavioral Health Services, the BHO's Provider Hotline must meet the requirements in **Section 8.1.16.2**.

If HHSC determines that it is necessary to conduct onsite monitoring of the MCO's Provider Hotline functions, the MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) relating to that monitoring. For purposes of this section, "reasonable travel costs" may include airfare,

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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. 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 behavioral healthcare needs of the STAR Kids 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. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

8.1.4.6 Provider Reimbursement

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

The MCO must pay Out-of-Network providers using the Medicaid methodology as defined by HHSC in 1 Tex. Admin. Code § 353.4 and ensure that claims payment is timely and accurate as described in **Section 8.1.20.5**, "Claims Processing Requirements," and **UMCM Chapter 2**. The MCO must require tax identification numbers from all participating Providers. The MCO is required to do back-up withholding from all payments to Providers who fail to give tax identification numbers or who give incorrect numbers.

Provider payments must comply with all applicable state and federal laws, rules, and regulations, including the following sections of the Patient Protection and Affordable Care Act (PPACA) and, upon implementation, corresponding federal regulations:

1. Section 2702 of PPACA, entitled "Payment Adjustment for Health Care-Acquired Conditions;"
2. Section 6505 of PPACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United States;" and

Section 1202 of the Health Care and Education Reconciliation Act as amended by PPACA, entitled "Payments to Primary Care Physicians." The MCO must comply with registration requirements in Tex. Ins. Code § 1458.051 and with reimbursement and fee schedule requirements in Tex. Ins. Code § 1451.451 and 1458.101–102.

The MCO 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

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unless: (1) it receives HHSC's prior approval, or (2) the reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by HHSC. For purposes of this requirement an across-the-board rate reduction is a reduction that applies to all similarly-situated providers or types of providers. The MCO must submit a written request for an across-the-board rate reduction to HHSC's Director of Managed Care Compliance and Operations and provide a copy to HHSC's Health Plan Manager, if the reduction is not based on a change in the Medicaid fee schedule or cost containment initiative implemented by HHSC. The MCO must submit the request at least 90 Days prior to the planned effective date of the reduction. If HHSC does not issue a written statement of disapproval within 45 Days of receipt, then the MCO may move forward with the reduction on the planned effective date.

Further, the MCO must give Providers at least 30 Days' notice of changes to the MCO's fee schedule, excluding changes derived from changes to the Medicaid fee schedule, before implementing the change. If the MCO fee schedule is derived from the Medicaid fee schedule, the MCO must implement fee schedule changes after the Medicaid fee schedule change, and any retroactive claim adjustments must be completed within 60 Business Days after HHSC retroactively adjusts the Medicaid fee schedule.

8.1.4.6.1 Provider Preventable Conditions

STAR Kids MCOs must identify Present on Admission (POA) indicators as required in the **UMCM Chapter 2** and must reduce, deny, or recoup payments for Provider Preventable Conditions that were not POA as set forth in 42 C.F.R § 434.6(a)(12) and § 447.26. This includes any hospital-acquired conditions or healthcare acquired conditions identified in the Texas Medicaid Provider Procedures Manual.

As a condition of payment to Hospital Providers, STAR Kids MCOs must require Providers to report provider-preventable conditions on Institutional Claims using appropriate POA indicators. STAR Kids MCOs must include all identified POA indicators on Encounter Data submitted to the State. Upon request by the State, STAR Kids MCOs must report the amount of Provider payments denied, reduced, or recouped from an individual Provider for the requested service dates for provider-preventable conditions that were not POA.

8.1.4.6.2 Safety-net Hospital Incentives

On an annual basis, HHS must provide a list to the MCOs that identifies the safety-net hospitals that are awarded incentive payments for potentially preventable complications and potentially preventable remissions as defined in Texas Government Code § 536.001. This list will consist of hospitals that are recipients of incentives funds, based on exemplary performance on potentially preventable complications (PPC) and potentially preventable readmissions (PPR). The list provided by HHS will contain the hospital NPI, hospital name, and amount of incentive payments awarded to each hospital based on PPC and PPR performance. HHS must build in costs for these incentives into the MCO capitation payments. Consistent with HHS direction, MCOs must pay the amount identified by HHS to the eligible hospitals identified by HHS. HHS develops the program and methodology for determining awards for hospitals.

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8.1.4.6.3 Advanced Payments

MCOs are required to develop a process by which providers may request advanced payments for authorized services that have not yet been delivered. The MCO will develop an agreement with the provider to determine what portion of funds for claims payments will apply towards the balance of the advanced payments until that balance is reduced to zero. The MCO may not charge the provider interest on the balance of the advanced payments.

8.1.4.6.4 Provider Overpayments

The MCO must have a mechanism in place through which Network Providers report overpayments. The MCO must inform Providers of this mechanism. The mechanism must allow Providers to include a reason for the overpayment. The MCO must require that the Provider submit overpayments within 60 Days from identification. For purposes of this section, "identification" refers to when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.

8.1.4.6.5 Minimum Fee Schedule Rural Hospital

MCOs must adopt HHSC's Medicaid minimum fee schedule for rural hospitals, as defined in Texas Government Code § 531.02194, as of September 1, 2020. The Medicaid minimum fee schedule for rural hospitals includes only the following categories of service or provider type: clinical laboratory, ambulatory surgical centers, and hospital outpatient imaging services. The Medicaid minimum fee schedule also includes inpatient standard dollar amount rural rates. The Medicaid minimum fee schedule for rural hospitals can be found at the following links:

- https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/outpatient-services
- https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/inpatient-services
- http://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx

8.1.4.7 Termination of Provider Contracts

The MCO must notify HHSC within five Days after termination of a Network Provider contract that (1) impacts more than 10% of its Members or (2) impacts more than 10% of its Network for that provider type for that Service Area and Program. The MCO must also notify HHSC of all Provider terminations in accordance with **UMCM Chapter 5**.

Additionally, the MCO must make a good faith effort to give written notice of termination of a Network Provider to each Member who receives his or her primary care, or who is seen on a regular basis by, the Network Provider as follows:

1. For involuntary terminations of a provider (terminations initiated by the MCO), the MCO must provide notice to the Member of the Provider's termination from

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the network within 15 Days of either expiration of the provider's advance notice period, or once the provider has exhausted rights to appeal.

In cases of imminent harm to Member health, the MCO must give the Member notice immediately that the Provider will be terminated even if a final termination notice to the Provider has not been issued.

2. For voluntary terminations of a provider (terminations initiated by the Provider), the MCO must provide notice to the Member 30 Days prior to 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 15 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.

8.1.4.8 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 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 Network under the circumstances described in Texas Government Code § 531.066.

8.1.4.9 Provider Protection Plan

The MCO must comply with the HHSC's provider protection plan requirements for reducing the administrative burdens placed on Network Providers, and ensuring efficiency in Network enrollment and reimbursement. At a minimum, the MCO must have a Provider protection plan that complies with the following:

1. Ensure no Retaliation by the MCO and MCO staff against a Provider for filing Appeals or Complaints against the MCO on the Provider's or Member's behalf.
2. Provide for timely and accurate claims adjudication and proper claims payment in accordance with **UMCM Chapter 2.0**.
3. Include Network Provider training and education on the requirements for claims submission and appeals, including the MCO's policies and procedures (see also **Section 8.1.4.4**, "Provider Relations Including Manual, Materials and Training.")
4. Ensure Member access to care, in accordance with **Section 8.1.3**, "Access to Care."
5. Ensure prompt credentialing, as required by **Section 8.1.4.2**, "Provider Credentialing and Re-credentialing."

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6. Ensure compliance with state and federal standards regarding prior authorizations, as described in **Section 8.1.9**, "Utilization Management," and **Section 8.1.17.2**, "Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies."
7. Provide 30 Days' notice to Providers before implementing changes to policies and procedures affecting the prior authorization process. However, in the case of suspected Fraud, Waste, or Abuse by a single Provider, the MCO may implement changes to policies and procedures affecting the prior authorization process without the required notice period.
8. Include other measures developed by HHSC or a provider protection plan workgroup, or measures developed by the MCO and approved by HHSC.

8.1.4.10 Primary Care Providers and the Health Home

8.1.4.10.1 Primary Care Providers

The MCO's PCP Network may include Providers from any of the following practice areas:

1. General Practice;
2. Family Practice;
3. Internal Medicine;
4. Pediatrics;
5. Obstetrics/Gynecology (OB/GYN);
6. Advanced Practice Registered Nurses (APRNs);
7. Physician Assistants (PAs)
8. Federally Qualified Health Centers (FQHCs);
9. Rural Health Clinics (RHCs), and similar community clinics; and
10. Specialist physicians who are willing to provide a Health Home to selected Members with special needs and conditions.

In addition, the MCOs Network must include a sufficient number of Indian Health Care Providers to ensure that eligible Members enrolled in the MCO have timely access to services.

The MCO must require PCPs to coordinate with Members, Caregivers, other Providers, STAR Kids Service Coordinators, and state and non-state entities to assure that the Member's medical and behavioral health needs are met. Other PCP requirements include screening, identification, and referral to Medically Necessary or Functionally Necessary Covered Services and assessment and coordination of non-clinical services that impact the Member's health. The MCO must ensure that all STAR Kids PCPs provide patient- and family-centered care that serves the goals of improving Member care, outcomes, and satisfaction.

In order to qualify as a PCP for the STAR Kids program, APRNs and PAs must practice under the supervision of a Network physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this contract.

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The MCO may include an advanced practice registered nurse (APRN) as a Network PCP, even if the APRN's supervising physician is not a Network Provider. The MCO must treat APRNs and PAs in the same manner as other Network PCPs with regard to: (1) selection and assignment as PCPs, (2) inclusion as PCPs in the MCO's Provider Network, and (3) inclusion as a PCP in any Provider directory maintained by the MCO.

An internist or other Provider who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member. An internist or other Provider who provides primary care to adults and children may be a PCP for children if:

1. The Provider assumes all 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.

The PCP 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 Member or the Member's LAR may initiate the request through the MCO for a specialist to serve as a PCP for the Member. The MCO must process such requests in accordance with 28 Tex. Admin. Code § 11.900. Specialists may limit the number of Members for whom they will serve as a PCP.

STAR Kids PCPs must either have admitting privileges at a Medicaid Hospital or make referral arrangements with a Provider who has admitting privileges to a Medicaid Hospital with a Pediatric Unit.

The MCO must require, through contract provisions, that PCPs are accessible to Members 24 hours a Day, 7 Days a week. The MCO is encouraged to include in its Network sites that offer primary care services during evening and weekend hours. The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours.

Acceptable after-hours coverage:

1. The office telephone is answered after-hours by an answering service, which meets language requirements of the Major Population Groups and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;
2. The office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the Member to call another number to reach the PCP or another Provider designated by the PCP. Someone must be available to answer the designated Provider's telephone. Another recording is not acceptable; and

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3. The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable after-hours coverage:

1. The office telephone is only answered during office hours;
2. The office telephone is answered after-hours by a recording that tells Members to leave a message;
3. The office telephone is answered after-hours by a recording that directs Members to go to an Emergency Room for any services needed; and
4. Returning after-hours calls outside of 30 minutes.

The MCO must require PCPs, through contract provisions, to provide children birth through age 20 with preventive services in accordance with the Texas Health Steps periodicity schedule. The MCO must require PCPs, through contract provisions, to provide adult Members over the age of 18 with preventive services in accordance with the U.S. Preventive Services Task Force requirements. The MCO must make best efforts to ensure that PCPs follow these periodicity requirements for children and adult Members. Best efforts must include: Provider education, Provider profiling, monitoring, and feedback activities.

The MCO must require PCPs, through Network Provider contract provisions or the Provider Manual, to assess the medical needs of Members for referral to specialty care Providers and provide referrals as needed. PCPs must coordinate Members' care with specialty care Providers after referral. The MCO must make best efforts to ensure that PCPs assess Member needs for referrals and make these referrals. Best efforts must include, but not be limited to: Provider education activities and review of Provider referral patterns.

This section does not apply to Dual Eligible Members.

8.1.4.10.2 Health Home

The MCO must provide access to a Health Home to any Member the MCO determines would most benefit from a Health Home or for any Member who requests a Health Home. A Health Home must provide an array of services and supports, outlined below, that extend beyond what is required of a PCP. STAR Kids Health Homes must operate through either a primary care practice or, if appropriate, a specialty care practice and must provide a team-based approach to care that is designed to enhance ease of access, coordination between Providers, and quality of care.

Health Home services must be part of a person-based approach and holistically address the needs of persons with multiple chronic conditions or a single serious and persistent mental or health condition.

Health Home services must include:

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1. Patient self-management education;
2. Provider education;
3. Patient-centered and family-centered care;
4. Evidence-based models and minimum standards of care; and
5. Patient and family support (including authorized representatives).

Health Home Services may also include:

1. A mechanism to incentivize providers for provision of timely and quality care;
2. Implementation of interventions that address the continuum of care;
3. Mechanisms to modify or change interventions that are not proven effective;
4. Mechanisms to monitor the impact of the Health Home Services over time, including both the clinical and the financial impact;
5. Comprehensive care coordination and health promotion;
6. Palliative care options in the event of a life-limiting diagnosis;
7. Comprehensive traditional care, including appropriate follow-up, from inpatient to other settings;
8. Data management focused on improving outcome-based quality of care and improved patient and provider satisfaction;
9. Referral to community and social support services, if relevant; and
10. Use of health information technology to link services, as feasible and appropriate.

8.1.4.10.3 Health Home Services and Participating Providers

The MCO must provide information and other resources to PCPs and other Health Home Providers regarding federal incentive programs and nationally recognized accreditation, recognition, and certification programs addressing medical and Health Home models. At a minimum, the MCO must consider offering financial incentives to Health Homes that achieve nationally recognized levels of accreditation, recognition, and certification for the development of a medical or Health Home model.

The MCO must develop provider incentive programs for designated Providers who meet the requirements for patient-centered medical homes found in Texas Government Code § 533.0029.

At a minimum, the MCO must:

1. Maintain a system to track and monitor all Health Home Services participants for clinical, utilization, and cost measures;
2. Implement a system for Providers to request specific Health Home interventions;
3. Inform Providers about differences between recommended prevention and treatment and actual care received by Members enrolled in a Health Home Services program and Members' adherence to a service plan; and
4. Provide reports on changes in a Member's health status to his or her PCP for Members enrolled in a Health Home Services program.

8.1.4.11 PCP Notification

The MCO must furnish each PCP with a current list of enrolled Members assigned to that Provider no later than five Business Days after the MCO receives the Enrollment

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File from the HHSC Administrative Services Contractor each month. The MCO may offer and provide the enrollment information in alternative formats, such as through access to a secure Internet site, when that format is acceptable to the PCP.

8.1.5 Member Services

The MCO must maintain a Member Services Department to assist Members in obtaining Covered Services. Each Member Services Department or another appropriate department must include Transition Specialists who are dedicated to assisting Members and Service Coordinators with transition planning for adulthood as described in **Section 8.1.38.8**. The MCO must maintain employment standards and requirements for Member Services Department staff and provide a sufficient number of staff for the Member Services Department to meet the requirements of this Section, including Member Hotline response times, and Linguistic Access capabilities, see **Section 8.1.5.6** "Nurse and Member Hotline Requirements." All Member Services Department staff must be provided with training that includes the following topics:

1. Eligibility policy;
2. Covered Services;
3. The STAR Kids Screening and Assessment Instrument and coordinating additional assessments and evaluations;
4. STAR Kids Program requirements;
5. Cultural Competency;
6. Trauma-informed care;
7. Positive Behavior Supports;
8. Community inclusion;
9. Person-centered practices;
10. Member assessments and special evaluations;
11. Communication strategies for Members with limited English proficiency;
12. The purpose and information included in an Individual Service Plan (ISP); and
13. Non-capitated Services.

8.1.5.1 Member Materials

The MCO must design, print, and distribute Member identification (ID) cards and a Member Handbook to Members. Within five Business Days following the receipt of an Enrollment File from the HHSC Administrative Services Contractor, the MCO must mail a Member ID card and Member Handbook to the Case Head or Account Name for each new Member. When the Case Head or Account Name is associated with two or more new Members, the MCO is only required to send one Member Handbook. The MCO is responsible for mailing materials only to those Members for whom valid address data are contained in the Enrollment File.

The MCO must ensure all information provided by the MCO to Members complies with the information requirements in 42 C.F.R. § 438.10, as applicable.

All Member Materials must be at or below a 6th grade reading level as measured by the appropriate score on the Flesch Reading Ease test. Member Materials must be written

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and distributed in English, Spanish, and the languages of other Major Population Groups making up ten percent or more of the managed care eligible population in the MCO's Service Area, as specified by HHSC. HHSC will provide the MCO with reasonable notice when the population reaches the 10 percent threshold in the MCO's Service Area. 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 the **UMCM**, including required critical elements and marketing policies and procedures.

The MCO must make Member Materials that are critical to obtaining services, including at a minimum, Provider directories, Member handbooks, Appeal and grievance notices, and denial and termination notices, available in the Prevalent Languages in its particular service area. These materials must also be made available in alternative formats upon request of the Member at no cost. Auxiliary aids and services must also be made available upon request of the Member at no cost. These materials must include taglines in the Prevalent Languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's Member Services Hotline. Large print means printed in a font size no smaller than 18 point. These materials must use a font size no smaller than 12 point. These materials must also include a large print tagline and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.

The MCO must submit Member Materials to HHSC for approval prior to publication or distribution, including revisions to previously approved Member Materials. See **UMCM Chapter 3** and **4** for material and submission requirements. HHSC reserves the right to require discontinuation, revision, or correction of any Member Materials, including those previously approved by HHSC, that violate the terms of this Contract, including the Marketing Policies and Procedures as described in the **UMCM Chapter 4**.

If the MCO distributes HHSC-approved Member Materials to groups of Members or all Members (i.e., "mass communications,") it also must post a copy of the materials on its website.

The MCO's Member Materials and other communications cannot contain discretionary clauses, as described in Texas Insurance Code Section 1271.057(b).

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;
3. The effective date of the PCP assignment;
4. The PCP's name (not required for Dual Eligible STAR Kids Members), address (optional for all products), and telephone number (not required for Dual Eligible STAR Kids Members);
5. The name of the MCO;

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6. The 24-hour, 7-Day a week toll-free Member services telephone number and BH Hotline number operated by the MCO; and
7. Any other critical elements identified in the UMCM Chapter 3.

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

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**, 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**.

The MCO must produce and distribute a revised Member Handbook, or an insert informing Members of changes to Covered Services upon HHSC notification and at least 30 Days prior to the effective date of the change in Covered Services. In addition to modifying the Member Materials for new Members, the MCO must notify all existing Members of the Covered Services change during the timeframe specified in this subsection.

8.1.5.4 Provider Directory

The MCO must have a process in place to compare the information in the master Provider file provided by the HHSC Administrative Services Contractor with the MCOs Provider directory. When the MCO identifies a discrepancy, the MCO must assist the Provider through the process of updating inaccurate information with the HHSC Administrative Services Contractor. MCOs must contact Providers monthly until the information on the master Provider file reflects the information attested to by the Provider. This includes but is not limited to, information identified through the MCO Provider Verification survey in Section 8.1.3.3 or other data sources provided to the MCOs by HHSC or identified by the MCO. The MCO must include in its Provider Contract that the Provider will update its information with HHSC Administrative Services Contractor in a timely fashion or immediately upon request by the MCO.

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.

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As described in **Section 7**, during the Readiness Review, the MCO must develop and submit the draft Provider directory template for HHSC's approval and must submit a final Provider Directory incorporating changes required by HHSC prior to the Operational Start Date. The MCO must submit draft and final Provider 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**.

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**. The Provider directory must include only Network Providers credentialed by the MCO in accordance with **Section 8.1.4.2**. 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

The hard copy Provider directory must contain the requirements of **UMCM Chapter 3**.

The MCO must update the Provider directory in accordance with 42 C.F.R. § 438.10 or as directed by HHSC. The MCO must make the updates available to existing Members upon request, and must provide the updates to the HHSC Administrative Services Contractor in hard copy at the beginning of each month. HHSC will consult with the MCOs and the HHSC Administrative Services Contractors to discuss methods for reducing the MCO's administrative costs for producing new Provider Directories. Weight limits for the Provider Directories are included in **UMCM Chapter 3**. Weight limits may vary by Service Area. HHSC will require MCOs that exceed the weight limits to compensate HHSC for postage fees in excess of the weight limits.

The MCO must send the most recent Provider directory, including any updates, to Members within five Business Days of the request. The MCO must, at least annually provide written communication to its Members to inform of and offer the most recent Provider directory.

8.1.5.4.2 Online Provider Directory

The MCO must develop, implement, and maintain an online Provider directory to provide an electronic provider look-up search of its Provider Network. The MCO must develop and maintain policies and operating procedures with respect to its Provider Network database, which must include a predictable schedule for systematically updating the database. The MCO Online Provider directory must be updated at least on a weekly basis to reflect the most current MCO Provider Network.

The MCO must 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

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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 Provider directory must comply with the requirements set forth in **UMCM Chapter 3**.

The MCO must inform Members that the Provider directory is available in paper form without charge upon the Member's request and provide it within five Business Days of the Member's request.

8.1.5.5 Internet Website

The MCO must develop and maintain, consistent with HHSC standards and Texas Insurance Code § 843.2015 and other applicable state laws, a website to provide general information about the MCO, its Provider Network, including an online Provider directory as outlined in **UMCM Chapter 3**, its customer services, and its Complaints and Appeals process. The website must contain a link to financial literacy information on the Office of Consumer Credit Commissioner's webpage. The MCO may develop a page within its existing website to meet the requirements of this section. The MCO must also maintain a mobile optimized site for mobile device use.

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

To minimize download and "wait times," the website must not use tools or techniques that require significant memory, disk resources, or special user interventions.

The MCO must develop and make available a Member website to provide STAR Kids specific information to Members. The MCO must also optimize this website for mobile device use. The website's STAR Kids content must be:

1. Written in English, Spanish, and the languages of any other Major Population Groups (i.e., groups making up 10 percent or more of the managed care eligible population in the MCO's Service Area. HHSC will provide the MCO with reasonable notice when the population reaches the 10 percent threshold);
2. Culturally appropriate;
3. Person-centered
4. Written for understanding at the 6th grade reading level; and
5. Be geared to the needs of the enrolled population.

At a minimum, the MCO's Member website must include:

1. A Provider Directory or Network Provider search functionality;
2. MCO contact information, including physical and mailing addresses and phone and fax numbers of MCO headquarters and any regional offices;

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3. Information about Service Coordination and how to obtain Service Coordination, including contact information;
4. Information about Member Advocates, including contact information;
5. Information about the Complaints and Appeals process, including contact information;
6. A list of Covered Services;
7. Information on outages and downtime for Member-facing systems; and
8. An electronic version of the Member handbook; and
9. A link for Members to access the Member Portal

The MCO's internet website must contain the requirements of **UMCM Chapter 3.**

The MCO's pharmacy website must contain the requirements of **UMCM Chapter 3.**

The online Provider directory or online Provider search functionality must also identify Providers that provide MDCP STAR Kids services. All MCOs must list home health and Ancillary Providers on their websites. The search functionality must, at a minimum, allow a user to search or sort by: geographic location (i.e., distance in miles from a starting address); Provider name; practice name; Provider specialty and sub-specialty; open or closed panel; hours of operations and after hour availability; and languages in which the Provider is fluent. Home and Community-based LTSS Providers must be listed by subcategory.

HHSC may require discontinuation, revision, or correction of any Member Materials posted on the MCO's website, including those previously approved by HHSC.

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 Kids 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.
5. Information regarding outages and downtime for Provider-facing systems.

8.1.5.5.1 Member Portal

Each STAR Kids MCO must provide a Member Portal that supports functionality to allow access to Member's documents listed below and to reduce burdens placed on Members. The Member Portal must provide functionality for the following:

1. Explanation of Benefits
2. Prior authorization requests status
3. Prior authorization determinations
4. Results from STAR Kids Screening and Assessment Instrument

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5. Individual Service Plans
6. Provider Search
7. Contact information for technical support

MCOs must post the above required documents to the Member's Member Portal within seven Days of receiving or finalizing the document.

8.1.5.6 Nurse and Member Hotline Requirements

The MCO must operate a toll-free Nurse hotline and a toll-free Member hotline. Nurse hotline and Member hotline services must meet Cultural Competency requirements and must appropriately handle calls from non-English speaking callers, as well as calls from individuals who are deaf or hard-of-hearing. The MCO must employ bilingual Spanish-speaking and other multi-lingual Member Services representatives, as appropriate, 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 the Member and Nurse 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 and Members. The MCO must ensure that both toll-free Hotlines meet the following minimum performance requirements for the MCO Program:

1. At least 80 percent of calls must be answered by toll-free line staff within 30 seconds measured from the time the call is placed in queue after selecting an option.
2. The call abandonment rate is seven percent or less; and
3. The average hold time is two minutes or less.

The MCO must conduct ongoing quality assurance to ensure these standards are met.

Members 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 Member hotline must be dedicated to serving STAR Kids Members. The Nurse hotline may also serve members of other programs operated through the MCO. 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 8.1.22.2** and the **UMCM Chapter 5**.

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If HHSC determines that it is necessary to conduct onsite monitoring of the MCO's Nurse hotline or Member hotline functions, the MCO is responsible for all authorized reimbursable travel costs incurred by HHSC relating to such monitoring. For purposes of this section, "authorized reimbursable travel costs" include airfare, lodging, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring. Reimbursement by the MCO will be due to HHSC within a timely manner, no longer than within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

8.1.5.6.1 Nurse Hotline

The MCO must operate a toll-free Nurse hotline that Providers and Members can call 24 hours a Day, 7 Days a week. The Nurse hotline must be staffed with nurses who are knowledgeable about the STAR Kids Program, Covered Services, the STAR Kids Population, and Provider resources. Nurses must be available 24 hours per day and able to respond to calls from Providers and Members seeking clinical information, guidance on specialty referrals or requests for specialty Provider consultations. Nurses must have access to an on-call licensed Behavioral Health 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:

1. Knowledgeable about Covered Services, including Behavioral Health Services, Texas Health Steps, the Medical Transportation Program, pharmacy and vision.
2. Knowledgeable about the Medical Home Services Model, Health Homes, and Integrated Primary Care.
3. Able to answer questions pertaining to the role of the PCP and the Health Home.
4. Able to answer clinical and non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services.
5. Knowledgeable and trained in issues related to child abuse and how to assist Members seeking care and services.
6. Knowledgeable of crisis services and supports.
7. Able to give information about Providers in a particular geographical area.
8. Trained regarding Cultural Competency.
9. Trained to handle and properly refer behavioral health crises.
10. Able to answer clinical and non-clinical questions pertaining to accessing services that the MCO does not provide or arrange for such as Non-capitated Services; community and social service resources; and community-based case management services for which the STAR Kids population may be eligible.
11. Able to respond to Provider questions regarding specialty referrals and to arrange for consultations with MCO clinical staff, Service Coordinators or

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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 behavioral health Provider.

12. Able to respond to questions regarding the Disease Management programs included in the Model.
13. Trained regarding:

    - 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. The 24-hour nurse hotline will attempt to respond immediately to problems concerning emergency medicines by means at its disposal, including explaining the rules to Members so that they understand their rights and, if need be, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy and DME processes;
    - The HHSC OIG Lock-in Program pharmacy override process to ensure Member access to Medically Necessary outpatient drugs; and
    - DME processes for obtaining services and how to address common problems.

8.1.5.6.2 Member Hotline

In addition, the MCO must operate a toll-free Member hotline that Members can call 24 hours a Day, seven Days a week. The Member hotline must be staffed between the normal business hours of 8:00 a.m. to 5:00 p.m. local time 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 the Texas State Auditor's Office website.

Member Service representatives must be knowledgeable about the STAR Kids Program, Covered Services, Non-capitated Services, and the STAR Kids Population. The MCO must develop a process to authenticate callers as the Member or the Member's LAR through the Member hotline. Before the MCO implements the caller authentication process, HHSC must approve the process in writing. Only those persons who can identify themselves through the caller authentication process as the Member or the Member's LAR may obtain the Member's 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.

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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. In order to ensure service standards are achieved, the MCO must implement a call and customer service monitoring plan. At a minimum, the MCO's Member Service representatives must be:

1. Knowledgeable about Covered Services, including behavioral health, Texas Health Steps, MDCP STAR Kids, HCBS waiver programs, the Medical Transportation Program, pharmacy, dental and vision;
2. Trained regarding:
   a) 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;
   b) How Members in the Lock-in Program can fill prescriptions at a non-designated pharmacy in an emergency situation; and
   c) DME processes for obtaining services and how to address common problems;
3. Able to answer non-technical questions pertaining to the role of the PCP and about the Health Home, and Integrated Primary Care;
4. Trained regarding the Service Coordination process and how to transfer Members to Service Coordinators;
5. Able to answer non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services;
6. Knowledgeable and trained in issues related to child abuse and how to assist Members seeking care and services;
7. Able to give information about Providers in a particular geographical area.
8. Knowledgeable about Fraud, Waste, and Abuse including the Lock-in Program and the requirements to report any conduct that, if substantiated, may constitute Fraud, Waste, and Abuse in the Program;
9. Trained regarding Cultural Competency in accordance with Section 8.1.5.8, including arranging for interpreter services;
10. Trained to triage calls to the appropriate MCO staff person;
11. Able to answer non-clinical questions pertaining to accessing services that the MCO does not provide or arrange for, such as Non-capitated Services and community and social service resources for which the STAR Kids population may be eligible;
12. Trained to help Members obtain Covered Services and Non-capitated Services, as appropriate;
13. Able to provide information on how to file Member MCO Internal Appeals and Complaints;
14. Knowledgeable about how 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 Kids program;
15. Knowledgeable about Service Management, Service Coordination, and Service Plans offered by the MCO for Members; and

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16. Trained to assist a Member, Member's authorized representative, or LAR with scheduling an appointment with a Provider during the Provider's hours of operation and within the Member's availability, in accordance with **UMCC Section 8.1.3.2**. The MCO may have dedicated staff to assist with scheduling non-emergency appointments, and may use a three-way call with the Provider and Member or Member's representative to schedule the appointment. Hotline services staff must offer Members the opportunity to participate in a facilitated three-way call between the Member, Member's authorized representative, or LAR and a Provider's office to schedule an appointment. The MCO may have dedicated staff for this purpose. If the Member does not want to participate, the MCO must document Member Refusal and offer a list of Network Providers; and including offering the Member a Provider directory at no cost to the Member.

8.1.5.7 Member Education

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

1. How the MCO system operates, including the role of the PCP; Health Home; Individual Service Plan (ISP); prior authorization process; and what may be provided through Service Coordination;
2. How to obtain Covered Services and non-covered services after hours and on weekends;
3. The Member MCO Internal Complaints and Appeals and State Fair Hearings process;
4. Covered Services, and limitations and any Value-added Services offered by the MCO;
5. The value of screening and preventive care; and
6. How to obtain Covered Services and non-covered services, including:
   a. Emergency Services;
   b. Specialty care;
   c. HCBS waiver services;
   d. Behavioral Health Services;
   e. Private Duty Nursing;
   f. Personal Care Services;
   g. Disease Management services;
   h. Service Coordination;
   i. Durable medical equipment and supplies;
   j. Early Childhood Intervention (ECI) services;
   k. Screening and preventive services, including well-child care (Texas Health Steps medical checkups);
   l. Consumer-directed services;
   m. Member copayment responsibilities (if HHSC implements Medicaid cost sharing after the Effective Date of the Contract);
   n. Suicide prevention;
   o. Head start;

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p. Identification and health education related to obesity;
q. Obtaining 72-hour supplies of emergency prescriptions from pharmacies enrolled with HHSC as Medicaid Providers;
r. Cognitive rehabilitation therapy;
s. Community First Choice (CFC) services;
t. Case Management for Children and Pregnant Women;
u. The medical transportation program; and
v. Prescribed Pediatric Extended Care Center services, if PPECCs are available in the Service Area.

The MCO must provide health promotion and wellness information tailored to the needs of individual Members. The MCO must propose, implement, and assess innovative Member education strategies for wellness and immunizations, as well as general health promotion and prevention. The MCO must conduct wellness promotion programs to improve the health status of its Members, including information on its Service Coordination (**Section 8.1.38**) and Disease Management (**Section 8.1.14**) programs. 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**.** Condition- and disease-specific information must be oriented to various groups within the STAR Kids eligible population.

Per Texas Health and Safety Code § 48.052(c), MCOs may use certified Community Health Workers to conduct outreach and Member education activities.

8.1.5.7.1 Member Education on Abuse, Neglect, or Exploitation

At the time a STAR Kids 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.

8.1.5.8 Cultural Competency Plan

The MCO must have a comprehensive written Cultural Competency plan describing how the MCO will ensure culturally competent services and provide Linguistic Access and Disability-related Access. The Cultural Competency plan must be developed in adherence to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) in the format as required by HHSC as described in **UMCM Chapter 16.1**. The Cultural Competency plan must adhere to the following: Title VI of the Civil Rights Act guidelines and the provision of auxiliary aids and services, in compliance with the Americans with Disabilities Act, Title III, Department of Justice Regulation 28 C.F.R. 36.303, 42 C.F.R. § 438.206(c)(2), and 1 Tex. Admin. Code § 353.411. Additionally, the Cultural Competency plan must describe how the MCO will implement each component of the National CLAS Standards as described in **UMCM Chapter 16.1**.

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The Cultural Competency plan must describe how the individuals and systems within the MCO will effectively provide services to people of all cultures, education levels, family composition, races, ethnic backgrounds, languages, communication needs, and religions, as well as those with disabilities, in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. The MCO must submit the Cultural Competency plan to HHSC for Readiness Review. During Readiness Review, the Cultural Competency plan will be assessed to determine the extent to which it aligns with the National CLAS Standards as described in **UMCM Chapter 16.1**. The Cultural Competency plan must detail how the MCO implements each component of the National CLAS Standards 2 through 15. By implementing Standards 2 through 15, MCOs are working toward CLAS Standard 1, the Principal Standard: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

During the Operations Phase, the MCO must submit modifications and amendments to the Cultural Competency plan to HHSC no later than 30 Days prior to implementation. The Cultural Competency plan must also be made available to the MCO's Provider Network. HHSC may require the MCO to update the Cultural Competency plan to incorporate new or amended requirements based on HHSC guidance. In that event, the MCO has 60 Days to submit the updated Cultural Competency plan to HHSC.

The MCO must arrange and pay for Competent Interpreter services, including written, spoken, and sign language interpretation, for Members, or Legally Authorized Representative, as applicable to ensure effective communication regarding treatment, medical history, or health condition. The MCO must maintain policies and procedures outlining the manner in which Members, or Legally Authorized Representative, as applicable, and the Members' Providers can access Competent Interpreter services including written, spoken, and sign language interpretation, when the Member, or Legally Authorized Representative, as applicable is receiving services from a Provider in an office or other location or accessing Emergency Services.

Over-the-phone interpretation (OPI), including three-way calls facilitated between the MCO, Provider and telephone interpreter, must not require advance notification by the Member, Legally Authorized Representative, or Provider.

Upon a Provider, Member, or Legally Authorized Representative request, in-person interpreters for scheduled appointments shall be arranged as quickly as possible, with "rush" appointments available for Urgent Conditions. For Routine Care, in-person requests will be scheduled according to the requested date and time, or upon the next availability of the interpreter for the requested language, including American Sign Language (ASL). If an in-person interpreter is not available for the requested date and time, the MCO must notify and coordinate with the Provider and Member or Legally Authorized Representative, as applicable, and offer alternative interpretation options, such as OPI, Video Remote Interpretation, or the earliest availability of an in-person interpreter. Members may select an in-person interpreter whether they require ASL or another language. The MCO may recommend, but not require, an advance notice timeframe for arranging an in-person interpreter. MCOs must make a good faith effort to

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arrange an in-person interpreter when one is requested, regardless of the advance notice.

8.1.5.9 Member Complaint and Appeal Process

The MCO must develop, implement and maintain a transparent system for tracking, resolving, and reporting Member Complaints regarding its Member assessments, services, processes, procedures, and staff. In this case transparency involves adoption and use of tracking methodologies that are streamlined, document, easily understood and frequently updated. The MCO must ensure that Member Complaints are resolved within 30 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 the **Attachment A**, "STAR Kids Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix."

The MCO must develop, implement, and maintain a transparent system for tracking, resolving, and reporting Member Appeals regarding the denial or limited authorization of a requested service. The system must include information on 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 the Service Coordinator for all Level 1 and Level 2 Members is informed about the status of the Appeal. For all Members the MCO must establish a mechanism that allows Member Service representatives to view and report to the Member or Member's LAR on the status of a Complaint or Appeal.

The MCO must ensure that standard and expedited Member Appeals are resolved within the specified timeframes, 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 for Member Appeals not resolved within the performance standard.

The MCO must use providers with appropriate experience to review Complaints and Appeals. Appeals submitted on behalf of STAR Kids Members must be reviewed by clinicians with pediatric experience or appropriate specialists before issuing a final decision.

The MCO must follow the Member Complaint and Appeal System described in **Section 8.1.29**.

8.1.5.10 Member Advisory Groups

The MCO must establish an advisory group consisting of Members, their authorized representatives or caregivers, and advocates. An advisory group must meet and conduct quarterly meetings with Members in each Service Area in which the MCO operates a STAR Kids program. The meetings may only address STAR Kids program

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and the needs and goals of STAR Kids Members. The MCO must publicize quarterly meetings so that Members, Member families and consumer advocates are made aware of the meeting time and location at least three weeks in advance of each meeting. Membership in the Member Advisory Group(s) must include, at least five Members or Member's LARs attending each meeting and allow for member advocates to participate. The MCO must maintain a record of Member Advisory Group meetings, including agendas and minutes, for at least three years. The MCO must submit to HHSC a quarterly summary of major items discussed and concerns or feedback received at the Member Advisory Group meetings. For MCOs offering long-term services and supports (LTSS), the Member advisory group must include a reasonably representative sample of the LTSS Member population or advocates. For the LTSS Member population the advisory group must include at least three Members or their representatives receiving LTSS through the MCO or their representative.

8.1.5.11 Member Eligibility

The MCO must, if possible, provide eligibility renewal assistance for Members whose eligibility is about to expire. MCOs must adhere to minimum requirements set in **UMCM Chapter 16**.

8.1.5.12 Member Service Email Address

The MCO must have a secure email address through which a Member or the Member's Provider may contact the MCO to receive assistance with identifying Network Providers and schedule an appointment for the Member or to access services. The MCO must reply to the Member's request with an email response informing the Member or Provider that by communicating via email the Member or Provider consents to receive information through the same means. When the MCO receives the Member's email, Member Services staff must provide the Member or Member's Provider requested information within three Business Days following the receipt of the email.

8.1.6 Marketing and Prohibited Practices

The MCO and its Subcontractors must adhere to the Marketing Policies and Procedures as set forth by HHSC in this 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, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO must work in collaboration with Providers to actively improve the quality of care provided to Members, consistent with the Quality Improvement Goals and all other requirements of the Contract. The MCO must provide mechanisms for Members and Providers to offer input into the MCO's quality improvement activities.

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8.1.7.1 QAPI Program Overview

The MCO must develop, maintain, and operate a quality assessment and performance improvement (QAPI) Program consistent with this 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. § 438.330.

The MCO must inform HHSC whether it has been accredited by a private independent accrediting entity and the MCO must authorize the private independent accrediting entity to provide HHSC and its EQRO a copy of its most recent accreditation review in accordance with 42 C.F.R. § 438.332.

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 Provider Contracts.

The MCO must approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of continuous quality improvement (CQI)/total quality management (TQM) and must:

1. Evaluate performance using objective quality indicators;
2. Foster data-driven decision-making;
3. Recognize that opportunities for improvement are unlimited;
4. Solicit Member and Provider input on performance and QAPI activities;
5. Support continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;
6. Support programmatic improvements of clinical and non-clinical processes based on findings from on-going 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;

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3. Includes annual objectives and 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 the clinical indicator data in the development, assessment, and modification of its QAPI Program.

8.1.7.4 QAPI Program Subcontracting

If the MCO subcontracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the MCO must maintain a file of the Subcontractors. The file must be available for review by HHSC or its designee upon request.

8.1.7.5 Behavioral Health Integration into QAPI Program

The MCO must integrate behavioral health into its QAPI Program and include a systematic and on-going process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members. The MCO must collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care. The MCO must also collect data and monitor and evaluate prevention of inpatient psychiatric utilization resulting from the administration of adequate outpatient Behavioral Health Services.

8.1.7.6 Clinical Practice Guidelines

The MCO must adopt not less than two evidence-based clinical practice guidelines. 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 health care professionals, and be reviewed and updated periodically, as appropriate. The MCO must develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

The MCO may coordinate the development of clinical practice guidelines with other STAR Kids MCOs so that Service Area Providers do not receive conflicting practice guidelines from different MCOs.

The MCO must disseminate the practice guidelines to all affected Providers and, upon request, to Members and potential Members.

The MCO must take steps to encourage adoption of the guidelines, and to measure compliance with the guidelines, until 90 percent or more of the Providers are consistently in compliance, based on MCO measurement findings. The MCO must employ

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substantive Provider motivational incentive strategies, such as financial and non-financial incentives, to improve Provider compliance with clinical practice guidelines. The MCO's decisions regarding Utilization Management, 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 Clinical and Administrative Advisory Committee

The MCO will establish clinical and administrative advisory committees in each Service Area in which it operates a STAR Kids program. The clinical and administrative advisory committees will perform the following functions:

1. Assist the MCO in developing, reviewing, and revising clinical practice guidelines, based on clinical best practices and community standards.
2. Assist the MCO in reviewing general clinical practice patterns and assessing Provider compliance with clinical guidelines.
3. Assist the MCO, HHSC, and the state's External Quality Review Organization (EQRO) in developing Quality Improvement strategies and studies.
4. Assist in developing improved administrative procedures.
5. Provide the MCO with recommendations on how to improve care based on Member feedback.
6. Connect network Providers and MCO clinical experts for purposes of peer support and best practice information sharing.

Each clinical and administrative advisory committee must meet at least once per quarter. The clinical and administrative advisory committee must be comprised of community Providers and other physical health and Behavioral Health experts that serve STAR Kids Members. The STAR Kids MCO must publicize the meetings to Network Providers and chair the meetings. Membership in the clinical and administrative advisory committee must include, at a minimum, a PCP, Specialty Care Provider, Behavioral Health Provider, Home and Community Support Services Agency representative, a therapy Provider, a medical equipment and supplies Provider, and a Pharmacy Provider in order to enable it to provide specialized review, expertise and consultation on a variety of health issues. The MCO may establish specialized workgroups that report findings to the clinical and administrative advisory committee. The MCO must maintain a record of clinical and administrative advisory committee meetings, including agendas and minutes, for at least three years.

8.1.7.8 Provider Credentialing and Profiling

In accordance with **Section 8.1.4.2**, 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 in **UMCM Chapter 5**.

The MCO must conduct PCP and other Provider profiling activities at least annually. As part of its QAPI Program, the MCO must describe the methodology it uses to identify

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which and how many Providers to profile and to identify measures to use for profiling the Providers.

Provider profiling 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 enrolled population. At least one of the indicators must measure the number of Texas Health Steps checkups completed by the Member's PCP.
2. Including the Medical Advisory Committees Clinical Advisory Committees 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, group, Service Area or regional Benchmarks for areas profiled, where applicable; 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 profiling activities to identify areas of improvement for PCPs and Providers;
2. Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established MCO standards or improvement goals;
3. Develop and implement incentives, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures; and
4. At least annually, measure and report to HHSC on the Provider Network and individual Providers' progress, or lack of progress, towards the improvement goals.

8.1.7.9.1 Physician Incentive Plans

If the MCO implements a physician incentive plan under 42 C.F.R. § 438.3(i), 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

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to 42 C.F.R. § 422.208 for information concerning “substantial financial risk” and “stop-loss protection”).

The MCO must make information regarding physician incentive plans available to Members upon request, in accordance with the **UMCM’**s requirements. The MCO must provide the following information to the Member:

1. Whether the Member’s PCP or other Providers are participating in the MCO’s physician incentive plan;
2. Whether the MCO uses a physician incentive plan that affects the use of referral services;
3. The type of incentive arrangement; and
4. Whether stop-loss protection is provided.

No later than five Business Days prior to implementing or modifying a physician incentive plan, the MCO must provide the following information to HHSC:

1. Whether the physician incentive plan covers services that are not furnished by a physician or physician group. The MCO is only required to report on items 2 - 4 below if the physician incentive plan covers services that are not furnished by a physician or physician group.
2. The type of incentive arrangement (e.g., withhold, bonus, capitation);
3. The percent of withhold or bonus (if applicable);
4. The panel size, and if Members are pooled, the HHSC approved 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 Alternative Payment Models with Providers

HHSC requires the MCOs to transition the provider payment methodologies from volume-based payment approaches, i.e. fee for service, to quality-based alternative payment models, increasing year-over-year percentages of provider payments linked to measures of quality or efficiency. MCO should design alternative payment models (APMs) to improve health outcomes for Members, empower Members and improve experience of care, lower healthcare cost trends, and incentivize Providers. Examples of APMs are programs to improve access to primary care, support care coordination or integration, reduce inappropriate utilization of services, or improve medication adherence.

The MCO must:

1. Achieve a minimum Overall APM Ratio and a Risk-Based APM Ratio in year one and reach target ratios within four years. The ratios are expressions of APM-based provider payments relative to total provider payments. The calculations and minimum yearly values for the APM Ratios, as well as exceptions to the APM Ratios,

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are delineated under the Methodology tab of **UMCM Chapter 8** Alternative Payment Models Data Collection Tool.

2. Submit to HHSC its inventories of HHSC its inventories of APMs with Providers by July 1st of each year, using the data collection tool in **UMCM Chapter 8.10**. The data collection tool will capture APM activity for previous year, and will be used to calculate the APM ratios. Provider types include, but are not limited to: Primary Care Providers, specialists, Hospitals, Long Term Services and Supports Providers, Chemical Dependency Treatment facilities, pharmacies, and pharmacists. Upon request by HHSC, the MCO shall submit to HHSC underlying data for the information reported on the data collection tool (e.g., names of providers, NPIs, TAPIs, etc.).
3. Implement processes to share data and performance reports with Providers on a regular basis. MCOs shall dedicate sufficient resources for Provider outreach and negotiation, assistance with data or report interpretation, and other activities to support Provider's improvement. HHSC may request evidence of these reports and processes from the MCOs. To the extent possible MCOs within Service Areas should collaborate on development of standardized formats for the Provider performance reports and data requested from Providers.
4. Dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment.
5. MCOs must obtain HHSC approval of all APMs altering the outpatient drug benefit (pharmacy and clinician-administered) in advance of implementation. MCOs must provide a brief description of the program including: overall goal, a description of how the APM will operate, information on how providers are impacted, information on how Members are impacted, and the target implementation date. Proposals must be submitted to HHSC Pharmacy Operations inbox at vdp-operations@hhsc.state.tx.us. Approvals/Denials will be issued within 30 Days of the proposal submission.

If the MCO's APM data collection tool does not adhere to HHSC requirements or is not submitted by the required deadline, the MCO shall be required to submit a corrective action plan and may be subject to additional contractual remedies, including liquidated damages.

If the MCO does not achieve the minimum APM Ratios and one of the exception conditions does not apply, the MCO shall be required to submit a corrective action plan and may be subject to additional contractual remedies, including liquidated damages.

8.1.7.10 This Section Intentionally Left Blank
8.1.7.11 This Section Intentionally Left Blank
8.1.7.12 Collaboration with the External Quality Review Organization (EQRO)

The MCO will collaborate with HHSC's External Quality Review Organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to Members and to identify opportunities for MCO improvement. To facilitate this process, the MCO will supply claims data to the

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EQRO in a format identified by HHSC in consultation with MCOs, 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 HHSC selected Healthcare Effectiveness Data and Information Set (HEDIS) measures that require chart reviews. MCOs must conduct chart reviews, for HEDIS hybrid measures and submit results to the EQRO in a format and timeline specified by HHSC. MCOs are responsible for all costs associated with these reviews.

8.1.7.12.1 Survey Reports

The EQRO conducts Member surveys using validated and nationally accepted instruments, including Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, Experience of Care & Health Outcomes (ECHO) surveys, and the RAND Health surveys. This process helps to ensure that Members' perspectives about their experiences with care are captured and communicated to stakeholders and the MCOs.

8.1.8 Other Quality Initiatives

MCOs must participate in all quality initiatives developed by HHSC and must provide HHSC, the EQRO, or the Quality Vendor with all information requested for quality purposes. This includes participating in all surveys conducted by HHSC, the EQRO, or the Quality Vendor. MCOs must also collaborate with the EQRO or the Quality Vendor to ensure medical records are available for focused clinical reviews.

8.1.9 Utilization Management

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

1. Procedures to evaluate the need for Medically Necessary Covered Services;
2. The clinical review criteria used, the information sources, and the process used to review and approve the provision of Covered Services;
3. The method for periodically reviewing and amending the UM clinical review criteria; and
4. The staff position functionally responsible for the day-to-day management of the UM function.

The MCO must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UM determinations. When making UM determinations, the MCO must comply with the requirements of 42 C.F.R. § 456.111 (Hospitals) and 42 C.F.R. § 456.211 (Mental Hospitals), as applicable.

To ensure Continuity of Care, the MCO must ensure that the Member is reassessed using the STAR Kids SAI prior to the expiration date of the Member's ISP. When a provider submits a reauthorization prior to the current authorization expiring, the MCO

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must ensure that the reassessment or authorization determination is timed to prevent any lapse in service authorization or program eligibility.

The MCO must issue coverage determinations according to the following timelines:

1. within one Business Day for concurrent hospitalization decisions;
2. within one hour for post-stabilization or life-threatening conditions, except that for Emergency Medical Conditions and Emergency Behavioral Health Conditions, the MCO must not require prior authorization; and
3. for a Member who is hospitalized at the time of the request, within one Business Day of receiving the request for Services or equipment that will be necessary for the care of the Member immediately after discharge, including if the request is submitted by an Out-of-Network Provider, Provider of Acute Care Inpatient Services, or a Member.
4. within three Business Days after receipt of all other prior authorization requests. For prior authorization requests received with insufficient or inadequate documentation, MCOs must follow timeframes established by the commission as set forth in UMCM Chapter 3.22.

The MCO must have a process in place that allows a Provider to submit a prior authorization or service authorization request for services at least 60 Days prior to the expiration of the current authorization period. If practicable, the MCO must review the request and issue a determination prior to the expiration of the existing authorization. The MCO's process must consider if the request contains sufficient clinical information to justify reauthorization of services.

The MCO's UM Program must include written policies and procedures to ensure:

1. consistent application of review criteria that are compatible with Members' needs and situations;
2. determinations to deny or limit services are made by physicians under the direction of the Medical Director;
3. the prior authorization process does not result in undue delays in services;
4. at the MCO's discretion, pharmacy prior authorization determinations may be made by pharmacists, subject to the limitations described in **Attachment A**, **Section 4.04**, "Medical Director;"
5. appropriate personnel are available to respond to Utilization Review inquiries 8:00 a.m. to 5:00 p.m., Monday through Friday, with a telephone system capable of accepting utilization review inquiries outside of these hours and that the MCO responds to calls within one Business Day;
6. confidentiality of clinical information; and
7. compensation to individuals or entities conducting Utilization Review activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services as required by 42 C.F.R. § 438.210(e), and quality is not adversely impacted by financial and reimbursement-related processes and decisions.

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

The MCO UM Program must include policies and procedures to:

1. Routinely assess the effectiveness and the efficiency of the UM Program.
2. Evaluate the appropriate use of medical technologies, including medical procedures, drugs and devices;
3. Target areas of suspected inappropriate service utilization;
4. Detect over- and under-utilization;
5. Routinely generate Provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;
6. Compare Member and Provider utilization with norms for comparable individuals;
7. Routinely monitor inpatient admissions, emergency room use, ancillary, and out-of-area services;
8. Ensure that when Members are receiving Behavioral Health Services from the local mental health authority that the MCO is using the same UM guidelines as those prescribed for use by Local Mental Health Authorities by MHMR which are published at the DSHS website under Utilization Management; and
9. Refer suspected cases of Provider or Member Fraud, Waste, or Abuse to the HHSC Office of Inspector General (HHSC OIG) as required by **Section 8.1.21**.

In accordance with the requirements in **UMCM Chapter 16**, MCOs must share utilization management data among all relevant MCO employees, including both physical and behavioral health staff, or, if applicable, between the MCO and the third party or subsidiary contracted with the MCO to manage Behavioral Health Services.

8.1.9.1 Compliance with State and Federal Prior Authorization Requirements

The MCO must adopt prior authorization (PA) requirements that comply with state and federal laws governing authorization of health care 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 prior authorization of prescription drug and health care benefits no later than two years after adoption, and accept PA requests submitted using in the Texas Department of Insurance's standard form, once adopted.

In the case of service code, procedure code, or benefit change that affects a current PA issued to a provider, the MCO must provide guidance to the provider holding the PA no less than 45 Days prior to effective date of the change. If the change is a result of a service code, procedure code, or benefit change adopted by HHSC, the MCO must issue notice of the change by the later of: (1) 45 Days prior to the effective date of the change, or (2) within 10 Business Days of receiving notice of the change from HHSC. MCOs may choose to reissue PAs or publish guidance to providers on updating current PAs. Information must be sufficient for providers to accurately bill for services. The MCO must establish and document a plan to inform all impacted providers of the

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changes. The MCO must be able to demonstrate that each impacted provider is notified of the changes within the prescribed timeframe through broadcast messages or individual notifications. The MCO must provide a copy of the plan and any associated notifications to HHSC upon request.

8.1.9.2 Toll-free Fax Line for Service Authorizations

The MCO must provide access to a toll-free fax line and Provider portal where Providers may send requests for authorization of services and any supplemental information related to service authorization.

8.1.10 Early Childhood Intervention

8.1.10.1 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 Early Childhood Intervention (ECI) referral information to the LAR of any Member under the age of three suspected of having a developmental delay or otherwise meeting eligibility criteria for ECI services in accordance with 40 Tex. Admin. Code Chapter 108 within seven Days from the day the Provider identifies the Member. The MCO must permit Members to self-refer to local ECI Providers without requiring a referral from the Member's PCP. The MCO's policies and procedures, including its Provider Manual and Member handbook, must include written policies and procedures for allowing a self-referral to ECI providers. The MCO must use written educational materials developed or approved by HHSC ECI for these child find activities.

The MCO must inform the Member's LAR that ECI participation is voluntary. The MCOs is required to provide medically necessary services to a Member if the Member's LAR chooses not to participate in ECI.

8.1.10.2 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.

8.1.10.3 Providers

The MCO must contract with an adequate number of qualified ECI Providers to provide ECI Covered 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

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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).

8.1.10.4 Individual Family Service Plan

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, advocates, or other persons as requested by the authorized representative. If the Member's LAR provides written consent, the Member's PCP or MCO staff may be included in IFSP meetings. The IFSP is a contract between the ECI contractor and Member's LAR. The Member's LAR signs the IFSP to consent to receive the services in amount, duration, scope, and service setting established by the IFSP. The IFSP contains information specific to the Member, as well as information related to family needs and concerns. If the Member's LAR provides written consent, the ECI program may share a copy of IFSP sections relevant only to the Member with the MCO and PCP to enhance coordination of the plan of care. These sections may be included in the Member's medical record or service plan.

8.1.10.5 Covered Services and Reimbursement

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 IFSP.

ECI Targeted Case Management services and Early Childhood Intervention Specialized Skills Training are Non-capitated Services, as described in **Section 8.1.24.8**.

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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.

8.1.11 Special Supplemental Nutrition Program for Women, Infants, and Children - Specific Requirements

The MCO must, by contract, require its Providers to coordinate with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit, or hemoglobin. The MCO must make referrals to WIC for Members potentially eligible for WIC. The MCO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract.

8.1.12 Coordination with Texas Department of Family and Protective Services

The MCO must cooperate and coordinate with the Department of Family and Protective Services (DFPS) for a Member receiving family based services or for a Member who is in DFPS conservatorship but not enrolled in the STAR Health program.

For the purposes of **Section 8.1.12**, court order means an order entered by a court of continuing jurisdiction requiring participation in DFPS services or placing a child or young adult under DFPS conservatorship.

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

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

The MCO cannot deny or reduce the Medical Necessity of any Covered Services, including Behavioral Health Services, included in the above-referenced Court Orders or service plans. Any modification or termination of court-ordered services must be approved by the court having jurisdiction over the matter.

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

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

1. Providing medical records to DFPS;
2. Testifying in hearings; and
3. Scheduling medical and Behavioral Health Services appointments within 14 Days unless requested earlier by DFPS.

8.1.13 Services for Members with Special Health Care Needs

All STAR Kids Members are considered to be Members with Special Health Care Needs (MSHCN). Due to tremendous variation in the service needs of MSHCN, STAR Kids MCOs must determine service and support needs on an individual basis.

8.1.13.1 Identification

The MCO must use the STAR Kids Screening and Assessment Process described in **Section 8.1.39,** as well as other methods determined appropriate by the MCO, to identify Members who require special services described in this section and ongoing special conditions requiring a course of treatment or regular monitoring. The MCOs assessment methods must use appropriate health care professionals.

The MCO must develop and maintain a system and procedures for identifying:

1. Members who are medically complex;
2. Children with Severe Emotional Disturbance (SED);
3. Members with disabilities or chronic or complex physical, behavioral health, and chemical dependency conditions, including high-cost catastrophic cases;
4. Members with high-risk pregnancies; and
5. Members with significant challenges in their natural support systems.

The MCO will determine whether the Member requires additional Service Coordination and special services. The MCO must provide information to the HHSC Administrative Services Contractor that identifies all Members with Complex Conditions. The information must be provided to HHSC as specified in the Joint Interface Plan found in the **UMCM**, and updated with newly identified Members with Complex Conditions by the 10th day of each month.

In order to prevent duplication of activities if a Member changes MCOs, the former MCO must provide the receiving MCO with information concerning the results of the MCO's identification and assessment of that Member's needs, including results from the STAR Kids Screening and Assessment Instrument (SAI) and the Member's Individual Service Plan (ISP). To ensure Continuity of Care, if a Member is transitioning from another MCO, the MCO must contact the Member's prior MCO and request information regarding the Member's needs, current Medical Necessity determinations, authorized care, and treatment plans. The receiving MCO must ensure that the Member's new Service Coordinator, once assigned, contacts the Member's former Service Coordinator at the former MCO to ensure a seamless transition of service coordination. The MCO must

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continue to provide services included in the prior treatment plan until the authorized treatment plan is completed, or until the MCO is able to complete their own STAR Kids Screening and Assessment Process and issue a new treatment plan. The MCO must allow the Member to continue to receive services with his or her existing provider and allow an Out-of-Network authorization to ensure the Member's condition remains stable and services are consistent to meet the Member's needs. The Out-of-Network 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.

8.1.13.2 Access to Care for MSHCN

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

The MCO must have a mechanism in place to allow Members with Special Health Care Needs to have direct access to a specialist as appropriate for the Member's condition and identified needs, such as a standing referral to a specialty physician.

8.1.14 Disease Management

The MCO must provide, or arrange to have provided to Members, comprehensive Disease Management (DM) services consistent with Texas state statutes and regulations. DM services must be part of a person-based approach to DM and holistically address the needs of persons with multiple chronic conditions. The MCO must have a DM Program that addresses asthma and diabetes and must develop and implement DM services that relate to chronic conditions that are prevalent among Members. HHSC will not identify individual Members with chronic conditions. The MCO must implement policies and procedures to ensure that Members that require DM services are identified and enrolled in a program that provides DM services.

The MCO must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of participants at risk for or diagnosed with asthma, diabetes, and other chronic conditions identified by the MCO. 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.

For all new Members not previously enrolled in the MCO and who require DM services, the MCO must evaluate and ensure continuity of care with any previous DM services in accordance with the requirements in the **UMCM**.

The MCO's DM Program must include:

1. Patient Self-management Education;
2. Provider/Practice Delivery System Design;

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3. Provider education;
4. Evidence-based models and minimum standards of care;
5. Standardized protocols and participation criteria;
6. Physician-directed or physician-supervised care;
7. Implementation of interventions that address the continuum of care;
8. Mechanisms to modify or change interventions that are not proven effective; and
9. Mechanisms to monitor the impact of the DM Program over time, including both the clinical and the financial impact; and
10. Technological support

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

HHSC encourages MCOs to develop provider incentive programs for designated Providers who meet the requirements for patient-centered medical homes found in Texas Government Code § 533.0029.

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

8.1.14.1 Special Populations

The MCO must 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 sub-contracted with the MCO.
5. Evaluation process to determine effectiveness of super-utilizer program. As part of the annual evaluation of effectiveness, the MCO should include a description or example of an intervention it found effective. It can be a Member case study with a description of the interventions and improvements or a specific project with demonstrated effectiveness.

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Upon request, MCOs must demonstrate to HHSC their methodologies for identification and intervention strategies for this population, to include the MCO's resources to support this effort on an ad hoc basis, the MCO must provide HHSC with its plan for management of super-utilizers including the criteria listed above 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 8.1.14.3**. An MCO may reuse elements of the same plan as long as the submission reflects the current state of their special population program and is updated as necessary on evaluation methodologies and key findings.

8.1.14.2 DM Services and Participating Providers

At a minimum, the MCO must:

1. Implement a system for Providers to request specific DM interventions;
2. Give Providers information, including differences between recommended prevention and treatment and actual care received by Members enrolled in a DM Program, and information concerning Members' adherence to a service plan; and
3. For Members enrolled in a DM Program, provide reports on changes in a Member's health status to their PCP.

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.

8.1.14.3 MCO DM Evaluation

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

HHSC or its EQRO will also evaluate DM as it relates to specialized populations identified in **Section 8.1.14.1**. These evaluations will be on a retrospective basis, and will include an analysis of MCO Encounter Data and other relevant data (e.g. reports). Evaluations could also include interviews with MCO staff that oversee the STAR Kids Program and identified Providers. Based on HHSC's retrospective evaluation, the MCO may be required to submit a Corrective Action Plan if directed by HHSC.

It is HHSC's intent to hold quarterly collaborative calls or webinars with MCO Medical Directors to discuss plan implementation, barriers, successful strategies, etc.

8.1.15 Comprehensive Care Program Community-Based Services

The MCO must provide all benefits and services authorized through the THSteps Comprehensive Care Program (CCP), including Personal Care Services (PCS) and Private Duty Nursing (PDN), and Prescribed Pediatric Extended Care Centers (PPECCs). PCS must be made available to Members who require assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health maintenance activities (HMAs) because of a physical, cognitive, or behavioral limitation that is related to the Member's disability or chronic health condition. PCS must be

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authorized if determined appropriate through the STAR Kids Screening and Assessment Instrument and upon receipt of a Practitioner Statement of Need (PSON).

PDN must be authorized for any Member when the services are medically necessary to correct or ameliorate the Member's disability, physical or mental illness, or condition, and documented in compliance with all requirements in 1 Tex. Admin. Code, Chapter 363, Subchapter C.

PPECC services include nursing, caregiver training, and personal care services while the Member is in the PPECC. Members seeking PPECC services must be determined eligible in compliance with medical necessity and other requirements in 1 Tex. Admin. Code, Chapter 363, Subchapter B. PPECC services require a physician prescription.

The MCO must ensure STAR Kids Members who receive PCS, PDN, PPECC, or a combination of these services, have access to appropriate Providers. For example, if the Member is receiving PCS for Behavioral Health reasons, the PCS Provider should have the experience with or training on working with children and youth with Behavioral Health challenges.

8.1.16 Behavioral Health Services and Network

Appropriate access to Behavioral Health Services is a critical component of effective healthcare for STAR Kids Members. The MCO must contract with Behavioral Health Providers specializing in treatment of issues that are common to children and young adults in the STAR Kids population. These special populations include children and adolescents with dual or multiple diagnoses, persons with physical disabilities and IDD, and cultural or linguistic minorities. The MCO must identify and attempt to improve inpatient and outpatient treatment options for Members with both IDD and Behavioral Health concerns. Behavioral Health service Providers with experience serving these Members must be trained and willing to provide Behavioral and Mental Health Services that go beyond behavior management in order to identify, address and treat underlying mental health illnesses including depression, bi-polar disorder and post-traumatic stress disorder. MCO must provide all Behavioral Health services to promote the recovery of Members experiencing mental illness and enhance the development of resiliency for Members impacted by mental illness, substance use disorder issues.

As allowed by 42 C.F.R. § 438.3(e), the MCO may provide certain HHSC-approved services in lieu of Behavioral Health Services, as described in UMCM Chapter 16.

The MCO must include Significant Traditional Providers (STPs) of these benefits in its Network. The MCO must enter into Provider Contracts 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 Behavioral Health Providers in the MCO's Network about how to refer Members for treatment.

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MCO's Provider Network capacity and distribution must permit Members to have ready access to services as specified in **Section 8.1.3.2**.

The Network must include psychiatrists and child and adolescent psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; licensed social workers (LCSWs); licensed marriage and family therapists (LMFTs); licensed professional counselors; Board Certified Behavior Analysts; peer support specialists; Qualified Mental Health Professionals (QMHPs) working under the authority of a Local Mental Health Authority and as defined in 25 Tex. Admin. Code Chapter 412; licensed adolescent Chemical Dependency Treatment facilities; and licensed chemical dependency counselors (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 mental health and substance use disorders;
2. The diagnosis and treatment of IDD;
3. Treating young children;
4. Treating children dually diagnosed with IDD and mental health issues;
5. Treating children with autism;
6. Treating Members with a disability caused by an accident or illness;
7. Treating Members with traumatic brain injuries;
8. Medication training and support;
9. Working with the LAR and families of children and young adults with behavioral health conditions;
10. Treating children and young adults with life threatening illnesses; and
11. Screening and treating children with fetal alcohol syndrome or related disorders.

The MCO must use available Telemedicine, or Telehealth services to increase access to specialty behavioral health assessment and treatment Providers.

To best address the special needs of the STAR Kids population and provide effective treatment, MCO must ensure Network Providers are 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 evidence-based treatments for disorders common to the STAR Kids population.

8.1.16.1 Member Education and Self-referral for Behavioral Health Services

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

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

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

8.1.16.2 Behavioral Health Services Hotline

This Section includes Hotline functions pertaining to Members. Requirements for Provider hotlines are found in **Section 8.1.5.6**. The MCO must have an emergency and crisis Behavioral Health Services hotline staffed by trained personnel 24 hours a Day, 7 Days a week, toll-free throughout the Service Area. Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess behavioral health emergencies. Emergency and crisis Behavioral Health Services may be arranged through Mobile Crisis Teams. It is not acceptable for an emergency intake line to be answered by an answering machine.

The MCO must operate a toll-free hotline as described in **Section 8.1.5.6** to handle Behavioral Health-related calls. The MCO may operate one hotline to handle behavioral health calls (including emergency and crisis behavioral health calls) and other routine Member calls unrelated to behavioral health. However, the MCO must submit hotline performance reports separately as required by **UMCM Chapter 5.** The MCO cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Member. Hotline services must meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.

The Behavioral Health Services hotline may serve multiple MCO Programs or Service Areas if the hotline staff is knowledgeable about all of the MCO Programs or Service Areas, including the Behavioral Health Provider Network in each Service Area. The MCO must ensure that the toll-free Behavioral Health Services hotline meets the following minimum performance requirements for the MCO Programs:

1. At least 80 percent of calls must be answered by toll-free line staff within 30 seconds measured from the time the call is placed in queue after selecting an option;
2. The call abandonment rate is 7 percent or less; and
3. The average hold time is 2 minutes or less.

The MCO must conduct on-going quality assurance to ensure these standards are met.

The MCO must monitor the MCO's performance against the Behavioral Health Services hotline standards and submit performance reports summarizing call center performance as indicated in **Section 8.1.22.2**, "Reports," and the Behavioral Health Services hotline Report in **UMCM Chapter 5**.

If HHSC determines that it will conduct onsite monitoring of the MCO's Behavioral Health Services Hotline functions, the MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) relating to such monitoring. For purposes of this section, "authorized reimbursable travel costs" may

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include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

8.1.16.3 Coordination between the BH Provider and the PCP

The MCO must ensure that the behavioral and physical health information is shared efficiently and effectively between the PCP and Behavioral Health Service Providers. If the MCO uses a behavioral health organization (BHO) as a Material Subcontractor, the MCO must ensure that MCO and BHO have shared, integrated data systems to facilitate Service Coordination and the timely sharing of Member information with PCPs and behavioral health specialists.

The MCO must require, through Provider contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or appropriate referral for, any known or suspected behavioral health problems and disorders. The MCO must provide training to Network PCPs on how to screen for and identify behavioral health disorders, the MCO's referral process for Behavioral Health Services and clinical coordination requirements for such services. The MCO must include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.

The MCO must develop and disseminate policies regarding clinical coordination and the sharing of Member information between Behavioral Health Service Providers and PCPs, as clinically indicated. The MCO must require that Behavioral Health Service 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 Behavioral Health Service 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 behavioral health condition. The MCO must develop a simple communication format for sharing information between Behavioral Health Service Providers and PCPs and other subspecialty Providers. The MCO must consult with PCPs, child psychiatrists, and other relevant Behavioral Health Service Providers when developing the communication format, then require the PCP team to use the format when sharing information among team members. The MCO must educate all Members of the PCP Team members on the role of the Service Coordinator in the coordination and sharing of health information and status. Behavioral Health Service Providers may only provide physical Healthcare Services if they are licensed in Texas to do so.

The MCO must require that Behavioral Health Service Providers and PCPs send each other initial and updated summary reports of a Members' physical and behavioral health status, as agreed to by the PCP Team members.

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PCPs must screen Members for any behavioral health 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 health care 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 *Psychotropic Medication Utilization Parameters for Foster Children* found on the Department of Family and Protected Services website.

The MCO must seek to recruit PCPs and Behavioral Health Service 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 behavioral health coordination of treatment and services. The MCO must seek to recruit providers who practice using the Medical Home Model and Integrated Primary Care. The MCO must 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 behavioral health problems.

MCO training for PCPs must include the use of valid screening and assessment instruments and the use of the Texas Health Steps Forms. The MCO must train Network PCPs on identifying and referring all Members 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 require qualified Providers to conduct appropriate evaluations and psychometric testing for Members who may need access to IDD services and supports and HCBS Waiver services.

The MCO will provide information on evidence-based interventions for behavioral health problems commonly seen in primary care (e.g., depression and anxiety disorders). The MCO will encourage PCPs to contact MCO Service Coordinators to discuss the Member's needs, referral and treatment options, and request names of specialty behavioral health care 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 Telemedicine or Telehealth resources.

The MCO must require behavioral health providers to refer Members with known or suspected and untreated physical health problems or disorders to their PCP.

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8.1.16.4 Follow-up after Hospitalization for Behavioral Health 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. Also, prior to discharge the MCO must review the Member's case history and Individual Service Plan and attempt to communicate with the Member or Member's LAR and key Providers to determine if additional Community-Based Services and other supports might reduce subsequent need for re-admission. If additional service and support needs are identified through this process, the MCO must work with the Member and the Member's LAR to establish the services.

The MCO must ensure that Behavioral Health Service Providers contact Members who have missed appointments within 24 hours to reschedule appointments. The MCO must adopt additional policies to work with the Member and the Member's LAR following an inpatient BH admission for the purpose of preventing re-admission.

8.1.16.5 Chemical Dependency

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

8.1.16.6 Court-Ordered Services

The MCO is required to pay for Medicaid Covered Services ordered by a court pursuant to the statutory citations listed below. The MCO cannot deny, reduce, or controvert the court orders for Medicaid inpatient mental health Covered Services for STAR Kids Members, provided pursuant to:

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

Further, the MCO may not limit substance use disorder treatment or outpatient mental health services provided pursuant to:

1) a court order; or
2) a condition of probation for STAR Kids Members.

The MCO cannot apply its own utilization management criteria through prior authorizations, concurrent reviews or retrospective reviews for such services.

Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Member who has been ordered to receive treatment pursuant to a court order can only Appeal the court order through the court system.

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MCOs are required to have a mechanism to receive court order documents from Providers at the time of an authorization request.

8.1.16.6.1 Psychiatric Services

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

1) by a court of competent jurisdiction including services ordered pursuant to the Texas Health and Safety Code Chapter 573 Subchapters B and C, Texas Health and Safety Code Chapter 574, Subchapters A and G, Texas Family Code Chapter 55, Subchapter D; or
2) as a condition of probation.

These requirements are not applicable when the Member is considered incarcerated, as defined by Section 16.1.15.2 in **UMCM Chapter 16.1**.

8.1.16.6.2 Substance Use Disorder Treatment Services

MCOs must provide Medicaid-covered substance use disorder treatment services, including residential treatment, required as a:

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

These requirements are not applicable when the Member is considered incarcerated, as defined by Section 16.1.15.2 in **UMCM Chapter 16.1**.

8.1.16.7 Local Mental Health Authority

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

The MCO is required to comply with additional Behavioral Health Services requirements relating to coordination with the LMHA and care for special populations. These requirements are described in **Section 8.1.30**.

8.1.16.8 Behavioral Health Emergencies

Through the STAR Kids screening and assessment process, ISP, and Service Coordination, the MCO must identify Members at the highest risk for Emergency Behavioral Health Conditions. The MCO must identify a behavioral health crisis

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prevention and crisis intervention plan for those identified at the highest risk. The MCO must seek participation from the Member; the Member's LAR; appropriate behavioral health Providers; and identified community groups when developing the behavioral health crisis prevention plan.

The MCO must also develop a strategy for effectively responding to Emergency Behavioral Health Conditions, including Emergency Detentions as defined under Chapter 573, Subchapter A of the Texas Health and Safety Code and Chapter 462, Subchapter C of the Texas Health and Safety Code, and preventing them from reoccurring. Member Services and Service Coordination staff must be informed of the strategy and trained, if appropriate.

8.1.16.9 This Section Intentionally Left Blank

8.1.16.10 Mental Health Parity

The MCO must comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all related regulations. The MCO must work with HHSC to be in compliance with parity, and must provide HHSC with a non-quantitative treatment limitation assessment tool(s); survey(s); or corrective action plans related to compliance with MHPAEA; and statements of attestation stating compliance with MHPAEA and any other information as requested by HHSC. The information must be provided within the timeframe included in HHSC's request.

8.1.17 Pharmacy Services

The MCO must provide pharmacy-dispensed prescriptions as a Covered Service. The MCO must ensure that such coverage meets the standards provided for by U.S.C. § 1396r-8, as applied to Medicaid managed care in accordance with 42 C.F.R. § 438.3(s).

The MCO must submit pharmacy clinical guidelines and prior authorization policies procedures for review and approval during Readiness Review, then after the Operational Start Date prior to any changes. In determining whether to approve these materials, HHSC will review factors such as the clinical efficacy and Members' needs.

The MCO must allow pharmacies to fill prescriptions for covered drugs ordered by any licensed provider regardless of Network participation MCO must ensure through its Provider Contracts that a pharmacy only fills prescriptions for covered drugs that have been prescribed by a prescribing provider who is licensed to prescribe.

The MCO is responsible for negotiating reasonable pharmacy provider reimbursement rates, including individual MCO maximum allowable cost (MAC) rates as described in **Section 8.1.17.11**, "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.

The MCO must comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 for pharmacy services. The MCOs must demonstrate compliance for all covered outpatient drugs on the formulary, including

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those provided under a non-risk based payment mode or otherwise carved-out of managed care. The MCO must demonstrate compliance with any fee-for-service edits or other prescription drug limitations applicable to managed care organizations or related to the HHSC's preferred drug list and any other state-mandated prior authorization or clinical edit.

8.1.17.1 Formulary and Preferred Drug List

The MCO must provide access to covered outpatient drugs, biological products, certain limited home health supplies (LHHS), and vitamins and minerals through formularies and a preferred drug list (PDL) developed by HHSC. HHSC will maintain the Medicaid formulary and 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 Medicaid formulary and 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. If the MCO has clinical edits that are identical to HHSC VDP's clinical edits or less stringent than VDP's clinical edits, then the MCO can reference VDP's Texas Medicaid formulary on Epocrates. The MCO must feature HHSC's formularies on the MCO's website. The MCO must also inform Members that the formulary is available in paper form without charge and provide it upon request within five Business Days.

In accordance with Texas Insurance Code Chapter 1369, Subchapter J, the MCO must establish a process by which the MCO, the Member, the prescribing physician or health care provider, and a pharmacist may jointly approve a medication synchronization plan. A medication synchronization plan may be used only for prescribed drugs that treat chronic illnesses and that comply with Texas Insurance Code §1369.453. The eligibility of a Member's prescriptions for medication synchronization must be determined on a case-by-case basis, considering Member-specific needs as determined by the Member's physician or health-care provider.

The MCO must submit its proposed medication synchronization plan to HHSC for approval before the MCO may undertake any implementation activities. All MCO implementation activities must adhere to the approved medication synchronization plan.

The MCO may not pro-rate the dispensing fee associated with a prescription that is eligible for medication synchronization. The MCO must pro-rate any associated co-payment, although this section may not be read to authorize an MCO to charge a co-payment.

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8.1.17.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies

The MCO must adopt prior authorization (PA) policies and procedures that are consistent with **Section 8.1.9.1** "Compliance with State and Federal Prior Authorization Requirements."

HHSC will identify both "required" and "optional" Clinical PAs on HHSC's Vendor Drug Program website, or as required under the Contract. If the information about a Member's medical condition meets the Clinical PA criteria, the claim or PA request may be approved. If a Member's medical condition does not meet the Clinical PA criteria, the claim or PA request may be denied. The MCO is responsible for managing Clinical PA denials through its appeal process.

The MCO must also adhere to HHSC VDP's PDL for Medicaid drugs. Preferred drugs must adjudicate as payable without PDL PA, unless subject to Clinical PAs. If a requested drug is subject to more than one drug PA (e.g., the drug is both non-preferred and subject to one or more Clinical PAs), the MCO must process all edits concurrently and independently so that each drug PA (Clinical PA or PDL PA) is checked for approval.

Any proposed MCO clinical criteria not listed on the Vendor Drug Program Website described above as a required or optional Clinical PA or listed in the Contract must be submitted to HHSC for review and approval following the process outlined in **UMCM Chapter 3.29**. 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 PA to HHSC for DUR Board review and approval. The MCO must submit all Clinical PA proposals in compliance with the required information outlined in **UMCM Chapter 3.29**. 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 Vendor Drug Program are available on HHSC's Vendor Drug Program website. HHSC's website also includes exception criteria for each drug class included on HHSC's Medicaid PDL. These exception criteria describe the circumstances under which a non-preferred drug may be dispensed without a PDL PA. If HHSC modifies the policies described above on the Vendor Drug Program website, HHSC will notify MCOs.

The MCO 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.

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

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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 or 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 provide a response to the PA request within 24 hours after receipt or the prescriber is not available to make a PA request because it is after the prescriber's office hours and the dispensing pharmacist determines it is an emergency situation, the MCO must allow the pharmacy to dispense a 72-hour supply of the drug. In this context, emergency situation includes a situation in which, based on the dispensing pharmacist's judgement, a Member may experience a detrimental change in his or her health status within 72 hours from when the pharmacy receives the prescription due to the inability to obtain the drug. The MCO must ensure through its Provider Contracts, Provider Contract oversight, and Provider education that pharmacies do not use 72-hour emergency supplies routinely and continuously. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.

The MCOs must have an automated process that may be used to assess a Member's medical and drug claim history to determine whether the Members medical condition satisfies the applicable criteria for dispensing a drug without an additional prior authorization request. (See Texas Government Code § 531.073(h).) This process must automatically evaluate whether a submitted pharmacy claim meets Prior Authorization criteria for both PDL and Clinical PAs. (See **UMCM, Chapter 2.2**., Section V for the definition of an Automated Prior Authorization Request.) The MCO's PA system must accept PA requests from prescribers that are sent electronically, by phone, fax, or mail. The MCO may not charge pharmacies for PA transaction, software, or related costs for processing PA requests.

If the MCO or its PBM operates a separate call center for PA requests, the PA call center must meet the provider hotline performance standards set forth in **Section 8.1.4.5**, "Provider Hotline." The MCO must train all PA, provider hotline, and pharmacy call center staff on the requirements for dispensing 72-hour emergency supplies of medication.

The MCO may not require a PA for any drug exempted from PA requirements by federal law.

For drug products purchased by a pharmacy through the Health Resources Services Administration (HRSA) 340B discount drug program, the MCO may impose Clinical PA requirements only. These drugs must be exempted from all PDL PA requirements.

A provider may appeal PA denials on a Member's behalf, in accordance with **Sections 8.1.29**.

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If a Member changes Medicaid or CHIP MCOs, the previous MCO must provide the new MCO with information about the Member's PA and medication history at no cost and upon request. The MCO in consultation with HHSC will develop a standard process and timeline for implementing a standard format for sharing member medication and PA history. HHSC expects the former MCO to respond with the requested information within 72-hours of the new MCO's request.

8.1.17.3 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 Medicaid website under "Medicaid Drug Rebate Program," "Contact Information".

An MCO may restrict some compounded medications available through the pharmacy benefit. MCOs' coverage of compounded medications must follow the same requirements as outlined in this section and must be listed on the Texas Medicaid formulary. MCOs may not reimburse pharmacies for compounding powders are not included on the Texas Medicaid formulary.

8.1.17.4 Compounded Medications

The MCO must allow approval for the following:

1. Compounded medications prepared for Members with allergies to the commercially prepared medications.
2. Compounded oral medications used for Members 12 years and younger or for Members with difficulty swallowing.
3. Compounded medications if the FDA-approved product is not available or in short supply, but not because the drug has been withdrawn or removed from the market for safety reasons.
4. Compounded medications, if the specific Member has a medical need for a different dosage, form, or strength than is commercially available.

The MCO may reject claims for compounded medications for which the MCO, based on the MCO's determination, finds no evidence that the compounded medication is safe and effective. The MCO may reject a claim for a compounded medication if the MCO determines the drug is included in one or more of the classes as defined in 1 Tex. Admin. Code § 354.1923 (c). The MCO may reject a claim for a compounded medication if the active ingredients and the use of the compound prescriptions do not have a medically accepted use supported by the compendia or peer review literature. The MCO may select from and use the following compendia: Thomson Micromedex, American Hospital Formulary Service, clinical pharmacology, physician supported guidelines, or current primary literature when available. The MCO must have a process

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in place to allow a prescriber or pharmacy to dispute a rejected claim for compounded medications.

The MCO may pend a claim for compounded medication for $200.00 or more for further review to determine if the product is safe and effective.

8.1.17.5 Pharmacy Rebate Program

Under the provisions of 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 Medicaid outpatient drug claims, including provider-administered drugs, must be exempt from such rebate agreements. The MCO must include rebatable National Drug Codes (NDCs) on all encounters for outpatient drugs and biological products, including clinician-administered drugs. Encounters containing clinician-administered drugs must include, in addition to a CMS-rebate-eligible NDC, the correctly matched HCPCS code and billing units per the applicable date of service according to HHSC NDC-to-HCPCS Crosswalk.

The MCO must implement a process to timely support HHSC's Medicaid rebate dispute resolution processes:

1. The MCO must allow HHSC or its designee to contact Network pharmacy Providers to verify information submitted on claims, and upon HHSC's request, assist with this process.
2. The MCO must establish a single point of contact where HHSC's designee can send information or request clarification.

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.

8.1.17.6 Drug Utilization Review Program

The MCO must have a drug utilization review program (DUR) to conduct prospective and retrospective utilization review of prescriptions. The MCO's DUR program must comply with 42 U.S.C. § 1396r-8 and 42 C.F.R. part 456, subpart K. The MCO must submit an annual report to HHSC Vendor Drug Program (VDP) that provides a detailed description of its DUR program activities, as provided for under 42 C.F.R. § 438.3(s). Prospective review must 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,

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adverse drug-drug interaction, incorrect drug dosage, incorrect duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. The MCO's retrospective review must monitor prescriber and contracted pharmacies for outlier activities. Retrospective reviews must also determine whether services were delivered as prescribed and consistent with the MCO's payment policies and procedures.

The MCO's DUR must specifically assess prescribing patterns for psychotropic medications as defined by Texas Family Code § 266.001(7) for all Members. If the MCO identifies patterns outside of the MCO's parameters for psychotropic medications, or if HHSC notifies the MCO of outlier prescribing patterns, then the MCO must conduct a review and, if necessary, an intervention, such as a letter or phone call to the prescriber or a peer-to-peer review between the prescriber and the MCO. For children, the MCO must model its parameters on DFPS's "Psychotropic Medication Utilization Parameters for Foster Children." The MCO must base its parameters for psychotropic medications on peer-reviewed, industry standard. The MCO must submit a Psychotropic Medication Utilization Review Plan and Report on an annual basis as specified in **UMCM Chapter 5**.

8.1.17.7 Pharmacy Benefit Manager (PBM)

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 these Subcontractors. These assurances and procedures must be submitted for HHSC's review during Readiness Review (see **Section 3**, "Transition Phase Requirements") then prior to initiating any PBM Subcontract after the Operational Start Date.

The MCO must ensure its subcontracted PBM follows all pharmacy-related Contract, **UMCM**, state, and federal law requirements related to the provision of pharmacy services.

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.**

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.

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8.1.17.8 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**, provides HHSC with the right to audit this information at any time. HHSC agrees to maintain the confidentiality of information disclosed by the MCO pursuant to this section, to the extent that the information is confidential under state or federal law.

8.1.17.9 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 after the Effective Date of this Contract, then the MCO must comply with the requirements of Texas Government Code § 531.089 prohibiting the provision of sexual performance enhancing medication to persons required to register as sex offenders under Texas Code of Criminal Procedure Chapter 62.

8.1.17.10 Specialty Drugs

The MCO must adhere to the HHSC Specialty Drug List for specialty drugs provided through selective specialty pharmacy contracts. The MCO's policies and procedures must comply with 1 Tex. Admin. Code §§ 353.905 and 354.1853 and include processes for notifying Network pharmacy Providers.

8.1.17.11 Maximum Allowable Cost Requirements

The MCO must develop maximum allowable cost (MAC) prices and lists that comply with state and federal laws, including Texas Government Code § 533.005(a)(23)(K). To place an outpatient drug on a MAC list, the MCO must ensure that:

1. the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's *Approved Drug Products with Therapeutic Equivalence Evaluations,* also known as the *Orange Book,* has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and
2. the drug is generally available for purchase by pharmacies in Texas from national or regional wholesalers and is not obsolete.

In formulating the MAC price for a "market basket" of drugs (a group of therapeutically related drugs that will be assigned the same price), MCOs and PBMs must use only the prices of the drugs listed as therapeutically equivalent in the most recent version of the *Orange Book*. Drugs listed as therapeutically equivalent are A-rated drugs. Therefore, MCOs and PBMs can only use A-rated drugs to set MAC prices. B-rated drugs cannot be used in MAC pricing calculation. MCOs and PBMs can include B-rated drugs in the

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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 provide a quarterly report regarding MAC price review and updates in the manner and format specified in the UMCM.

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 and resolve a challenge by the 15th Day after it is received by the MCO. If the challenge is successful, the MCO must adjust the drug price, effective on the date the challenge is resolved, and apply the new price to all similarly situated Network pharmacies, as appropriate and determined by the MCO. If the challenge is denied, the MCO must provide the pharmacy the reasons for the denial. The MCO must provide a quarterly report regarding MAC price challenges in the manner and format specified in the **UMCM**.

The MCOs or PBMs, as applicable, must provide a process for each of its Network pharmacies to readily access the MAC list specific to that pharmacy directly from the MCO or PBM, even if the pharmacy is contracted with a PSAO. At a minimum, MCOs and PBMs must allow a Network pharmacy to download a searchable file of the MAC list specific to that pharmacy from the MCO or PBM website. Alternatively, MCOs or PBMs may allow a Network pharmacy to view and search the MAC list specific to that pharmacy on the website. The list provided on the website must be searchable by drug name. The MCO must provide HHSC with access to MAC lists upon request as outlined in Article 9 of Attachment A, "Uniform Managed Care Contract Terms and Conditions" no later than 10 Days after the MCO receives the request. The MCO must submit the process for HHSC's review and approval prior to implementation and modification. As described in Texas Government Code § 533.005(a-2), a MAC price list that is specific to a Network pharmacy is confidential for all other purposes.

The MCO must inform HHSC no later than 21 Days after implementing a MAC price list for drugs dispensed at retail pharmacies but not by mail.

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8.1.17.12 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.

In Medicaid fee-for-service, the Vendor Drug Program pays qualified community retail pharmacies for pharmaceutical delivery services. The MCO must implement a process to ensure that Medicaid and CHIP Members receive free outpatient pharmaceutical deliveries from community retail pharmacies in their Service Areas, or through other methods approved by HHSC. Mail order delivery is not an appropriate substitute for delivery from a qualified community retail pharmacy unless requested by the Member. The MCO's process must be approved by HHSC, submitted using HHSC's template, and include all qualified community retail pharmacies identified by HHSC.

8.1.17.13 Health Resources and Services Administration 340B Discount Drug Program

The MCO must use a shared-savings approach for reimbursing Network Providers that participate in the federal Health Resources and Services Administration's (HRSA's) 340B discount drug program.

The MCO through its Provider Contract must require a 340B-covered entity seeking to use 340B stock to contract with the MCO as a 340B pharmacy and accept the payment terms of the MCO's shared-savings model. If the 340B covered entity does not accept the terms of the MCO's shared savings model for the reimbursement of 340B-purchased drugs, then the MCO may contract with the covered entity as a retail pharmacy. If the covered entity contracts with the MCO as a retail pharmacy, the MCO must prohibit the entity from using 340B-purchased drugs.

The MCO cannot require a Network Provider to submit its actual acquisition cost (AAC) on outpatient drugs and biological products purchased through the 340B program, consistent with **UMCM Chapter 2.** In addition, the MCO cannot impose PA requirements based on non-preferred status ("PDL PAs") for these drugs and products.

8.1.17.14 Pharmacy Claims and File Processing

The MCO must process claims in accordance with **UMCM Chapter 2**. and Texas Insurance Code § 843.339. This law requires the MCO to pay clean claims that are submitted electronically no later than 18 Days after adjudication, and no later than 21 Days after adjudication if the claim is not submitted electronically. In addition, the MCO

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must comply with **Sections 8.1.23** regarding payment of out-of-network pharmacy claims.

HHSC will provide the MCO or its designee with pharmacy interface files, including formulary, PDL, third party liability, master provider, and drug exception files. Due to the point-of-sale nature of outpatient pharmacy benefits, the MCO must ensure all applicable MIS systems, including pharmacy claims adjudication systems, are updated to include the data provided in the pharmacy interface files. The MCO must update within two Business Days of the files becoming available through HHSC's file transfer process, unless clarification is needed or data or 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 Joint Interface Plan are loaded into the pharmacy claims adjudication system within two Days of receipt.

8.1.17.15 Pharmacy Audits

The MCO and its PBM are prohibited from using extrapolation in pharmacy audits.

8.1.17.16 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.

8.1.17.17 Cancellation of Product Orders

If a Network Provider offers delivery services for covered products, such as durable medical equipment (DME), home health supplies, or outpatient drugs or biological products, then the MCO's Provider Contract must require the Provider to reduce, cancel, or stop delivery at the Member's or the Member's authorized representative's written or oral request. The Provider must maintain records documenting the request.

For automated refill orders for covered products, the MCO's Provider Contract must require the Provider to confirm with the Member that a refill, or new prescription received directly from the physician, should be delivered. Further, the MCO must ensure that the Provider completes a drug regimen review on all prescriptions filled as a result of the auto-refill program in accordance with 22 Tex. Admin. Code § 291.34. The Member or Member's LAR must have the option to withdraw from an automated refill delivery program at any time.

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8.1.18 Financial Requirements for Covered Services

The MCO must pay for or reimburse Providers for all Medically Necessary Covered Services provided to all Members. The MCO is not liable for costs incurred in connection with health care rendered prior to the date of the Member's Effective Date of Coverage in that MCO.

Coverage under Medicaid and CHIP is secondary to all other insurance coverage, unless an exception applies under federal law. 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 by the MCO. See **Section 8.1.31**, "Third Party Liability and Recovery and Coordination of Benefits," for additional information regarding coordination of benefits and recoveries from third parties.

8.1.19 Accounting and Financial Reporting Requirements

The MCO's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations ("FAR"), Generally Accepted Accounting Principles (GAAP), and the cost principles contained in the Cost Principles Document in the **UMCM**. The state will not recognize or pay services that cannot be properly substantiated by the MCO and verified by HHSC.

The MCO must:

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

MCO will reimburse HHSC, if reimbursement is sought from the MCOs for reasonable costs incurred by HHSC to perform examinations, investigations, audits, or other types of attestations that HHSC determines are necessary to ensure MCO compliance with this Contract. The use of and selection of any external parties to conduct examinations, investigations, audits, or other types of attestations as well as the scope of work of examinations, investigations, audits, or other types of attestations are also at HHSC's sole discretion.

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8.1.19.1 General Access to Accounting Records

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

The MCO must:

1. Cooperate with the state and federal governments in their evaluation, inspection, audit, or review of accounting records and any necessary supporting information;
2. Permit authorized representatives of the state and federal government full access, during normal business hours, to the accounting records that the state and the federal governments determine are relevant to the Contract. Access is guaranteed at all times during the performance and retention period of the Contract, and will include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the MCO;
3. Make copies of any accounting records or supporting documentation relevant to the Contract, including Provider Contracts, available to HHSC or its agents within seven Business Days, or as otherwise specified by HHSC, of receiving a written request from HHSC for specified records or information. If the documentation is not made available as requested, the MCO agrees to reimburse HHSC for all costs, including, but not limited to: transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, and reproduction functions at the location(s) of the accounting records; and
4. Pay any and all additional costs incurred by the state and federal governments that are the result of the MCO's failure to provide the requested accounting records or financial information within ten Business Days of receiving a written request from the state or federal government.

8.1.19.2 Financial Reporting Requirements

HHSC will require the MCO to provide financial reports by Service Area to support Contract monitoring as well as state and federal reporting requirements. HHSC will consult with MCOs regarding the format and frequency of the reporting. All financial information and reports are the property of HHSC and will be public record, with the exception of any protected Member information contained within the documents. Any deliverable or report in this section without a specified due date is due quarterly on the last day of the month. 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.

HHSC's **UMCM** will govern the timing, format and content for the following reports.

(a) **Audited Financial Statement –**The MCO must provide the annual audited financial statement, for each year covered under the Contract, no later than June 30. The

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MCO must provide the most recent annual financial statements, as required by the Texas Department of Insurance for each year covered under the Contract, no later than March 1.

(b) **Affiliate Report –** The MCO must submit an Affiliate Report to HHSC if this information has changed since the last report submission. The report must contain the following:

1. A list of all Affiliates, and
2. For HHSC's prior review and approval, a schedule of all transactions with Affiliates that, under the provisions of the Contract, will be allowable as expenses in the FSR Report for services provided to the MCO by the Affiliate. Those must include financial terms, a detailed description of the services to be provided, and an estimated amount that will be incurred by the MCO for the services during the Contract Period.

(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 the payments are allowable administrative expenses in accordance with the Cost Principles Document in the **UMCM**. The written plan must include a description of the MCO's criteria for establishing bonus or incentive payments, the methodology to calculate bonus or incentive payments, and the timing of bonus or incentive payments. The 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. The report format is contained in the **UMCM Chapter 5**. The report must disclose the amount of incurred claims each month and the amount paid each month.

(e) **DSP Report -** The MCO must submit a monthly Delivery Supplemental Payment (DSP) Report that includes the data elements specified by HHSC in the format specified by HHSC in the **UMCM**. The DSP Report must include only unduplicated deliveries and only deliveries for which the MCO has made a payment, to either a Hospital or other Provider.

(f) **MCO Disclosure Statement -** The MCO must file:

1. an updated MCO Disclosure Statement by September 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:

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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. This report will replace, and be in lieu of, the former "Section 1318 Financial Disclosure Report" and the "Form CMS 1513," and will disclose the same information, plus other information as may be required by HHSC and CMS Program Integrity requirements. Minor quarterly adjustments in stock holdings for publicly-traded corporations are excluded from the reporting requirements. The reporting format is included in the **UMCM**.

(g) **FSR Reports –** The MCO must file quarterly and annual Financial-Statistical Reports (FSR) in the format and timeframe specified by HHSC. HHSC will include the FSR format and directions in the **UMCM**. The MCO must incorporate financial and statistical data of delegated networks (e.g., IPAs, ANHCs, Limited Provider Networks), if any, in its FSR Reports. Administrative expenses reported in the FSRs must be reported in accordance with the Cost Principles Document in the **UMCM**. Quarterly FSR reports are due no later than 30 Days after the end of the quarter and must provide information for the current quarter and year-to-date information through the current quarter. The first annual FSR report must reflect expenses incurred through the 90th day after the end of the fiscal year. The first annual report must be filed on or before the 120th Day after the end of each fiscal year. Subsequent annual reports must reflect data completed through the 334th day after the end of each fiscal year and must be filed on or before the 365th day following the end of each fiscal year.

HHSC will post all FSRs on the HHSC website.

(h) **HUB Reports –** Upon contract award, the MCO must attend a post-award meeting in Austin, Texas, at a time specified by HHSC, to discuss the development and submission of a Client Services 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** for the HUB monthly reports. The MCO must comply with HHSC's standard Client Services HUB Subcontracting Plan requirements for all Subcontractors.

(i) **TDI Examination Report -** The MCO must furnish HHSC with a copy of any TDI Examination Report, including the financial, market conduct, target exam, quality of care components, and corrective action plans and responses, no later than ten Days after receipt of the final report from TDI.

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(j) **TDI Filings –** The MCO must submit annual figures to HHSC for controlled risk-based capital, as well as quarterly financial statements, both as 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 registration statement, also known as Form B, and all amendments to this form, and any other information filed by the insurer with the insurance regulatory authority of its domiciliary jurisdiction.

(l) **Third Party Liability and Recovery (TPL/TPR) Reports -** The MCO must file TPL/TPR reports in accordance with the **UMCM** Chapter 5.3.4. MCOs must submit TPL/TPR reports quarterly, by MCO Program and Service Area. The reports must include total dollars cost avoided, and total dollars recovered from third party payers through the MCOs coordination of benefits efforts during the Quarter.

(m) **Report of Legal and Other Proceedings and Related Events** - The MCO must comply with the **UMCM Chapter 5.8**, 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 September 1st. The as-occurs report is due no later than 30 Days after the event that triggered the notification requirement.

(n) **Medical Loss Ratio (MLR) Report -** The MCO must submit an annual Medical Loss Ratio (MLR) Report in accordance with the specific requirements as stated in **UMCM** Chapter 5. The first report will apply to the rating period commencing September 1, 2017. The Deliverable will be due as specified in **UMCM 5**.

8.1.20 Management Information System Requirements

The MCO must maintain a Management Information System (MIS) that supports all functions of the MCO's processes and procedures for the flow and use of MCO data. If the MCO subcontracts a MIS function, the Subcontractor's MIS must comply with the requirements of this section. The MCO must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS subsystems for the following operational and administrative areas:

1. Enrollment/Eligibility Subsystem;
2. Provider Subsystem;
3. Encounter/Claims Processing Subsystem;
4. Financial Subsystem;
5. Utilization/Quality Improvement Subsystem;
6. Reporting Subsystem;
7. Interface Subsystem; and
8. TPR Subsystem.

The MIS must enable the MCO to meet the Contract requirements, including all applicable state and federal laws, rules, and regulations. The MIS must have the capacity and capability to capture and utilize various data elements required for MCO administration.

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MCO must use an address verification and standardization software when contracting with Providers. The software must standardize Provider addresses by fixing spelling errors, correcting abbreviations and fixing capitalization so that the address matches the format preferred by the United States Postal Service (USPS). MCOs must validate addresses to the master Provider file as it implements the new Provider enrollment system.

HHSC will provide the MCO with a one-time historical pharmacy data file on the MCO's Members through the HHSC Vendor Drug Program. HHSC will provide a sample format of pharmacy data to contract awardees.

The MCO must have a system that can be adapted to changes in Business Practices and Policies within the timeframes negotiated by the Parties. The MCO is expected to cover the cost of the 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 of Major Systems Changes and implementations no later than 180 Days prior to the planned change or implementation, including any changes relating to Material Subcontractors, in accordance with the requirements of this Contract and **Attachment A, STAR Kids Contract Terms.** HHSC reserves the right to require a desk or on-site readiness review of the changes.

The MCO must notify HHSC of Major Systems Changes in writing, as well as by e-mail to HPM staff. The notification must detail the following:

1. The aspects of the system that will be changed and date of implementation;
2. How these changes will affect the Provider and Member community, if applicable;
3. The communication channels that will be used to notify these communities, if applicable; and
4. A contingency plan in the event of downtime of system(s).

Major Systems Changes are subject to HHSC desk review and onsite review of the MCO's facilities as necessary to test readiness and functionality prior to implementation. Prior to HHSC approval of the Major Systems Change, the MCO may not implement any changes to its operating systems. Failure to comply will result in contractual remedies, including damages. HHSC retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

The MCO must provide HHSC any updates to the MCO's organizational chart relating to MIS and the description of MIS responsibilities at least 30 Days prior to the effective date of the change. The MCO must provide HHSC official points of contact for MIS issues on an on-going basis.

HHSC or its designee may conduct a Systems Readiness Review to validate the MCO's ability to meet the MIS requirements as described in **Section 7**. The System Readiness

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Review may include a desk review, an onsite review, or both, and must be conducted for the following events:

1. A new MCO is brought into the STAR Kids Program;
2. An existing MCO begins business in a new Service Area;
3. An existing MCO changes location;
4. An existing MCO changes its processing system, including changes in Material Subcontractors performing MIS or claims processing functions; and
5. An existing MCO in one or two HHSC MCO Programs is initiating a Contract to participate in any additional MCO Programs.

If HHSC determines that it will conduct an onsite review, the MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) related to such monitoring. For purposes of this section, "authorized reimbursable travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

If for any reason an MCO does not fully meet the MIS requirements, the MCO must, upon request by HHSC, either correct the deficiency or submit to HHSC a Corrective Action Plan and Risk Mitigation Plan to address the deficiency. Immediately upon identifying a deficiency, HHSC may impose contractual remedies according to the severity of the deficiency in accordance with **Attachment A, Article 12,** until the deficiency is corrected. Refer to **Section 7** and **Section 8.1.4.1** for additional information regarding MCO Readiness Reviews. Refer to **Attachment A, Section 4.08(c)** for information regarding Readiness Reviews of the MCO's Material Subcontractors.

In accordance with **UMCM Chapter 16**, the MCO must share and integrate service authorization data among all relevant MCO employees, including physical and Behavioral Health staff or, if applicable, between the MCO and the third party or subsidiary contracted with the MCO to manage Behavioral Health Services.

8.1.20.1 Encounter Data

The MCO must provide complete and accurate Encounter Data for all Covered Services, including MDCP STAR Kids Covered Services and Value-added Services. Encounter Data is subject to the requirements in 42 C.F.R. § 438.242 and § 438.818. The data will be submitted by the MCO in accordance with HHSC's required format and required data elements for Medicaid MCOs. 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, the submission schedule, and any other requirements in the **UMCM**. The MCO must submit Encounter Data transmissions monthly, and include all Encounter Data and Encounter Data adjustments processed by the MCO. In addition,

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Pharmacy Encounter Data must be submitted no later than 25 Days after the date of adjudication and include all Encounter Data and Encounter Data adjustments processed by the MCO. Encounter Data quality validation must incorporate assessment standards developed jointly by the MCO and HHSC. The MCO must submit complete and accurate encounter data not later than the 30th Day after the last Day of the month in which the claim was adjudicated. The MCO must make original records available for inspection by HHSC for validation purposes. Encounter Data that do not meet quality standards must be corrected and returned within a time period specified by HHSC.

In addition to providing Encounter Data in the 837 format described above, HHSC may request that the MCO submit an Encounter Data file to HHSC's EQRO, in the format provided in the **UMCM**. This additional submission requirement is time-limited and may not be required for the entire term of the Contract.

For reporting Encounters and fee-for-service claims to HHSC, the MCO must use the procedure codes, diagnosis codes, and other codes as directed by HHSC. Any exceptions will be considered on a code-by-code basis after HHSC receives written notice from the MCO requesting an exception. The MCO must also use the Provider numbers as directed by HHSC for both Encounter and fee-for-service claims submissions, as applicable.

HHSC will use the Encounter Data to run the Quarterly Encounter Reconciliation Report, which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Vision 21 Data Warehouse. This report is based on querying the Vision 21 Data Warehouse 60 Days after the last day of the quarter.

The MCO's Provider Agreements 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.

8.1.20.2 MCO Deliverables Related to MIS Requirements

The MCO must submit the following documents and corresponding checklists for HHSC's review and approval:

1. Disaster Recovery Plan;
2. Business Continuity Plan; and
3. Security Plan.

The Disaster Recovery Plan and the Business Continuity Plan may be combined into one document.

Additionally, if the MCO modifies the following documents, it must submit the revised documents and corresponding checklists for HHSC's review and approval:

1. Joint Interface Plan;
2. Risk Management Plan; and

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3. Systems Quality Assurance Plan.

The MCO must submit plans and checklists to HHSC according to the format and schedule identified the **UMCM**. Additionally, if a Systems Readiness Review is triggered by one of the events described in **Section 8.1.20**, the MCO must submit all of the plans identified in this **Section 8.1.20.2** in accordance with an HHSC-approved timeline.

The MCO must follow all applicable Joint Interface Plans (JIPs) and all required file submissions for HHSC's Administrative Services Contractor, External Quality Review Organization (EQRO) and HHSC Medicaid Claims Administrator. The JIPs can be accessed through the **UMCM**.

8.1.20.3 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 transactions;
3. Transmit or transfer Encounter Data transactions on electronic media in the HIPAA format to the contractor designated by HHSC to receive the Encounter Data;
4. Maintain a history of changes and adjustments and audit trails for current and retroactive data;
5. Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure;
6. Employ industry standard medical billing taxonomies (procedure codes, diagnosis codes) to describe services delivered and Encounter transactions produced;
7. Accommodate the coordination of benefits;
8. Produce standard Explanation of Benefits (EOBs) for providers;
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**) or otherwise required by HHSC;
12. Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;
13. Maintain and cross-reference all Member-related information with the most current Medicaid Provider number; and
14. Ensure that the MIS is able to integrate pharmacy data from HHSC's Vendor Drug Program file (available through the Virtual Private Network (VPN)) into the MCO's Member data.

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8.1.20.4 Health Insurance Portability and Accountability Act Compliance

The MCO's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191 (August 21, 1996) and the Health Information Technology for Economic and Clinical Health Act (HITECH), P.L. 111-5 (February 17, 2009), and as amended or modified. The MCO must comply with HIPAA EDI requirements. The MCO's enrollment files must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 format with the exception of pharmacy services. Pharmacies may submit eligibility inquiries in the NCPDP E1 HIPAA-compliant format. Claim transactions for pharmacy services must be in the NCPDP B1/B2 HIPAA-compliant formats; all others must be in the 837/835 HIPAA-compliant format. The MCO must also be 5010 compliant.

The following website includes the final rules for 5010 Compliancy and ICD-10 Compliancy, which is located on the CMS website under Medicare and Coding.

The MCO must provide its Members with a privacy notice as required by HIPAA, including 45 C.F.R. § 164.520. The MCO must provide HHSC with a copy of its privacy notice during Readiness Review and any changes to the notice prior to distribution.

8.1.20.5 Claims Processing Requirements

The MCO must process and adjudicate all Provider claims for Medically Necessary health care Covered Services that are filed within the time frames specified in the **UMCM Chapter 2** and pharmacy claims in that are filed in accordance with the timeframes specified in **UMCM Chapter 2.** The MCO is subject to remedies, including liquidated damages and interest, if the MCO does not process and adjudicate claims in accordance with the procedures and the timeframes listed in the **UMCM**.

The MCO must administer an effective, accurate, and efficient claims payment process in compliance with federal laws and regulations, applicable state laws and rules, and the Contract, including the **UMCM**. In addition, the MCO must process and pay Medicaid provider claims in accordance with the benefit limits and exclusions as listed in the **Texas Medicaid Provider Procedures Manual**. The MCO and its Subcontractors cannot directly or indirectly charge or hold a Member, Network Provider, or Out-of-Network provider responsible for claims adjudication or transaction fees.

The MCO must maintain an automated claims processing system that registers the date a claim is received by the MCO, the detail of each claim transaction (or action) at the time the transaction occurs, and has the capability to report each claim transaction by date and type to include interest payments. The claims system must maintain information at the claim and line detail level. The claims system must maintain adequate audit trails and report accurate claims performance measures to HHSC.

The MCO's claims system must maintain online and archived files. The MCO must keep online automated claims payment history for the most current 18 months. STAR Kids

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MCOs must keep online automated Nursing Facility claims payment history for the most current 24 months. The MCO must retain other financial information and records, including all original claims forms, for the time period established in **Attachment A, Section 9.01**. All claims data must be easily sorted and produced in formats as requested by HHSC.

The MCO must offer its Providers/Subcontractors the option of submitting and receiving claims information through 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.

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.

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 must be submitted. The MCO will be expected to have an interface that allows receipt of these electronic submissions. If HHSC implements this requirement, then the MCO must maintain a mechanism to receive claims in addition to the HHSC claims portal. Providers must be able to send claims directly to the MCO or its Subcontractor.

The MCO must provide a Provider portal that supports functionality to reduce administrative burden on Network Providers at no cost to the Providers. If an MCO and its Subcontractor or subsidiary maintains separate Provider portals for physical health and Behavioral Health Services Network Providers, the MCO must comply with the requirements in **UMCM Chapter 16.** The Provider Portal functionality must include the following.

1. Member eligibility verification;
2. Submission of electronic claims;
3. Prior Authorization requests;
4. Claims appeals and reconsiderations;
5. Exchange of clinical data and other documentation necessary for prior authorization and claim processing;
6. An online process for providers to access the following information on their patients, with the Member's consent:
    a. STAR Kids Screening and Assessment Instrument (SK-SAI);
    b. Member SK-SAI MDCP review signature page (Form 2605), as applicable; and
    c. Individual Service Plan (ISP), as applicable.

The Member eligibility verification information in STAR Kids MCO portals available to Nursing Facility Providers must, at a minimum, include data elements related to service authorization, RUG levels and applied income for current members at the time the data elements are received by the MCO. STAR Kids MCOs must upload this Member eligibility verification data into their Provider Portals within 48 hours of receiving the file

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from HHSC. STAR Kids MCOs portals available to Nursing Facility Providers must keep online automated data for the most current 24 months.

To the extent possible, the Provider Portal must support both online and Batch Processing as applicable to the information being exchanged. To facilitate the exchange of clinical data and other relevant documentation, the Provider Portal must provide a secure exchange of information between the Provider and MCO, including, as applicable, a Subcontractor of the MCO.

The MCO must make an electronic funds transfer (EFT) payment process for direct deposit available to Network Providers when processing claims for Medically Necessary Covered Services.

The MCO may deny a claim submitted by a Provider for failure to file in a timely manner as provided for in the **UMCM**. The MCO must withhold all or part of payment for any claim submitted by a Provider:

1. excluded or suspended from the Medicare, Medicaid, CHIP, or CHIP Perinatal programs for Fraud, Waste, or Abuse;
2. on payment hold under the authority of HHSC or its authorized agent(s);
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, 2021 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 and 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)**, conclude an examination, audit, or inspection of a provider more than two years after the MCO received the claim.

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 appeals rights. Finally, the two-year limitation does not apply when HHSC has recovered a capitation from the MCO based on a Member's

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ineligibility. If an exception to the two-year limitation applies, then the MCO may recoup related payments from providers.

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 MCO/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.

The MCO's provider agreement must specify that program violations arising out of performance of the contract are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General as specified in 1 Tex. Admin. Code Chapter 371, Subchapter G.

8.1.20.5.1 Claims Project

For purposes of this section, claims project (Project) means a project initiated by an MCO outside of the Provider appeal process after payment or denial of claim(s) for the purpose of conducting any necessary research on the claim(s) and/or to adjust the claim(s), if appropriate, excluding Nursing Facility Daily/Unit rate claims.

MCO may initiate a Project at its own initiative. All claims included in a particular Project must be finalized within 60 Days of the Project being opened or within an agreed upon timeframe between the Provider and the MCO. If the MCO is unable to complete the Project within 60 Days, the MCO must enter a written agreement with the Provider before the expiration of the initial 60 Day period to establish the Project's agreed upon time frame. MCO must maintain the agreement for 18 months from the conclusion of the Project and make the agreement available to HHSC upon request. MCO will report monthly to HHSC the start and end date for all Projects using HHSC's report template. For Nursing Facility Daily/Unit rate claims, please see **UMCM Chapter 8**.

8.1.20.6 National Correct Coding Initiative

Effective for claims filed on or after October 1, 2010, the MCO must comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 11-148), regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

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8.1.21 Fraud, Waste, and Abuse

The MCO is subject to all state and federal laws 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 (HHSC 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, 531.1131, and 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 HHSC OIG.
4. When requested by the HHSC OIG, the MCO will be required to provide employees to participate in administrative proceedings pursued by the HHSC OIG. Such employees must be knowledgeable about the subject matter on which they called to testify and must be available for preparatory activities and for formal testimony. The MCO must provide the employees at no cost to the State and the HHSC OIG.
5. For the purposes of Nursing Facility and Hospital Utilization Reviews, Section 8.1.21(4) also applies to HHSC requests.
6. Failure to comply with any requirement of **Sections 8.1.19 and 8.1.20.2(c) and (d)** may subject the MCO remedies under **Attachment A, Section 12** or administrative enforcement pursuant to 1 Tex. Admin. Code Chapter 371 Subchapter G, in addition to any other available legal remedy.

8.1.21.1 Special Investigative Units

In order to facilitate cooperation with HHSC OIG, the MCO must establish and maintain a special investigative unit (SIU), either in-house or by contract with another entity, to investigate possible acts of Fraud, Waste, or Abuse for all services provided under the Contract, including those that the MCO subcontracts to outside entities.

1. The MCO's SIU does not have to be physically located in Texas but must be adequately staffed to handle Texas volume. The SIU must have adequate staff and resources apportioned at the levels and experience sufficient to effectively work Texas cases based on objective criteria considering, but not necessarily limited to, the MCO's total member population, claims processes, risk exposure, current caseload, and other duties as described in 1 Tex. Admin. Code §§ 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 HHSC 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.

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3. The MCO must maintain a full-time SIU manager dedicated solely to the Texas Medicaid and CHIP programs to direct oversight of the SIU and Fraud, Waste, and Abuse activities.
4. The MCO SIU must employ or subcontract, at minimum, one full-time investigator, in addition to the SIU manager, who is dedicated solely to the services provided under the Texas Medicaid and CHIP contracts. The investigator must hold credentials such as a certification from the Association of Certified Fraud Examiners, an accreditation from the National Health Care Anti-Fraud Association, or have a minimum of three (3) years Medicaid or CHIP Fraud, Waste and Abuse investigatory experience.

8.1.21.2 General requests for and access to data, records, and other information

The MCO and its subcontractors must allow access to all premises and provide originals or copies of all records and information requested free of charge to the HHSC OIG, HHSC or its authorized agent(s), CMS, the U.S. Department of Health and Human Services (DHHS), the Federal Bureau of Investigation (FBI), the Office of the Attorney General, the Texas Department of Insurance (TDI), or other units of state government.

1. Each MCO must designate one primary and one secondary contact person for all HHSC OIG records requests. Each MCO must also identify a central email inbox that will receive all HHSC OIG records requests. HHSC OIG records requests will be sent to the central group email inbox and also may be sent to the designated MCO contact person(s) in writing by e-mail, fax, or mail, and will provide the specifics of the information being requested (see below).
2. The MCO must respond to the appropriate HHSC OIG staff member within the timeframe designated in the request. If the MCO is unable to provide all of the requested information with in the designated timeframe, the MCO may request an extension in writing (e-mail) to the HHSC OIG requestor no less than two Business Days prior to the due date.
3. The MCO's response must include data for all data fields, as available. The data must be provided in the order and format requested. If any data field is left blank, an explanation must accompany the response. The MCO must not add or delete any additional data fields in its response. All requested information must be accompanied by a notarized Business Records Affidavit unless indicated otherwise in HHSC OIG's record request.
4. The MCO must retain records in accordance with **UMCM Chapter 18**.

The most common requests include, but are not limited to:

1. 1099 data and other financial information – three Business Days.
2. Claims data for sampling and recipient investigations – five Business Days.
3. Urgent claims data requests – three Business Days (with HHSC OIG manager's approval).
4. Provider education information – ten Business Days.

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5. Files associated with an investigation conducted by an MCO – 15 Business Days.
6. Provider profile, UR summary reports, and associated provider education activities and outcomes – as indicated in the request.
7. Member and/or pharmacy data as required by HHSC OIG.
8. Requests submitted to the MCO/Dental Contractor for interpretations or clarifications of the MCO/Dental Contractor policy and procedure - five Business Days.
9. The basis for providing specific authorized services, including case-by-case services, value-added services, and Comprehensive Care Program (CCP) services provided through Texas Health Steps – as needed.
10. Other time-sensitive requests – as needed.

8.1.21.3 Claims Data Submission Requirements

1. The MCO and its subcontractors must submit Adjudicated claims data per the frequency and scope prescribed by the HHSC OIG. This data must include submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats. In the event that the MCO denies provider claims, either as Adjudicated-Denied Claims or Deficient-Denied Claims, the MCO must submit all available claims data, for such denied claims, to the HHSC OIG without alteration or omission. The MCO and its subcontractors shall make changes or corrections to any systems, processes, or data transmission formats as needed to comply with HHSC OIG data quality standards and requirements as originally defined or subsequently amended.
2. The MCO and its subcontractors shall comply with industry-accepted clean claim standards for all data submissions to HHSC 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 HHSC 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 HHSC 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 HHSC OIG, complying with standard code sets and maintaining integrity with all reference data sources including provider and member data. All data submissions by the MCO and its subcontractors will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing.
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

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in accordance with this Section, the MCO and its subcontractors shall address any issues that prevent processing of a claims batch in accordance with procedures specified and defined by HHSC OIG.

6. The MCO and its subcontractors shall supply Electronic Funds Transfer (EFT) account numbers on a monthly basis in a format defined by HHSC OIG for all Medicaid providers who have elected to receive payments via EFT and who are participating in their plans.
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 other contractual remedies as identified in **Attachment A, Section 12**.

8.1.21.4 Payment Holds and Settlements

1. 42 C.F.R. § 455.23 requires the State Medicaid agency to suspend all Medicaid payments to a Provider after the agency determines there is a credible allegation of Fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or suspend payment only in part. The rules governing payment suspensions based upon pending investigations of credible allegations of Fraud apply to Medicaid managed care entities. Managed care capitation payments may be included in a suspension when an individual Network Provider is under investigation based upon credible allegations of Fraud, depending on the allegations at issue.
2. The MCO must cooperate with HHSC OIG when HHSC OIG imposes payment suspensions or lifts a payment hold. When HHSC OIG sends notice that payments to a Provider have been suspended, the MCO must also suspend payments to the Provider within one Business Day. When notice of a payment hold or a payment hold lift is received, the MCO must respond to the notice within three Business Days and inform HHSC OIG of action taken.
3. The MCO must also report all of the following information to HHSC OIG after it suspends payments to the Provider: date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, amount of adjudicated payments held, and, if applicable, the good cause rationale for not suspending payment (for example, the Provider is not enrolled in the MCO's network) or imposing a partial payment suspension. If the MCO does not suspend payments to the Provider, or if the MCO does not correctly report the amount of adjudicated payments on hold, HHSC may impose contractual or other remedies. The MCO must report the fully adjudicated hold amount on the monthly open case list report required by **UMCM Chapter 5.5** and provide this information to HHSC OIG upon request.
4. The MCO must follow the requirements set forth in a settlement agreement involving a MCO's Provider and HHSC OIG. The MCO must withhold the designated percentage of funds to be paid toward an identified overpayment. Upon HHSC OIG request, the MCO must forward the held funds to HHSC OIG, Attn: Chief Counsel Accounting, 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.

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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 8.1.21** and all state and federal laws and regulations relating to Fraud, Waste, and Abuse in healthcare and the Medicaid and CHIP programs are subject to administrative enforcement by HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

8.1.21.5 Treatment of Recoveries by the MCO for Fraud, Waste, and Abuse

Pursuant to 42 C.F.R § 438.608(d)(1)(i), the MCO must comply with all state and federal laws pertaining to Provider recoveries including Texas Government Code § 531.1131.

The MCO must have internal policies and procedures for the documentation, retention, and recovery of all overpayments, specifically for the recovery of overpayments due to Fraud, Waste, and Abuse.

1. In cases identified by the HHSC OIG, the HHSC OIG has the right to recover any identified overpayment directly from the Provider or to require the MCO to recover the identified overpayment and distribute funds to the State.
2. The MCO will have no claim to any funds that are recovered by the State of Texas or the United States Government from a Provider through an action under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws. The recovery of an overpayment by an MCO from a Provider does not preclude the prosecution of nor recovery from a Provider under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws.
3. Upon discovery of fraud or abuse the MCO shall:
    a. Submit a referral using the fraud referral form through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS); and
    b. Proceed with recovery efforts if the recovery amount is less than $100,000 or the recovery amount exceeds $100,000 and the OIG has notified the MCO it is authorized to proceed with recovery efforts.
4. The MCO may retain recovery amounts pursuant to Texas Government Code § 531.1131(c) and (c-1).
5. Pursuant to Texas Government Code § 531.1131(c-3), the MCO is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services, or claims upon which the recoupment or withhold are based meet one or more of the following criteria:
    a. Upon written notice from HHSC OIG that it has begun recovery efforts, the MCO is prohibited from taking any actions to recoup or withhold improperly paid funds.

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i. The prohibition described in this subsection shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims. The MCO must not engage in any reprocessing, recoupments, and other payment recovery efforts or claims adjustments of any kind based on the parameters set by HHSC OIG.
ii. The prohibition does not impact any current MCO contractual obligations as well as any reprocessing, recoupment, other payment recovery efforts or claims adjustments for claims that fall outside those identified in the written notice from HHSC OIG.

b. The improperly paid funds have already been recovered by HHSC OIG.

6. The MCO must report at least annually, or at the request of the HHSC OIG, to the status of their recoveries of overpayments, in the manner specified by the HHSC OIG.

8.1.21.6 Additional Requirements for STAR Kids MCOs:

In accordance with the Social Security Act § 1902(a)(68), 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 those laws, as described in Section 1902(a)(68)(A).
2. Include as part of those 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.

8.1.21.7 Lock-in Actions

HHSC OIG's Lock-in Program (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 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." MCOs must submit documentation on an annual basis demonstrating how the MCO complies with "HHSC OIG Lock-In Program Policies and Procedure"

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requirements. The MCO must submit the information 90 Days prior to the start of the State Fiscal Year in conjunction with the Fraud, Waste, and Abuse compliance plan.

8.1.22 Reporting Requirements

The MCO must provide and must require its Subcontractors to provide at no cost to HHSC:

1. All information required under the Contract, including but not limited to, the reporting requirements or other information related to the performance of its responsibilities hereunder as reasonably requested by the HHSC; and
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 MCOs to establish time frames and formats reasonably acceptable to both parties.

Any deliverable or report in this section without a specified due date is due quarterly on the last Day of the month following the end of the reporting period. Where the due date states 30 Days, the MCO is to provide the deliverable by the last Day of the month following the end of the reporting period. Where the due date states 45 Days, the MCO is to provide the deliverable by the 15th Day of the second month following the end of the reporting period.

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 has been reviewed by the MCO and is true and accurate to the best of their knowledge after reasonable inquiry.

8.1.22.1 Performance Measurement

The MCO must provide to HHSC or its designee all information necessary to analyze the MCO's provision of quality care to Members using measures to be determined by HHSC in consultation with the MCO.

8.1.22.2 Reports

The MCO must provide the following reports, in addition to the Financial Reports described in **Section 8.1.20.2** and those reporting requirements listed elsewhere in the Contract. The **UMCM** will include a list of all required reports and a description of the format, content, file layout, and submission deadlines for each report.

(a) **Claims Summary Report** - The MCO must submit one Claims Summary Report each month by Program to HHSC using the text file layout located in **UMCM Chapter 5.**

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(b) **QAPI Program Annual Summary Report** - The MCO must submit a QAPI Program Annual Summary in a format and timeframe as specified in the **UMCM**.

(c) **Fraudulent Practices Referral**- Utilizing the HHSC Office of Inspector General (HHSC OIG) fraud referral form, through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS), the MCO's assigned officer or director must report and refer all possible acts of Fraud, Waste, and Abuse to the HHSC OIG within 30 Business Days of receiving the reports of possible acts of Fraud, Waste, and Abuse from the MCO's Special Investigative Unit (SIU).

This requirement applies to all referrals of possible acts of Fraud, Waste, and Abuse. Additional guidance is provided in **UMCM 5**.

Additional reports required by the Office of Inspector General relating to Fraud, Waste, and Abuse are listed in the **UMCM 5**.

(d) **Provider Termination Report: -** The MCO must submit one Provider Termination Report each quarter by Program that identifies all Network Providers who cease to participate in the MCO's Provider Network, either voluntarily or involuntarily. The text file layout located in **UMCM 5,** must be submitted no later than 30 Days after the end of the reporting quarter.

(e) **Provider Complaints, Member Complaints, and Member Appeals** - The MCO must submit monthly Complaints and Member Appeals reports by Program. The MCO must include in its reports complaints, including Initial Contact Complaints, and appeals submitted to the MCO 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 complaints reports. An Inquiry must not be counted as a complaint on the MCO's complaint reports. The MCO Member Appeal report must include all appeals received prior to and during the month, appeals resolved during the month, and pending appeals. The MCO must submit its Member and Provider complaints and its Member appeals using the text file layouts in **UMCM Chapter 5.** The MCO must ensure that as many pending complaints and appeals as possible are resolved prior to submitting the reports.

(f) **Hotline Reports -** The MCO must submit a MCO Hotlines Report month per Program and hotline type that includes the Member Services hotline, the Behavioral Health Services hotline, the Provider hotline, and the Nurse hotline to measure the MCO's compliance in accordance with performance standards set out in **Sections 8.1.5.6** Nurse and Member Hotline Requirements, **8.1.4.5** Provider Hotline, and **8.1.16.2** Behavioral Health Services Hotline using the text file layout located in **UMCM Chapter 5**

If the MCO is not meeting a hotline performance standard, HHSC may require the MCO to implement corrective actions until the hotline performance standards are met.

(g) **Audit Reports –** The MCO must comply with the **UMCM** requirements regarding notification and submission of audit reports.

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(h) **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, or refusing to obtain the medical checkups. The MCO must also document and report those Members refusing to obtain the medical checkups. 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 Chapter 12**.

(i) **Migrant Farmworker Child(ren) Annual Report (FWC Annual Report) -** MCO must submit an annual report and log in the timeframe and format described in the **UMCM Chapters 12.**

(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. Medicaid MCOs 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**.

(k) **Drug Utilization Review (DUR) Reports** – MCOs must submit the DUR reports in accordance with the requirements of the **UMCM**.

(l) **STAR Kids LTSS Utilization Quarterly Reports** – The MCO must file quarterly LTSS Utilization Reports in accordance with the appropriate chapter in the **UMCM**. Quarterly reports are due 30 Days after the end of each quarter.

(o) **Perinatal Risk Reports—**The MCO must submit a quarterly perinatal risk report as described in **UMCM Chapter 5**. Quarterly reports are due 30 days after the end of each quarter.

(p) **Enrollment/Credentialing Denial Report**: The MCO must submit a quarterly report in accordance with the **UMCM Chapter 5.4.1.9** 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.

(q) **Long-Term Services and Supports Report –**The MCO must file quarterly Long-Term Services and Supports Reports including the data specified in the **UMCM Chapter 10.** Quarterly reports are due 30 Days after the end of each quarter.

(r) **MCO Pharmacy Quarterly Report** – MCOs must complete and submit a MCO Pharmacy Quarterly Report for each Program using the HHSC-provided template in **UMCM Chapter 5**. Reports must be submitted for each MCO and cannot be grouped by the Pharmacy Benefit Manager.

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(s) **Critical Incidents and Abuse, Neglect and Exploitation Report** – Medicaid MCOs must submit a quarterly report and annual report that includes the number of Critical Incidents unrelated to Abuse, Neglect, and Exploitation (ANE) identified by the MCO or reported by Network Providers and ANE reports received from Adult Protective Services (APS) for Members receiving LTSS. The ANE reports submitted by the MCOs for STAR Kids MDCP Members must include individualized de-identified information about the resolution of each confirmed incident of ANE reported.

(t) **Network and Capacity Report** - Each MCO must submit a quarterly report that includes all LTSS Providers, mail order pharmacies, and 24-hour pharmacies in its Provider Network. The report must be submitted using the text file layout located in **UMCM Chapter 5** no later than 30 Days after the end of the reporting quarter.

(u) **Value-added Services Utilization Report** - The MCO must submit a report of Member utilization of its Value-added Services (VAS). The report must be submitted to HHSC using the VAS Utilization Report template in **UMCM Chapter 4.14** and according to the timeframes identified in the **UMCM Chapter 5.**

(v) **LTSS Actions** - MCOs providing LTSS under their STAR Kids capitation must complete and submit a quarterly report of suspension, termination, or reduction of a Member's LTSS services, or of an adverse benefit determination relating to an LTSS service required by 42 C.F.R. § 438.228, specified in **UMCM Chapter 5**.

(w) **MDCP PDN PPECC Authorization Report** - The MCO must file monthly MDCP PDN PPECC Authorization Reports in accordance with the appropriate chapter in the **UMCM**. Monthly reports are due 15 Days after the end of each month.

(x) **MDCP Waiver Performance Measure Data Report** - For Members in the STAR Kids Medically Dependent Children Program (MDCP) waiver, the MCOs are required to report on the following Centers for Medicare and Medicaid Services assurance and sub-assurances through self-reported data, both quarterly and annually on the specific measures outlined in the UMCM Section 5.7.3.

1. The MCO demonstrates that it has designed and implemented an adequate system for assuring that all MDCP waiver services are provided by qualified providers.

2. The MCO verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing MDCP waiver services.

3. The MCO monitors non-licensed/non-certified providers to assure adherence to MDCP waiver requirements.

(y) **MCO CADs Paid as Non-risk Based Utilization Statistics** - Upon request by HHSC, the MCO must complete and submit a survey capturing monthly utilization data for specified clinician-administered drugs paid through the non-risk based model. The MCO must complete and submit the survey to HHSC according to the instructions provided in **UMCM Chapter 5.0.**

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(z) **TPR Report for Pharmacy TPL** – MCOs must complete and submit a TPR Report for Pharmacy TPL for each Program using the HHSC-provided template in **UMCM Chapter 5**. Reports must be submitted for each MCO and cannot be grouped by the Pharmacy Benefit Manager (PBM).

(aa) **Out-of-Network (OON) Utilization Reports** – The OON Utilization Report will provide an overview of each MCO's out-of-network claims. The MCO must file quarterly OON Utilization Reports in the format and timeframe specified in UMCM Chapter 5.

8.1.23 Continuity of Care and Out-of-Network Providers

The MCO must ensure continuity of care such that the healthcare of newly enrolled Members is not disrupted, compromised, or interrupted. The MCO must ensure that 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 is not disrupted, compromised, or interrupted.

The MCOs must allow a Member with coverage under a non-Medicaid health insurance organization who is receiving (a) Level 1 Service Coordination in STAR Kids to remain under the care of a Medicaid enrolled specialty provider from whom the Member is receiving care through the non-Medicaid health insurance organization at the time of initial MCO selection or on the date of enrollment into MCO, even if that specialty provider is OON with the MCO. The list of specialty provider types to be considered for this purpose are the individual providers located in UMCM Chapter 3.1, Attachment B. The MCO provider directories must be consistent with the specialty providers listed in UMCM Chapter 3.1. The MCO must comply with OON provider reimbursement rules as adopted by HHSC at 1 Tex. Admin. Code. § 353.4 until one of the following events occurs:

1. An alternate reimbursement agreement is reached with the Member's specialty provider;
2. The Member is no longer enrolled in a non-Medicaid health insurance organization;
3. The Member or the Member's LAR agree to select an alternate specialty provider; or
4. The Member is no longer enrolled in the MCO.

Under the provisions of this section, MCOs shall not include Members seeing an OON provider as part of its Out-of-Network Utilization Reporting requirements under UMCM Chapter 5.

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8.1.23.1 Requirements for Individuals who become Members on the Operational Start Date

For individuals who become Members on the Operational Start Date, the MCO must ensure Members previously 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) 6 months after the Operational Start Date, (2) until the end of the current authorization period, or (3) until the MCO has appropriately evaluated and administered the STAR Kids Screening and Assessment Process and issued or denied a new authorization.

The MCO is required to ensure that Members receiving Community-Based Services prior to the Operational Start Date continue to receive those services for up to six months after the Operational Start Date, unless the MCO has completed the STAR Kids Screening and Assessment Process and issued new authorizations as described in **Section 8.1.39**. During the Transition Phase an HHS Agency will provide a file identifying these Members to the MCO for this purpose. The MCO must work with HHSC and DADS to ensure that all necessary authorizations are in place within the MCO's system(s) for the continuation of Community-Based Services. The MCO must describe the process it will use to ensure continuation of current Community-Based Services in its Transition/Implementation Plan as noted in **Section 7.3.1**. The MCO must ensure that Community-Based Service Providers are informed and trained on this process prior to the Operational Start Date.

The MCO must allow pregnant Members past the 24th week of pregnancy to remain under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the Provider is Out-of-Network. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

The MCO must pay a Member's existing Out-of-Network Providers for Medically Necessary and Functionally Necessary Covered Services and equipment and supplies for six months following the Operational Start Date or until the Member's records, clinical information, and care can be transferred to a Network Provider, whichever is longer, unless the Member is no longer enrolled in that MCO. If, at the time of enrollment, the Member has an existing scheduled appointment with an Out-of-Network specialist physician, the MCO must authorize and pay the Out-of-Network specialist physician for any Covered Service provided to the Member during that Member's scheduled appointment with the Out-of-Network specialist physician. Payment to Out-of-Network Providers must be made within the time period required for Network Providers. The MCO must comply with Out-of-Network Provider reimbursement rules as adopted by HHSC.

With the exception of pregnant Members who are past the 24th week of pregnancy, this requirement does not extend the obligation of the MCO to reimburse the Member's existing Out-of-Network Providers for on-going care for:

1. More than six months after the Operational Start Date, or

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2. For more than 12 months in the case of a Member who, at the time of enrollment in the MCO, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the MCO.

The MCO's obligation to reimburse the Member's existing Out-of-Network Provider for services provided to a pregnant Member past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first 6 weeks of delivery.

The MCO must provide or pay Out-of-Network Providers who provide Medically Necessary Covered Services to Members who move out of the Service Area 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 Out-of-Network services for as long as those services are necessary and 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 Out-of-Network services if the services become available from a Network Provider. If a Member's PCP or other Provider determines that disrupting a Member's existing relationship with an Out-of-Network Provider would subject the Member to unnecessary psychological or medical risk, the MCO must provide the Member access to those Out-of-Network services through an appropriate agreement with the Out-of-Network Provider.

The MCO must ensure that each Member has access to a second opinion regarding the use of any Medically Necessary Covered Service. A Member must be allowed access to a second opinion from a Network Provider or Out-of-Network Provider, if a Network Provider is not available or does not have the clinical experience in a condition or treatment, at no cost to the Member, in accordance with 42 C.F.R. § 438.206(b)(3).The requirements in this **Section 8.1.23** regarding access to and payment of Out-of-Network providers apply only to Out-of-Network providers who are enrolled Texas Medicaid providers.

8.1.23.2 Requirements for Individuals who become Members after the Operational Start Date

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) 90 Days after the transition to a new MCO,
(2) until the end of the current authorization period, or
(3) until the MCO has appropriately evaluated and administered the STAR Kids Screening and Assessment Process and issued or denied a new authorization.

See **Section 8.1.14**, Disease Management, for specific requirements for New Members transferring to the MCO's DM Program.

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For instances in which a newly enrolled Member transitioning from FFS to managed care was receiving a service that did not require a prior authorization in FFS, but does require one by the new MCO, the MCO must ensure Members receive services for the same amount, duration, and scope for the shortest period of one of the following:

(1) 90 Days after the transition to a new MCO, or
(2) until the MCO has evaluated and assessed the Member and issued or denied a new authorization.

The MCO must allow pregnant Members past the 24th week of pregnancy to remain under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the Provider is Out-of-Network. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

The MCO must pay a Member's existing Out-of-Network Providers for Medically Necessary and Functionally Necessary Covered Services and equipment and supplies until the Member's records, clinical information, and care can be transferred to a Network Provider, or until the Member is no longer enrolled in that MCO, whichever is shorter. If, at the time of enrollment, the Member has an existing scheduled appointment with an Out-of-Network specialist physician and the MCO does not arrange for an earlier alternative appointment with a Network Provider with a comparable certification, specialty, and expertise, the MCO must authorize and pay the Out-of-Network specialist physician for any Covered Service provided to the Member during that Member's scheduled appointment with the Out-of-Network specialist physician. If the Member requires follow-up care, the MCO may transfer the Member's care to a Network Provider with a comparable certification, specialty, and expertise, in coordination with the Out-of-Network specialist physician and the Member or the Member's LAR. Payment to Out-of-Network Providers must be made within the time period required for Network Providers. The MCO must comply with Out-of-Network Provider reimbursement rules as adopted by HHSC.

With the exception of pregnant Members who are past the 24th week of pregnancy, this requirement does not extend the obligation of the MCO to reimburse the Member's existing Out-of-Network Providers for on-going care for:

1. More than 90 Days after a Member enrolls in the MCO, or
2. For more than 12 months in the case of a Member who, at the time of enrollment in the MCO, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the MCO.

The MCO's obligation to reimburse the Member's existing Out-of-Network Provider for services provided to a pregnant Member past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first 6 weeks of delivery.

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The MCO must provide or pay Out-of-Network Providers who provide Medically Necessary Covered Services to Members who move out of the Service Area 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 Out-of-Network services for as long as those services are necessary and 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 Out-of-Network services if the services become available from a Network Provider. If a Member's PCP or other Provider determines that disrupting a Member's existing relationship with an Out-of-Network Provider would subject the Member to unnecessary psychological or medical risk, the MCO must provide the Member access to those Out-of-Network services through an appropriate agreement with the Out-of-Network Provider.

The MCO must ensure that each Member has access to a second opinion regarding the use of any Medically Necessary Covered Service. A Member must be allowed access to a second opinion from a Network Provider or Out-of-Network Provider, if a Network Provider is not available or does not have the clinical experience in a condition or treatment, at no cost to the Member, in accordance with 42 C.F.R. § 438.206(b)(3).The requirements in this **Section 8.1.23** regarding access to and payment of Out-of-Network providers apply only to Out-of-Network providers who are enrolled Texas Medicaid providers.

8.1.23.3 HCBS LTSS Continuity of Care

If an MDCP Member receives supported employment or employment assistance, and the Provider is terminated or otherwise leaves the MCO Network:

1. The MCO must notify the Member of the upcoming change within ten Days of receiving final termination notice or ten Days prior to the MCOs effective date of termination, whichever is earlier.
2. If the Member wishes to stay with the current Provider, the MCO may seek to obtain a single-case-agreement, out-of-network authorization or similar arrangement with the Provider to ensure the Member's continued care.

If the Provider refuses to enter into a single-case-agreement, out-of-network authorization, or similar arrangement with the MCO, or if the MCO does not offer the Provider the option to enter in to one of those arrangements, the MCO must notify the Member of his or her option to change MCOs and how to make such a change. If the change in MCOs will occur after the Provider is terminated, the MCO must notify HHSC no later than five Days from the end of the month to request assistance expediting the Member's MCO change.

If the Member wishes to stay with the current MCO, the MCO must notify the Member of the date by which the Provider will no longer be in Network or eligible for reimbursement to serve the Member and assist the Member in locating and beginning services with a new Provider with minimal disruption in services.

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This section only pertains to residential and employment provider termination as a cause for disenrollment (42 C.F.R. § 438.56(d)(2)(iv); therefore, these requirements differ from those under **Section 8.1.4.9** of the Contract.

8.1.24 Provisions Related to Covered Services for Members

8.1.24.1 Emergency Services

MCO policy and procedures, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must comply with all applicable state and federal laws, rules, and regulations, including 42 C.F.R. § 438.114, whether the Provider is in the MCO's Network or Out-of-Network. MCO policies and procedures must be consistent with the prudent layperson definition of an Emergency Medical Condition and the claims adjudication processes required under the Contract and 42 C.F.R. § 438.114.

The MCO must pay for the professional, facility, and ancillary services that are Medically Necessary to perform the medical screening examination and stabilization of a Member presenting with an Emergency Medical Condition or an Emergency Behavioral Health Condition to the Hospital emergency department, 24 hours a day, 7 Days a week, rendered by either the MCO's Network or Out-of-Network Providers.

The MCO cannot require prior authorization as a condition for payment for an Emergency Medical Condition, an Emergency Behavioral Health Condition, including Emergency Detentions as defined under Chapter 573, Subchapter A of the Texas Health and Safety Code and Chapter 462, Subchapter C of the Texas Health and Safety Code, or labor and delivery. The MCO cannot limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. The MCO cannot refuse to cover Emergency Services based on the emergency room Provider, Hospital, or fiscal agent not notifying the Member's PCP or the MCO of the Member's screening and treatment within ten Days of presentation for Emergency Services. The MCO may not hold the Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. The MCO must accept the emergency physician or Provider's determination of when the Member is sufficiently stabilized for transfer or discharge.

A medical screening examination needed to diagnose an Emergency Medical Condition 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 exists, the MCO must pay for Emergency Services performed to stabilize the Member. 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

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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 necessary to comply with 42 C.F.R. § 438.114(b)&(e) and 42 C.F.R. § 422.113(c)(2). The MCO is financially responsible for Post-stabilization Care Services obtained within or outside the Network that are not pre-approved by a Provider or other MCO representative, but administered to maintain, improve, or resolve the Member's stabilized condition if:

1. The MCO does not respond to a request for pre-approval within 1 hour;
2. The MCO cannot be contacted; or
3. The MCO representative and the treating physician cannot reach an agreement concerning the Member's care and a Network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a Network physician and the treating physician may continue with care of the Member until a Network physician is reached. The MCO's financial responsibility ends as follows: the Network physician with privileges at the treating Hospital assumes responsibility for the Member's care; the Network physician assumes responsibility for the Member's care through transfer; the MCO representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

The requirements in this section regarding access to and payment of Out-of-Network Providers apply only to Out-of-Network providers who are enrolled Texas Medicaid Providers.

8.1.24.2 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 have the right to choose any Medicaid participating family planning Provider, whether the Provider chosen by the Member is in or outside the Provider Network. The MCO must provide Members access to information about available Providers of family planning services and the Member's right to choose any Medicaid family planning Provider. The MCO must provide access to confidential family planning services.

The MCO must provide, at 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 not covered by the Vendor Drug Program and will reimburse Out-of-Network family planning Providers

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in accordance with HHSC's administrative rules. The MCO cannot require prior authorization for family planning services whether rendered by a Network or Out-of-Network provider. As described in **Section 8.1.33**, the MCO must also have procedures in place to educate the following Members about family planning programs, including the Texas Women's Health Program and DSHS Family Planning, Primary Health Care, and Expanded Primary Health Care programs:

1. Pregnant Women in Medicaid who will lose eligibility after delivery
2. Young pregnant adults in Children's Medicaid who will have aged out of Children's Medicaid by the time of delivery

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 and Members, 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 confidentiality for family planning services.

8.1.24.3 Texas Health Steps (EPSDT)

8.1.24.3.1 Medical Checkups

The MCO must develop effective methods to ensure that children birth through age 20 receive Texas Health Steps medical checkup services when due and according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual. The MCO must arrange for Texas Health Steps medical checkup services for all eligible Members, except when Members or their representatives knowingly and voluntarily decline or refuse services after receiving sufficient information to make an informed decision.

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 Days after the child's birthday. For New Members birth through age 20, overdue or upcoming Texas Health Steps medical checkups must be offered as soon as practicable, but in no case later than 14 Days of enrollment for newborns, and no later than 90 Days of enrollment for all other eligible child Members. For purposes of this requirement, the terms "New Member" and "Existing Member" are defined in **UMCM Chapter 12**

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8.1.24.3.2 Oral Evaluation and Fluoride Varnish

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 check-up. 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.

8.1.24.3.3 Lab

The MCO must require Providers to send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section or 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 the **Texas Medicaid Provider Procedures Manual** for age-specific requirements) must be submitted to the DSHS Laboratory Services Section or to a laboratory approved by the department under Health and Safety Code § 33.016 for analysis unless the Texas Medicaid Provider Procedures Manual, 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.

8.1.24.3.4 Education/Outreach

The MCO must ensure that Members are provided information and educational materials about the following Covered Services and how they may be obtained:

1. Texas Health Steps
2. Personal Care Services
3. Private Duty Nursing
4. Behavioral Health Services
5. Durable Medical Equipment (DME) and supplies
6. Prescribed Pediatric Extended Care Center services, if PPECCs are available in the service area

The information must tell the Member how and when they can obtain preventive medical checkups, diagnostic and treatment services, dental benefits, services through the Medical Transportation Program, and advocacy assistance from the MCO. Standard language describing Texas Health Steps services, including medical, dental, and case management services is provided in the **UMCM**. The MCO must use this language for

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Member Materials. Any additions to or deviations from the standard language must be reviewed and approved by HHSC prior to publication and distribution to Members.

The MCO should provide outreach to Members to ensure Members are effectively informed about available Texas Health Steps services, and to ensure the Member has access to prompt services. 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 the Members to encourage scheduling the service as soon as possible. MCO staff must coordinate with the Texas Health Steps Outreach and Informing Unit, the Medical Transportation Program, and other agencies to ensure Member access to timely Texas Health Steps services.

The MCO must cooperate and coordinate with HHSC, outreach programs, and Texas Health Steps regional program staff and agents to ensure prompt delivery of services to Farmworker Children and other migrant populations who may transition into and out of the MCO more rapidly or unpredictably than the general population.

The MCO should 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. The MCO should coordinate with Head Start programs to assist Members enrolling in, or enrolled in, Head Start with scheduling Texas Health Steps checkups. This coordination should include informing Head Start programs in the service area how to request scheduling assistance from the plan when a plan Member needs a Texas Health Steps checkup.

8.1.24.3.5 Training

The MCO must provide appropriate training to all Network Providers and Provider staff in the Providers' area of practice regarding the scope of Texas Health Steps services. Training must include:

1. Texas Health Steps benefits (preventive care, diagnostic services, and treatment),
2. The periodicity schedule for Texas Health Steps medical checkups and immunizations,
3. The required components of Texas Health Steps medical 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 at 12 and 24 months), the importance of documenting all lab screening and results for Texas Health Steps medical checkups, and Comprehensive Care Program (CCP) services available under The Texas Health Steps program to Members birth through age 20;
5. Medical Transportation services available to Members such as rides to healthcare service by bus, taxi, van, airfare, gas money, mileage reimbursement, meals and lodging when away from home;

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6. Importance of updating contact information to ensure accurate Provider Directories and the Medicaid Online Provider Lookup;
7. Information about MCO's process for acceleration of Texas Health Steps services for Children of Migrant Farmworkers;
8. Missed appointment referrals and assistance provided by the MCO;
9. Administrative issues such as claims filing and services available to Members;
10. 72-hour emergency supply prescription policy and procedures;
11. Outpatient prescription drug prior authorization process;
12. How to access the Medicaid formulary and preferred drug list (PDL) on HHSC's website;
13. The MCO prior authorization process;
14. How to use HHSC's free subscription service for accessing the Medicaid formulary and PDL through the Internet or hand-held devices; and
15. Scope of Durable Medical Equipment (DME), in addition to medical supplies and other items commonly found in a pharmacy that are available for class members.

Providers must be educated and trained to treat each Texas Health Steps visit as an opportunity for a comprehensive assessment of the Member.

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 on the DSHS website, "Texas Childhood Lead Poisoning Prevention", "Screening". . 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.

8.1.24.3.6 Data Validation

The MCO must require all Texas Health Steps Providers to submit claims for services paid, either on a capitated or fee-for service basis, on the CMS 1500 claim form and use the HIPAA compliant code set required by HHSC.

Encounter Data will be validated by chart review of a random sample of Texas Health Steps eligible enrollees against monthly Encounter Data reported by the MCO. HHSC or its designee will conduct chart reviews to validate that all screens are performed when due and as reported, and that reported data is accurate and timely. Substantial deviation between reported and charted Encounter Data could result in the MCO and Network Providers being investigated for potential Fraud, Waste, or Abuse without notice to the MCO or the Provider.

8.1.24.4 Perinatal Services

The MCO's perinatal health care services must ensure appropriate care is provided to women and infant Members of the MCO from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code Chapter 32 (the Maternal and Infant

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Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M.

The MCO must have a perinatal health care 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; and
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 must also educate Providers on the prior authorization 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 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 in **Section 8.1.22.2**, “Reports” and in the **UMCM Chapter 5**.

The MCO must have procedures in place to contact and assist a pregnant Member or a delivering Member about selecting a PCP for her baby either before the birth or as soon as the baby is born.

The MCO must provide Medically Necessary Covered Services relating to the labor and delivery for its pregnant Members or 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 the 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

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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 Members or delivering Members and newborns, including Out-of-Network Providers and Hospitals, of the MCO's prior authorization requirements. The MCO cannot require a prior authorization for services provided to a pregnant Member or a delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the Emergency Medical Condition arises.

8.1.24.5 Sexually Transmitted Diseases and Human Immunodeficiency Virus

The MCO must provide Sexually Transmitted Diseases (STD) services that include STD/Human Immunodeficiency Virus (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 prior authorization or referral by a PCP.

The MCO must comply with Texas Family Code § 32.003, relating to a child's consent to treatment. 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 and Members 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, cancroid, gonorrhea, chlamydia, and HIV receive risk reduction and partner elicitation/notification counseling.

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.

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The MCO must have policies and procedures in place regarding obtaining informed consent and counseling Members provided STD/HIV services.

8.1.24.6 Tuberculosis

The MCO must provide Members and Providers with education on the prevention, detection, and effective treatment of tuberculosis (TB). The MCO must establish mechanisms to ensure all procedures required to screen at-risk Members, and to form the basis for a diagnosis and proper prophylaxis and management of TB, are available to all Members, except services referenced in **Section 8.1.24.8** as Medicaid Non-capitated Services. The MCO must develop policies and procedures to ensure that Members who may be or are at risk for exposure to TB are screened for TB. An at-risk Member means a person who is susceptible to TB because of the association with certain risk factors, behaviors, drug resistance, or environmental conditions. 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 Centers for Disease Control and Prevention (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 working day of identification, using the most recent DSHS forms and procedures for reporting TB. Upon request, the MCO must provide access to Member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases.

The MCO must coordinate with the local TB control program to ensure that all Members with suspected or confirmed 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 Hospital 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.

8.1.24.7 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

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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.

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.

An MCO must notify their Members of any policy change 30 Days before the policy effective date and must inform Members when these services are not covered and how to obtain information on receiving these services from the HHSC.

8.1.24.8 Medicaid Non-capitated Services

The following Texas programs, services, or benefits have been excluded from MCO Covered Services. Members may be eligible to receive these Non-capitated Services on another basis, such as a Fee-for-Service basis or through a Dental MCO (for most dental services). MCOs must refer to relevant chapters in the **Texas Medicaid Provider Procedures Manual** for more information.

1. Texas Health Steps dental (including orthodontia);
2. Texas Health Steps environmental lead investigation (ELI)
3. Early Childhood Intervention (ECI) targeted case management (TCM);
4. Early Childhood Intervention Specialized Skills Training;
5. Case Management for Children and Pregnant Women;
6. Texas School Health and Related Services (SHARS);
7. Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program;
8. Tuberculosis services provided by DSHS-approved Providers (directly observed therapy and contact investigation);
9. Health and Human Services Commission's Medical Transportation Program;
10. HHSC hospice services;
11. HHSC or DSHS HCBS Waiver programs, authorized under Social Security Act § 1915(c), including Youth Empowerment Services (YES), Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and Home and Community-based Services (HCS);
12. Nursing facility services and intermediate care facility (ICF) services; and
13. Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members.

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8.1.24.9 Referrals for Non-capitated Services

Although the MCO is not responsible for paying or reimbursing for Non-capitated Services, the MCO is responsible for educating Members about the availability of Non-capitated Services, and for providing appropriate referrals for Members 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.

8.1.24.10 Cooperation with Immunization Registry

The MCO must work with HHSC and health care Providers to improve the immunization rate of STAR Kids Members and the reporting of immunization information for inclusion in the Texas Immunization Registry, called "ImmTrac2."

8.1.24.11 Case Management for Children and Pregnant Women Services

The MCO must coordinate services with Case Management for Children and Pregnant Women services. This coordination includes, but is not limited to, Member education, outreach, case collaboration and referrals to Case Management for Children and Pregnant Women services. The MCO is required to follow referral procedures as outlined by the State. Referrals to Case Management for Children and Pregnant Women services are to be based upon guidelines provided by the State, assessment, plan of care, change in Member's physical, mental or psychosocial condition or at Member's request.

Annually, all MCO Service Coordination and Case Management Staff must complete the Texas Health Steps Online module titled: Case Management Services in Texas and maintain proof of completion.

8.1.24.12 Farmworker Child(ren)

The MCO must identify community and statewide groups that work with Farmworker Child(ren) (FWC) in the MCO's Service Area(s). The MCO must cooperate and coordinate with as many of these groups as possible and encourage the groups to assist with identification of FWC.

The MCO must make efforts to reach identified FWC to provide timely Texas Health Steps checkups and needed follow-up care. Checkups and follow-up care must be in accordance with the Contract's timeframes for appointment availability.

When necessary, the MCO must provide accelerated services to FWC Members. For purposes of this section, "accelerated services" are services that are provided to FWC prior to their leaving Texas for work in other states. Accelerated services include the provision of preventive services that will be due during the time the FWC Member is out of Texas or treatment that might be required prior to a travel date. The need for accelerated services must be determined on a case-by-case basis according to the needs of the FWC.

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The MCO must maintain accurate lists of all identified FWC. Additionally, the MCO must maintain the confidentiality of information about the identity of FWC.

In accordance with **UMCM Chapter 12**, the MCO must submit an annual report that describes:

1. develop an annual plan identifying the process and methods it will used to identify/validate FWC enrolled in the MCO and encourage timely checkups;
2. efforts to coordinate with community and statewide groups that work with FWC;
3. methods used to assess Member health needs and provide accelerated services when necessary;
4. how the MCO maintains accurate lists of FWC enrolled in the MCO; and
5. how the MCO maintains confidentiality about the identify of FWC and provide accelerated services to such Members in accordance with **UMCM. Chapter 12**.

8.1.24.13 Immunizations

The MCO must educate Providers on the Immunization Standard Requirements set forth in Tex. Health and Safety Code, Chapter 161; the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule; the AAP Periodicity Schedule for CHIP Members; 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 or its appropriate designee is responsible for administration of the immunization and must not refer children to Local Health Departments or other entities to receive immunizations.

The MCO must educate Providers about the importance of including documentation for immunizations in the Member's medical record, and the necessity of the Provider's documentation to support a qualification for reimbursement for appropriate provision of immunizations to eligible Members.

The MCO must educate Providers about, and require Providers to comply with the requirements of Tex. Health and Safety Code, Chapter 161, relating to the Texas Immunization Registry (ImmTrac2), to include parental consent on the Vaccine Information Statement.

The MCO must notify Providers that they may enroll, as applicable, as Texas Vaccines for Children Providers. In addition, the MCO must work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac2 registry.

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8.1.24.14 Preadmission Screening and Resident Review (PASRR) Referring Entity Requirements

The MCO must follow any PASRR requirements when acting as a referring entity for Members as required by 26 Tex. Admin. Code §§ 303.10 and 303.301, .

8.1.24.15 Prescribed Pediatric Extended Care Centers

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 the same time in that day and must not be billed such that PPECC and PDN services cover the same timeframe or overlap.

MCOs must ensure that Network PPECCs adhere to licensing requirements contained in 26 Tex. Admin. Code Chapter 550, "Licensing Standards for Prescribed Pediatric Extended Care Centers" and Health and Safety Code, Chapter 248A - Prescribed Pediatric Extended Care Centers. MCOs and Network PPECCs must also adhere to program rules contained in 1 Tex. Admin. Code, Chapter 363, § 363.201 - § 363.215 relating to Texas Health Steps Comprehensive Care Program PPECC services.

Pursuant to Texas Health and Safety Code § 248A.151, admission to a PPECC must be voluntary and based on the Member's parent or legal guardian preference in both managed care and non-managed care service delivery systems. The MCO must ensure continuity of PPECC services in accordance with the authorization timeframes established in **Section 8.1.23**, "Continuity of Care and Out-of-Network Providers." The MCO must also coordinate care and authorizations between PPECCs and a Member's other service 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.

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.

8.1.24.15.1 Prior Authorization for PPECC Services

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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.

8.1.25 Medicaid Significant Traditional Providers

Medicaid Significant Traditional Providers are defined as PCPs and Community-Based Service providers that, when listed by provider type and county in descending order by unduplicated number of Members, served the top 80 percent of unduplicated Members. Hospitals receiving Disproportionate Share Hospital (DSH) funds are also considered STPs in the Service Area in which they are located. The HHSC website includes a list of Medicaid STPs by Service Area.

Beginning September 1, 2017, Medicaid STP requirements apply statewide for Providers serving individuals in the Medicaid Breast and Cervical Cancer (MBCC) program. In addition, STP provisions apply to Providers for AA Members and PCA Members identified by HHSC.

Medicaid STP requirements apply statewide for CFC Providers with a valid certification or license, as applicable and who are:

1. Home and community support services agencies licensed under Texas Health and Safety Code Chapter 142 that are contracted to provide services under the Community Living Assistance and Support Services (CLASS) or Deaf Blind Multiple Disabilities (DBMD) waiver programs; or
2. 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 in the following manner.

Provider Type	STAR Kids Program Service Area	Expiration Date
Substance use disorders (SUD) providers	statewide	See 8.1.4 Provider Network
Nursing Facilities	statewide	August 31, 2019
LMHAs/LBHAs	statewide	See 8.1.4 Provider Network

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Provider Type	STAR Kids Program Service Area	Expiration Date
CFC Providers	statewide	August 31, 2019

For three years following the Operational Start Date, Network Providers and non-network providers who believe they meet the STP requirements may contact HHSC and request HHSC's consideration for STP status.

The MCO must give STPs the opportunity to participate in its Network for at least three years from the start of the STP requirement. However, the STP Provider must:

1. Agree to accept the MCO's Provider reimbursement rate for the Provider type; and
2. Meet the standard credentialing requirements of the MCO, provided that lack of board certification or accreditation by The Joint Commission is not the sole grounds for exclusion from the Provider Network.

The MCO may terminate a 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.

8.1.26 Payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

The MCO must make reasonable efforts to include FQHCs and RHCs, freestanding and Hospital-based, in its Provider Network. The MCO must pay full encounter rates to RHCs for Medically Necessary Covered Services using the prospective payment methodology described in Sections 1902(bb) and 2107(e)(1) of the Social Security Act. Because the MCO is responsible for the full payment amount in effect on the date of service for RHCs, HHSC cost settlements or "wrap payments" will not apply.

When the MCO negotiates payment amounts with FQHCs for Medically Necessary Covered Services provided to its Members, the amounts must be greater than or equal to the average of the MCO's payment terms for other Providers providing the same or similar services. Because the MCO may negotiate payment amounts with FQHCs, wrap payments apply. MCOs may elect to pay the FQHC wrap payment at the time of claim adjudication but no later than the 15th Day of the following month for claims paid in the prior month. After the MCO pays a wrap payment, HHSC will make a supplemental payment to the MCO in the amount of the wrap payment by the last day of the following month.

If a Member visits an FQHC, RHC, or a Municipal Health Department's public clinic ("public clinic") for Health Care Services at a time that is outside of regular business hours, the MCO must reimburse the FQHC, RHC, or public clinic for Medically Necessary Covered Services. The MCO must do so at a rate that is equal to the allowable rate for those services as determined under Tex. Hum. Res. Code § 32.028. The MCO must not require a referral from the Member's PCP. In this context, regular

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business hours has the meaning given to it in 1 Tex. Admin. Code § 353.2, as required by 1 Tex. Admin. Code § 353.407.

If a Member visits an Out-of-Network Indian Health Care Provider (IHCP) enrolled in Medicaid as an FQHC, for Medically Necessary Covered Services, the MCO must reimburse the OON IHCP a full encounter as if the provider were a Network Provider. This encounter rate is paid entirely as a wrap payment no later than the 15th Day of the following month for services provided in the prior month. After the MCO pays a wrap payment, HHSC will make a supplemental payment to the MCO in the amount of the wrap payment by the last day of the following month. An FQHC's Out-of-Network claim is subject to the same claim standards requirements as the MCO's Network Providers.

8.1.27 MCO Internal Provider Complaints and Appeals Process

8.1.27.1 Provider Complaints

The MCO must develop, implement, and maintain a system for tracking and resolving all Provider Complaints. Within this process, the MCO must respond fully and completely to each Complaint and establish a tracking mechanism to document the status and final disposition of each Provider Complaint. The MCO must provide information about the complaint and Internal MCO Appeal system to all Providers and Subcontractors at the time they enter into a contract. The MCO must resolve Provider Complaints within 30 Days from the date the Complaint is received 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, unless HHSC has granted a written extension as describe below. Please see the **Attachment A**, "STAR Kids Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix."

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

The MCO must use appropriately trained pediatric providers for the purposes of reviewing all medically-based Provider Complaints, such as Provider Complaints about the quality of care or services, utilization review or management, or claims processing.

8.1.27.2 Provider Appeal of MCO Claims Determinations

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. The MCO's process must comply with the requirements of Texas Government Code § 533.005(a)(19). The MCO must provide information in 42 C.F.R. § 438.10(g)(2)(xi) about the grievance and MCO appeal system to all Providers and subcontractors at the time

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they enter into a contract. The MCO must allow Community-Based LTSS Providers to appeal claims that the MCO has not paid or denied by the 31st day following receipt.

The MCO is subject to remedies including liquidated damages if at least 98 percent of Provider Appeals are not resolved within 30 Days of the MCO's receipt.

In addition, the MCO must contract with physicians who are not Network Providers 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 the 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.

8.1.28 Member Rights and Responsibilities

In accordance with 42 C.F.R. § 438.100, all Medicaid MCOs must maintain written policies and procedures for informing Members of their rights and responsibilities, and must notify their Members of their right to request a copy of these rights and responsibilities. The Member Handbook must include notification of Member rights and responsibilities, as set forth in the **UMCM**.

8.1.29 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 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.

MCOs also must resolve Member Complaints referred by HHSC no later than the due date indicated on HHSC's notification form. HHSC will provide MCOs up to ten Business Days to resolve 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 liquidated damages if Member Complaints are not resolved by the timeframes indicated herein.

The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC's State Fair Hearing System. The procedures must be the same for all Members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC's approval at least 30 Days prior to their implementation.

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The MCO must use appropriately trained pediatric providers for the purposes of reviewing all medically-based Member Complaints and Appeals, such as Member Appeals regarding a benefit denial or limitation and Member Complaints about the quality of care or services, the accessibility or availability of services, or claims processing.

For purposes of this section, an "authorized representative" is any person or entity acting on behalf of the Member in compliance with State law and 42 C.F.R § 438.402. A Provider may be an authorized representative.

8.1.29.1 MCO Internal Member Complaint Process

The MCO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting, and resolving Complaints by Members or their authorized representatives.

The MCO must accept a Complaint that is submitted orally or in writing. A Complaint submitted by a Member, a Member's LAR, or a Member's Service Provider must be accepted by the MCO. The MCO must resolve Complaints within 30 Days from the date the Complaint is received by the MCO and notify the Member or Member's LAR in writing to acknowledge the Complaint and following resolution. The resolution letter must summarize the Complaint, information considered in investigating the Complaint, and final conclusions and actions. 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. Please see **Attachment A**, "STAR Kids Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix." The Complaint procedure must be the same for all Members. The Member or Member's authorized representative may file a Complaint either orally or in writing. The MCO must also inform Members how to file a Complaint directly with HHSC, once the Member 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 **Section 8.1.29.2**, 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 policy and procedure improvements to address the Complaints.

The MCO's Complaint procedures must be provided to Members in writing and through oral interpretive services. A written description of the MCO's Complaint procedures must be available in Prevalent Languages for Major Population Groups identified by HHSC, at no more than a 6th grade reading level.

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The MCO must include a written description of the Complaint process in the Member Handbook. The MCO must maintain 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 publish this number in the Member Handbook. The MCO must provide this 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 must be acknowledged and recorded in a written record and logged with the following details:

1. a description of the reason for the internal MCO Complaint;
2. the date received;
3. the date of each review or, if applicable, review meeting;
4. resolution at each level of the internal MCO Complaint if applicable;
5. date of resolution at each level, if applicable; and
6. name of the covered person for whom the internal MCO Complaint was filed.

The records must be accurately maintained in a manner accessible to the state and available upon request to CMS. The MCO must acknowledge the Member's Complaint, in writing, within five Business Days after the MCO receives the Complaint unless the complaint is an Initial Contact Complaint.

For Complaints that are received in person or by telephone, the MCO must provide Members or their representatives with written notice of resolution if the Complaint cannot be resolved within one Business Day of receipt. As the Texas Department of Insurance does not require the reporting of those issues to TDI (see 28 Tex. Admin. Code. 3.9202(2)), the MCOs shall report this subcategory of Complaints to HHSC as "Initial Contact Complaints."

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making a Complaint.

If the Member makes a request for disenrollment from the MCO and wants to select a different MCO, or if the Member is voluntarily enrolled in the Managed Care model and would like to disenroll, the MCO must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the Member is enrolled in the Managed Care program on a mandatory basis and requests disenrollment from Managed Care, the MCO must direct the Member to HHSC. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

The MCO will cooperate with HHSC or its designee to resolve all Member Complaints. Cooperation may include providing information or assistance to HHSC Complaint team members.

The MCO must provide designated STAR Kids Member Advocates to assist Members in understanding and using the MCO's Complaint system as described in **Section 8.1.29 and 8.1.29.1**. Members must be able to simply access a Member Advocate through the

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Member Hotline. The availability of Member Advocates must also be noted in the STAR Kids Member Handbook. Member Advocates must assist Members and Members' LARs with how to write a written Complaint and are responsible for monitoring Complaints they become aware of through the MCO's Complaint process.

8.1.29.2 Medicaid Member MCO Internal Appeal Process

The MCO must develop, implement, and maintain an Appeal procedure that complies with state and federal laws and regulations, including 42 C.F.R. § 431.200 and 42 C.F.R. Part 438, Subpart F, "Grievance System." An Appeal is a disagreement with an MCO Adverse Benefit Determination as defined in **Attachment A**, "STAR Kids Contract Terms." The Appeal procedure must be the same for all Members. When a Member or a Member's LAR expresses orally or in writing any dissatisfaction or disagreement with an Adverse Benefit Determination, the MCO must treat the expression of dissatisfaction as a request to Appeal an Adverse Benefit Determination.

The provisions of Texas Insurance Code, Chapter 4201, relating to a Member's right to Appeal an Adverse Benefit Determination made by the MCO or a utilization review agent to an independent review organization, do not apply to a Medicaid recipient. Texas Insurance Code, Texas Medicaid is using the External Medical Review process provided in 42 C.F.R. 438.408(f)(1)(ii). Medicaid MCOs are still expected to comply with the other applicable requirements of the Texas Insurance Code, including Chapter 4201.

The MCO must have policies and procedures in place outlining the Medical Director's role in an Appeal of an Adverse Benefit Determination. 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 health care 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 8.1.29.9**, to assist Members in understanding and using the Appeal process. The MCO's Member Advocates must assist Members in writing or filing an Appeal and monitoring the Appeal through the MCO's Appeal process until the issue is resolved.

The MCO must have a routine process to detect patterns of Appeals. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Appeals.

The MCO's Appeal procedures must be provided to Members in writing and through oral interpretive services. A written description of the Appeal procedures must be available in Prevalent Languages identified by HHSC, at no more than a 6th grade reading level. The MCO must include a written description of the Appeals process in the Member Handbook. The MCO must maintain and publish in the Member Handbook at least one toll-free telephone number with TTY/TDD and interpreter capabilities for requesting an Appeal of an Adverse Benefit Determination. The MCO must provide oral interpretive service to callers free of charge.

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The MCO's process must require that every oral internal MCO Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless the Member or his or her representative requests an expedited resolution. The date of the oral request should be treated as the filing date of the request. All MCO Appeals must be recorded in a written record and logged with the following details:

1. A general description of the reason for the MCO appeal.
2. The date received.
3. The date of each review or, if applicable, review meeting.
4. Resolution at each level of the MCO appeal, if applicable.
5. Date of resolution at each level, if applicable.
6. Name of the covered person for whom the MCO appeal was filed.

The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.

A Member must file a request for an MCO Appeal within 60 Days from the date of the notice of the Adverse Benefit Determination. To ensure continuation of currently authorized services, the Member must file the Appeal on or before the later of:

1. ten Business Days following the MCO's sending of the notice of the Adverse Benefit Determination, or
2. the intended effective date of the proposed Adverse Benefit Determination.

The MCO must send a letter to the Member within five Business Days acknowledging receipt of the Appeal request. Except for the resolution of an Expedited Appeal as provided in **Section 8.1.29.3**, the MCO must complete the entire standard Appeal process within 30 Days after receipt of the initial written or oral request for Appeal. The timeframe for a standard Appeal may be extended up to 14 Days if the Member or his or her representative requests an extension; or the MCO shows 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 written notice of the reason for delay if the Member had not requested the delay. The MCO must designate an officer who has primary responsibility for ensuring that Appeals are resolved within these timeframes and in accordance with the MCO's written policies.

During the Appeal process, the MCO must provide the Member 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 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 and his or her representative 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 and his or her representative or the legal representative of a deceased Member's estate.

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In accordance with 42 C.F.R. § 438.420, the MCO must continue the 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 or his or her representative files the Appeal timely as defined in this Contract;
2. The Appeal involves the termination, suspension, or reduction of a previously authorized service;
3. The services were ordered by an authorized Provider;
4. The period covered by the original authorization has not expired; and
5. The Member or his or her representative timely requests an extension of the benefits.

If, at the Member'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 withdraws the Appeal or request for State Fair Hearing;
2. Ten Days pass after the MCO mails the notice resolving the Appeal against the Member, unless the Member, within the ten Day timeframe, has requested a State Fair Hearing with continuation of benefits; or
3. A State Fair Hearing officer issues a hearing decision adverse to the Member.

In accordance with state and federal regulations, if the final resolution of the Appeal is adverse to the Member and upholds the MCO's Adverse Benefit Determination, then, to the extent that the services were furnished to comply with the Contract, the MCO must not recover those costs from the Member without written permissions from HHSC.

If the MCO, IRO, or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the MCO Appeal was pending, the MCO must authorize or provide the disputed services as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

If the MCO, IRO, 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 IRO or 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.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making an Appeal.

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8.1.29.3 Expedited MCO Internal 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 or the Provider indicates, in making the request on the Member's behalf or supporting the Member's request that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The MCO must follow all Appeal requirements for standard Member Appeals as set forth in **Section 8.1.29.2**, except where differences are specifically noted. The MCO must accept oral or written requests for Expedited Appeals.

Members must exhaust the MCO's Expedited MCO Internal Appeal process before making a request for an Expedited State Fair Hearing/EMR. After the MCO receives the request for an Expedited MCO Internal Appeal, it must hear an approved request for a Member to have an Expedited MCO Internal Appeal and notify the Member of the outcome of the Expedited MCO Internal Appeal within 72 hours, 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 request for Expedited MCO Internal Appeal.

Except for an Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the Expedited MCO Internal Appeal may be extended up to 14 Days if the Member 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 written notice of the reason for delay if the Member had not requested the delay.

If the decision is adverse to the Member, the MCO must follow the procedures relating to the notice in **Section 8.1.29.5**. The MCO is responsible for notifying the Member of his or her right to access an EMR and/or an expedited State Fair Hearing from HHSC. The MCO will be responsible for providing documentation to the state and the Member, indicating how the decision was made, prior to HHSC's expedited State Fair Hearing.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an Expedited MCO Internal Appeal. The MCO must ensure that punitive action is not taken against a Provider who requests an Expedited MCO Internal Appeal or supports a Member'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 prompt oral notice of the denial, and follow up within two Days with a written notice.

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8.1.29.4 Access to State Fair Hearing and External Medical Review (EMR) for Medicaid Members

The MCO must inform Members that they have the right to access the State Fair Hearing process, with or without and External Medical Review, only after exhausting the MCO Internal Appeal System provided by the MCO. The Member may request an EMR and/or State Fair Hearing if the MCO fails to respond to the Member's Appeal within the timeframe in 42 C.F.R. § 438.408. The MCO must notify Members that they may be represented by an authorized representative in the State Fair Hearing process.

The EMR is an optional, extra step a Member may request to further review the MCO's adverse benefit determination. The EMR will not consider new evidence. The EMRs will be conducted by Independent Review Organizations (IROs) contracted by HHSC. The role of the IRO is to act as an objective arbiter and decide whether the MCO's original adverse benefit determination must be reversed or affirmed. The EMR will take place between the MCO Internal Appeal and the State Fair Hearing. The MCO will send a copy of the EMR decision to the Member, HHSC Intake Team, and State Fair Hearings office as directed by HHSC.

If a Member requests a State Fair Hearing, the MCO will complete and submit the request via TIERS to the appropriate State Fair Hearings office, within five Days of the Member's request for a State Fair Hearing. If the Member requests an EMR, the MCO will complete and submit the request via TIERS to the HHSC Intake Team within five Days of the Member's request for an EMR.

Within five Days of notification that the State Fair Hearing is set, the MCO will prepare an evidence packet for submission to the HHSC State Fair Hearings staff and send a copy of the packet to the Member. The evidence packet must comply with HHSC's State 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 State Fair Hearings as scheduled.

8.1.29.5 Notices of Adverse Benefit Determination and Disposition of Appeals for Medicaid Members

The MCO must notify the Member, in accordance with 1 Tex. Admin. Code Chapter 357, whenever the MCO takes an Adverse Benefit Determination. The notice must, at a minimum, include any information required by 1 Tex. Admin. Code Chapter 357 that relates to a MCO's notice of Adverse Benefit Determination and any information required by 42 C.F.R. § 438.404 as directed by HHSC, including but not limited to:

1. The dates, types, and amount of service requested;
2. The Adverse Benefit Determination the MCO has taken or intends to take;
3. The reasons for the Adverse Benefit Determination, if the Adverse Benefit Determination taken is based upon a determination that the requested service is not Medically Necessary, the MCO must provide an explanation of the medical

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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 right to access the MCO's Appeal process;
5. The procedures by which the Member may Appeal the MCO's Adverse Benefit Determination;
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, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services;
8. The date the Adverse Benefit Determination will be taken;
9. A reference to the MCO policies and procedures supporting the MCO's Adverse Benefit Determination;
10. An address where written requests may be sent and a toll-free number that the Member can call to request the assistance of a Member representative, file an Appeal, or request a State Fair Hearing;
11. An explanation that Members may represent themselves, or be represented by a Provider, a friend, a relative, legal counsel, or another spokesperson;
12. A statement that if the Member wants a State Fair Hearing on the Adverse Benefit Determination, the Member must make the request for a State Fair Hearing within 120 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 State Fair Hearing is requested.

8.1.29.6 Timeframe for Notice of Adverse Benefit Determination

In accordance with 42 C.F.R. § 438.404(c), the MCO must mail a notice of Adverse Benefit Determination within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 Business Days before the termination, suspension, or reduction of previously authorized services, or within the timeframes specified in 42 C.F.R. §§, 431.213 and 431.214;
2. For denial of payment, at the time of any Adverse Benefit Determination affecting the claim;
3. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R. § 438.210(d)(1);
4. If the MCO extends the timeframe in accordance with 42 C.F.R. § 438.210(d)(1), it must:
    a. Give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file an Complaint if he or she disagrees with that decision; and

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b. Issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires;

5. 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 Benefit Determination, on the date that the timeframes expire; and
6. For expedited service authorization decisions, within the timeframes specified in 42 C.F.R. § 438.210(d).

8.1.29.7 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 MCO Internal Appeals to the affected parties. The written resolution notice (e.g., approval, denial, etc.) must be sent to the Member and must also be sent to a person acting on behalf of the Member to ensure the Member has an adequate opportunity to request a State Fair Hearing/EMR within ten Days if they choose to do so, and legal representative acting on behalf of the Member The notice must include the results and date of the Appeal resolution. For decisions not wholly in the Member's favor, the notice must contain:

1. The right to request a State Fair Hearing/EMR;
2. How to request a State Fair Hearing/EMR;
3. The circumstances under which the Member may continue to receive benefits pending a State Fair Hearing/EMR;
4. How to request the continuation of benefits;
5. If the MCO's Adverse Benefit Determination is upheld in a State Fair Hearing, the Member may be liable for the cost of any services furnished to the Member while the Appeal is pending; and
6. Any other information required by 1 Tex. Admin. Code Chapter 357 that relates to a MCO's notice of disposition of an Appeal.

8.1.29.8 Timeframe for Notice of Resolution of Appeals

In accordance with 42 C.F.R. § 438.408, the MCO must provide written notice of the resolution of Appeals, including Expedited MCO Internal Appeals, as expeditiously as the Member's health condition requires, but the notice must not exceed the timelines as provided in this Section for MCO Internal Appeals or Expedited MCO Internal Appeals. For expedited resolution of Appeals, the MCO must make reasonable efforts to give the Member prompt oral notice of the resolution of the Appeal, and follow up with a written notice within the timeframes set forth in this Section for Expedited MCO Internal Appeals. If the MCO denies a request for expedited resolution of an Appeal, the MCO must transfer the Appeal to the timeframe for resolution as provided in this section, and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two Days with a written notice.

8.1.29.9 Member Advocates

The MCO must provide Member Advocates to assist Members. Member Advocates must be physically located within each MCO Service Area where the MCO operates a STAR

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Kids program, unless an exception is approved by HHSC. Member Advocates must be trained and knowledgeable about the MCO complaints and conflict resolution process. Member Advocates must inform Members of the following:

1. Their rights and responsibilities,
2. The functions and contact information for the HHSC Office of the Ombudsman,
3. The Complaint process,
4. The Appeal process,
5. Covered Services available to them, including preventive services, and
6. Non-capitated Services available to them.

Member Advocates must assist Members 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 helping or referring Members to community resources available to meet Member needs that are not available from the MCO as Covered Services. Member Advocates must be trained to handle complaints regarding Service Coordination. Member Advocates must work with appropriate MCO personnel to address complaints about Service Coordinators, either by requesting reassignment or by working with the Member, the Service Coordinator, and other appropriate MCO staff to facilitate resolution.

The MCO must ensure access to Spanish-speaking Member Advocates or Member Advocates who speak languages of other Major Population Groups, if requested.

8.1.30 Additional Medicaid Behavioral Health Provisions

8.1.30.1 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 Kids Members who require these services based on the appropriate standardized assessment, the Child and Adolescent Needs and Strengths (CANS), through a qualified Network of entities. Qualified entities can include both Local Mental Health Authorities (LMHAs), other entities such as multi-specialty groups, and clinic or group practices that employ providers of these services.

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

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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 provided to a Member who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or 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**, including ensuring providers meet all training requirements and the use of the DSHS Resiliency and Recovery Utilization Management Guidelines (RRUMG), and must coordinate with providers of Mental Health Targeted Case Management to ensure integration of behavioral and physical health needs of its Members.

Additionally, the MCO must ensure the following:

1. Providers of Mental Health Rehabilitative Services and Mental Health Targeted Case Management use, and are trained and certified to use, HHSC approved assessment tools for assessing Member's needs.
2. STAR Kids Service Coordinators coordinate with providers of Mental Health Targeted Case Management and Mental Health Rehabilitative Services to ensure the integration of behavioral and physical health needs of Members.
3. STAR Kids Service Coordinators refer Members that lose Medicaid eligibility to the Local Mental Health Authorities for indigent mental health services.

8.1.31 Third Party Liability and Recovery and Coordination of Benefits

Medicaid coverage is secondary when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under Medicaid will pay benefits for Covered Services that remain unpaid after all other insurance coverage has been paid. For Network Providers and Out-of-Network providers with written reimbursement arrangements with the MCO, the MCO must pay the unpaid balance for Covered Services up to the agreed rates. For Out-of-Network providers with no written reimbursement arrangement, the MCO must pay the unpaid balance for Covered Services in accordance with 1 Tex. Admin. Code § 353.4 regarding Out-of-Network payment.

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MCOs are responsible for establishing and documenting a plan and process, referred to as the Third Party Liability (TPL) MCO Action Plan, in accordance with UMCM Chapter 5.3.4.7, for avoiding and recovering costs for services that should have been paid through a third party [including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974)], service benefit plans, managed care organizations, Pharmacy Benefit Managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. The TPL MCO Action Plan and process must be in accordance with state and federal law and regulations, including Sections 1902(a)(25)(E) and (F) of the Social Security Act, which require MCOs to first pay and later seek recovery from liable third parties for (1) preventive pediatric care, and (2) services provided to an individual on whose behalf child support enforcement is being carried out by the State agency under Part D of Title IV of the Social Security Act.

Each MCO must submit the TPL MCO Action Plan to the Office of Inspector General-Third Party Recoveries (OIG-TPR) email address at: TPL_ManagedCare@hhsc.state.tx.us no later than September 1 for the upcoming State Fiscal Year for review and approval. MCOs must submit any change requests to the TPL MCO Action plan for review and approval no later than 90 Days prior to the date of the proposed changes. The projected amount of TPR that the MCO is expected to recover may be factored into the rate setting process.

HHSC will provide the MCO, by Plan code, a weekly Member file (also known as a TPR client file). The file is an extract of those Medicaid Members who are known to have other insurance. The file contains any TPR data that HHSC's claims administrator has on file for individual Members, organized by name and Member number, and adding additional relevant information where available, such as the insured's name and contact information, type of coverage, the insurance carrier, and the effective dates.

For non-dual-eligible clients with primary private insurance, the MCO may not require a written EOB (e.g., no EOB at all or may require a verbal denial) for LTSS (PCS, CFC, DAHS, PPECC, MDCP respite, MDCP flexible family support services, MDCP supported employment, MDCP employment assistance, MDCP minor home modification, MDCP adaptive aids, MDCP transition assistance services, MDCP financial management services) and mental health rehabilitation, and mental health targeted case management services.

HHSC's TPR client file will be considered the system of record. The MCOs are required to share other insurance information for its enrolled Members with HHSC that differs or is not included on the TPR client file, per the current process of submitting the TPR MCO Referral Form found in the **UMCM Chapter 5**.

The MCO must provide financial reports to HHSC, as stated in **Section 8.1.19.2(m)**, "Financial Reporting Requirements Third Party Liability and Recovery (TPL/TPR) Reports" in accordance with UMCM Chapter 5.3.4.1 and 5.3.4.3.

The MCO must provide all TPR reports to OIG-TPR at the frequency stated in and in accordance with **UMCM, Chapter 5**.

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The MCO has 120 Days from the date of adjudication of a claim that is subject to TPR to attempt recovery of the costs for services that should have been paid through a third party. The MCO shall provide to HHSC, on a monthly basis by the tenth Day of each month, a report indicating the claims where the MCO has billed or made a recovery up to the 120th Day from adjudication of a claim that is subject to TPR. After 120 Days, HHSC will attempt recovery for any claims in which the MCO did not attempt recovery and will retain, in full, all funds received as a result of any HHSC-initiated TPR. The MCO is precluded from attempting to bill for any recovery after 120 Days from claim adjudication date. Any collections by the MCO billed after 120 Days from the claim adjudication date must be sent to OIG-TPR in the format prescribed in UMCM Chapter 5.3.4.10, TPR Managed Care Recovery Payment Submission Requirements. The MCOs are to continue to cost avoid and cost recover where applicable.

After 365 Days from adjudication of a claim, the MCO loses all rights to pursue or collect any recoveries subject to TPR. HHSC has the sole authority for recoveries of any claim subject to TPR after 365 Days from the date of adjudication of a claim. Should the MCO receive payment on a HHSC-initiated recovery, the MCO must send the payment to OIG-TPR in the format prescribed in UMCM Chapter 5.3.4.10, TPR Managed Care Recovery Payment Submission Requirements.

HHSC retains the responsibility to pursue, collect, and retain recoveries of all non-health insurance resources such as casualty, liability, estates, child support, and personal injury claims, wherein payments have been made on behalf of a Member. The MCO must continue to pay all valid, non-health insurance claims and is not permitted to cost avoid or seek recovery of any non-health insurance resources. Should the MCO receive payment on a non-health insurance recovery, the MCO must send the payment to OIG-TPR in the format prescribed in UMCM Chapter 5.3.4.10, TPR Managed Care Recovery Payment Submission Requirements. Members with these other resources shall remain enrolled in the MCO.

8.1.32 Coordination with Public Health Entities

8.1.32.1 Reimbursed Arrangements with Public Health Entities

The MCO must make a good faith effort to enter into Provider Contracts for Covered Services with Public Health Entities. Possible Covered Services that could be provided by Public Health Entities include, but are not limited to, the following services:

1. Sexually Transmitted Disease services;
2. Confidential HIV testing;
3. Immunizations;
4. Tuberculosis care;
5. Family planning services;
6. Texas Health Steps medical checkups, and
7. Prenatal services.

These subcontracts must be available for review by HHSC or its designated agent(s) on the same basis as all other subcontracts. If the MCO is unable to enter into a contract

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with Public Health Entities, the MCO must document efforts to contract with Public Health Entities, and make that documentation available to HHSC upon request.

MCO Contracts with Public Health Entities must specify the scope of responsibilities of both parties, the methodology and agreements regarding billing and reimbursements, reporting responsibilities, Member and Provider educational responsibilities, and the methodology and agreements regarding sharing of confidential medical record information between the Public Health Entity and the MCO or PCP.

The MCO must:

1. Identify care managers who will be available to assist public health Providers and PCPs in efficiently referring Members to the public health Providers, specialists, and health-related service Providers, either within or outside the MCO's Network; and
2. Inform Members that confidential healthcare information will be provided to the PCP, and educate Members on how to better utilize their PCPs, public health Providers, emergency departments, specialists, and health-related service Providers.

8.1.32.2 Non-Reimbursed Arrangements with Local Public Health Entities

The MCO must coordinate with Public Health Entities in each Service Area regarding the provision of essential public health care services. The MCO must:

1. Report to public health entities regarding communicable diseases or diseases that are preventable by immunization as defined by state law;
2. Notify the local Public Health Entity, as defined by state law, of communicable disease outbreaks involving Members;
3. Educate Members and Providers regarding WIC services available to Members; and
4. Require Providers to coordinate with local Public Health Entities that have a child lead program, or with DSHS Texas Childhood Lead Poisoning Prevention Program when the local Public Health Entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure.

8.1.33 Coordination with Other State Health and Human Services Programs

The MCO must coordinate with other state Health and Human Services (HHS) Programs in each Service Area, or each Texas Health and Human Service Region, regarding the provision of essential public healthcare services. The MCO must meet the following requirements:

1. Coordinate with the Department of Aging and Disability Services and providers of Long-Term Services and Supports for Members who receive Long-Term Services and Supports outside of the MCO;

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2. Require Providers to use the DSHS Bureau of Laboratories for specimens obtained as part of a Texas Health Steps medical checkup, as indicated in **Section 8.1.24.3.3** under Laboratory Services;
3. Notify Providers of the availability of vaccines through the Texas Vaccines for Children Program;
4. Work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac2 registry;
5. Educate Providers and Members about the HHSC Case Management for Children and Pregnant Women services available;
6. Coordinate services with Case Management for Children and Pregnant Women specifically in regard to an MCO Member's health care needs that are identified by Case Management for Children and Pregnant Women and referred to the MCO;
7. Participate, to the extent practicable, in the community-based coalitions with the Medicaid-funded case management programs in the Department of Assistive and Rehabilitative Services (DARS), the Department of Aging and Disability Services (DADS), and DSHS;
8. Cooperate with activities required of state and local public health authorities necessary to conduct the annual population and community-based needs assessment;
9. Require Providers to, in accordance with Texas Health & Safety Code Chapter 88 and related rules at 25 Tex. Admin. Code Chapter 37, Subchapter Q, (1) report all blood lead results to the Childhood Lead Poisoning Program (if not performed at the DSHS state laboratory) and (2) follow-up of suspected or confirmed cases of childhood lead exposure with the Childhood Lead Poisoning Prevention Program and follow the Centers for Disease Control and Prevention guidelines for testing children for lead and follow-up actions for children with elevated lead levels located on the DSHS website, "Texas Childhood Lead Poisoning Prevention", "Screening."
10. Coordinate with Texas Health Steps Outreach and Informing Unit;
11. Coordinate Covered Services and hospice services for terminally ill Members with a life expectancy of six months or less who are receiving hospice services through DADS; and
12. Educate Providers and Members about primary and family planning services available through the Texas Women's Health Program and DSHS Family Planning, Primary Health Care, and Expanded Primary Health Care programs.

8.1.34 Minimum Wage Requirements for STAR Kids Attendants in Community Settings

The MCO must ensure that facilities and agencies that provide Personal Care Services (PCS) Personal Care Services – CFC, Acquisition, maintenance and enhancement of skills in CFC, and MDCP STAR Kids attendant services pay attendants at or above $8.00 per hour.

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8.1.35 Advance Directives

Federal and state law require MCOs and Providers to maintain written policies and procedures for informing all adult Members 18 years of age and older about their rights to refuse, withhold, or withdraw medical treatment and mental health treatment through advance directives (see Social Security Act §§ 1902(a)(57) and 1903(m)(1)(A)). The MCO's policies and procedures must include written notification to Members and comply with provisions contained in 42 C.F.R. Part 489, Subpart I, relating to advance directives for all Hospitals, critical access Hospitals, skilled nursing facilities, home health agencies, Providers of home health care, Providers of personal care services and hospices, as well as the following state laws and rules:

1. A Member's right to self-determination in making health care decisions;
2. The Advance Directives Act, Texas Health and 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;
   c. A Member's right to execute a Medical Power of Attorney to appoint an agent to make health care decisions on the Member's behalf if the Member becomes incompetent; and
3. The Declaration for Mental Health Treatment, Texas Civil Practice and Remedies 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 mental health treatment.

The MCO must maintain written policies for implementing a Member's advance directive. Those policies must include a clear and precise statement of limitation if the MCO or a 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 health care 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 its Subcontractors to comply with the requirements of state and federal law relating to advance directives. The MCO must provide education and training to employees and Members on issues concerning advance directives.

All materials provided to Members regarding advance directives must be written at a 6th 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 6th 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.

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The MCO must notify Members 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.

8.1.36 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 STAR Kids Members and home health Covered Services for all Members. The MCO must ensure that Providers of Community-based Services are appropriately licensed to deliver the service they provide. MDCP services must be provided in home and community based settings and comply with 42 C.F.R. § 441.301(c)(4).

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. MCOs must provide all necessary Covered Services to Members. 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.

8.1.36.1 Electronic Visit Verification

MCOs must use an Electronic Visit Verification system(s) approved by HHSC in a manner consistent with the terms and conditions of this Contract, including the **UMCM Chapter 8.7** and applicable state and federal requirements.

MCOs must follow any HHSC applicable requirements to exchange EVV data specified in **UMCM Chapter 8.7.1**.

The MCO may not pass any EVV-related costs to Providers or Members.

8.1.36.2 Community First Choice Services Available to Qualified Members

Community First Choice provides Community-Based Services to eligible Members with physical or cognitive disabilities as an alternative to living in an institution. To be eligible for Community First Choice services, a Member must meet income and resource requirements for Medicaid under the State Plan and receive a determination from HHSC that the Member meets medical necessity/level of care requirements for Nursing Facility care, an Intermediate Care Facility, or an Institution for Mental Diseases. The MCO must make available to Members who meet these eligibility requirements the array of services allowable under Community First Choice (see **Attachment B-2**, “Covered Services”).

The MCO must contract with Providers of CFC services to ensure access to these services for all qualified STAR Kids Members. CFC services must be provided in home and community based settings and comply with 42 C.F.R. § 441.301(c)(4). The

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administration of CFC in managed care is governed by Tex. Admin. Code Chapter 354, Subchapter A, Division 27. At a minimum, these Providers must meet all of the following state licensure and certification requirements for providing the services in **Attachment B-2**, "Covered Services."

Community First Choice (CFC) Services Available to Qualified Members	
Service	**Licensure and Certification Requirements**
CFC Services--with the exception of Emergency Response Service-CFC	The Provider 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. For Personal Assistance Services - CFC, the agency may have only the Personal Assistance Services level of licensure.
Emergency Response Service - CFC	The Provider must: (1) be licensed: (a) by the Public Security Bureau of the Texas Department of Public Safety as an alarm systems company; or (b) by the Department of State Health Services as a personal emergency response system provider.

8.1.37 STAR Kids Service Delivery Options

Three options are available to Members desiring to self-direct the delivery of Personal Care Services (PCS), personal assistance services and/or Habilitation in CFC, and, for the MDCP STAR Kids Respite Care, Supported Employment, Employment Assistance, Flexible Family Support Services, Adaptive Aides, and Minor Home Modifications. The three options are:

1. Consumer directed services option;
2. Service responsibility option; and
3. agency model

The MCO must provide information, including the risks and benefits about the three options to all eligible Members.

In addition to providing information concerning the three options, the MCO must provide Member orientation in the option selected by the Member. The MCO must provide information regarding all available options:

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1. At initial assessment;
2. At annual reassessment or annual contact with the Member;
3. At any time when a Member requests the information; and
4. In the Member Handbook.

The MCO must contract with Providers who are able to offer PCS, in-home or out-of-home respite, Community First Choice services, Supported Employment, and Employment Assistance and must also educate or train the MCO Network Providers regarding the three options. Network Providers must meet licensure or certification requirements as indicated in **Section 8.3.2**.

8.1.37.1 Consumer Directed Services Option

Consumer Directed Services (CDS) is a service delivery option in which a Member or Member's LAR employs and retains service providers and directs the delivery of PCS and respite services. In the CDS Model the Member or the Member's LAR is the employer of record and retains control over the hiring, management, and termination of an individual providing PCS or in-home or out-of-home respite. The Member or Member's LAR is responsible for assuring that the employee meets the qualifications and requirements for PCS or in-home or out-of-home respite. The Member 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 on being an employer, verifying provider qualifications (including criminal history and registry checks), and approving the budget. The MCO may not negotiate the "Consumer Payment Rates" that are used to determine the Member's budget and Service Plan for services delivered through the CDS option. The MCO must calculate the Member's budget and Service Plan using the "Consumer Payment Rates for Determining the Consumer's Budget" proxy rates adopted by HHSC, times the number of units authorized during the budget and Service Plan period. The FMSA must be qualified to perform these services, by having completed the mandatory FMSA enrollment training and becoming part of an existing MCO's network.

8.1.37.2 Service Responsibility Option

In the service responsibility option (SRO), the Member or the Member's LAR is actively involved in choosing his or 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 selects the personal attendant or respite provider from the HCSSA's personal assistance employees. The personal attendant's or respite provider's schedule is set up based on the Member input, and the Member manages the PCS or in-home or out-of-home respite. The Member retains the right to supervise and train the personal attendant. The Member 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 PCS or in-home or out-of-home respite. The MCO

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contracts with HCSSAs that are the employer or contractor of record for the attendant or nurse. In this model, the Member selects the attendant or nurse from the MCO's Provider Network. The attendant or nurse schedule is set up based on the Member's input, and the Member manages the attendant services or Nursing Services. The Member retains the right to supervise and train the attendant or nurse. The Member 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.

8.1.37.3 Agency Option

In the Agency Option, 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.

8.1.38 Service Coordination

8.1.38.1 Service Coordination Description

Service Coordination provides the Member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using Covered Services and other supports to enhance the Member's well-being, independence, integration in the community, and potential for productivity. MCO must ensure that Service Coordination is used to:

1. Provide a holistic evaluation of the Member's individual dynamics, needs and preferences.
2. Educate and help provide health-related information to the Member, the Member's LAR, and others in the Member's Support Network;
3. Help identify the Member's physical, behavioral, functional, and psychosocial needs;
4. Engage the Member and the Member's LAR and other caretakers in the design of the Member's Individual Service Plan (ISP);
5. Connect the Member to Covered and non-covered services necessary to meet the Member's identified needs;
6. Monitor to ensure the Member's access to covered services is timely and appropriate;
7. Coordinate Covered and non-Covered Services; and
8. Intervene on behalf of the Member if approved by the Member.

8.1.38.2 Individual Service Plan Description

Each STAR Kids MCO must create and regularly update a comprehensive Person-Centered Individual Service Plan (ISP) for each STAR Kids Member, unless the Member or Member's LAR declines the STAR Kids Screening and Assessment Process as

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described in **Section 8.1.39**. The purpose of the ISP is to articulate assessment findings, short and long-term goals, service needs, and Member preferences. The MCO must use the ISP to communicate and help align expectations between the Member, their LAR, the MCO and key service providers. The MCO must use the ISP to measure Member outcomes over time. The MCO must ensure that all ISPs must contain the following information:

1. A summary document describing the recommended service needs identified through the STAR Kids Screening and Assessment Process;
2. Covered Services currently received;
3. Covered Services not currently received, but that the Member might benefit from;
4. A description of non-covered services that could benefit the Member;
5. Member and family goals and service preferences;
6. Natural strengths and supports of the Member including helpful family members, community supports, or special capabilities of the Member;
7. With respect to maintaining and maximizing the health and well-being of the Member, a description of roles and responsibilities for the Member, their LAR, others in the Member's Support Network, key service providers, the Member's Health Home, the MCO, and the Member's school, if applicable;
8. A plan for coordinating and integrating care between Providers and Covered and Non-Covered Services;
9. Short and long-term goals for the Member's health and well-being;
10. If applicable, services provided to the Member through YES, TxHmL, DBMD, HCS, CLASS, or third-party resources, and the sources or providers of those services;
11. Plans specifically related to transitioning to adulthood for Members age 15 and older; and
12. Any additional information to describe strategies to meet service objectives and Member goals.

The MCO must ensure that the ISP is informed by findings from the STAR Kids Screening and Assessment Process, in addition to input from the Member; their family and caretakers; Providers; and any other individual with knowledge and understanding of the Member's strengths and service needs who is identified by the Member, the Member's LAR, or the MCO. To the extent possible and applicable, the MCO must ensure that the ISP accounts for school-based service plans and service plans provided outside of the MCO. The MCO is encouraged to request, but may not require the Member to provide a copy of the Member's Individualized Education Plan (IEP).

8.1.38.3 ISP Requirements

The MCO must update each Member's ISP:

1. at least annually;
2. following a significant change in health condition that impacts service needs;
3. upon request from the Member or the Member’s LAR;
4. at the recommendation of the Member's PCP;
5. following a change in life circumstance; and
6. following the STAR Kids Screening and Assessment Process or re-assessment process.

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Except for STAR Kids MDCP Members, see requirements below in **Section 8.3**, for new Members, the MCO must complete the narrative ISP, titled Individual Service Plan - Narrative Form, no later than 90 Days following completion of the STAR Kids Screening and Assessment Process, as described in **Section 8.1.39**. For current Members, the MCO must update the narrative ISP no later than 60 Days following completion of the STAR Kids Reassessment, as described in **Section 8.1.39.1**. As described in Section 8.1.38.7, for each Member to whom the Service Coordinator is assigned and no less than twice per year, the named Service Coordinator must review the Member's ISP to determine if updates are required. The MCO must provide a printed or electronic copy of the ISP to each Member or the Member's LAR following any significant update and no less than annually. Upon request, the MCO must provide a copy of the ISP to the Member's providers and other individuals specified by the Member or Member's LAR. The MCO must give the completed ISP, including the Individual Service Plan - Narrative Form and, if applicable, the Individual Service Plan - Service Tracking Tool, in the format that the Member or Member's LAR requests. The MCO must write the ISP in plain language that is clear to the Member or the Member's LAR and must be furnished in Spanish or languages of other Major Population Groups, if requested. The named Service Coordinator is responsible for examining the ISP for all Level 1 and 2 Members prior to a face-to-face visit and for ensuring the document is up-to-date, and adequately reflects the Member's status, goals, preferences, and needs. The MCO is responsible for developing a strategy to ensure the ISP is closely reviewed and monitored on a regular basis for all Level 3 Members. If the Member has an ISP, the named Service Coordinator or a representative of the MCO must review and update each Member's ISP with the Member and their LAR no less than annually during a face-to-face visit.

The MCO must complete the ISP in an electronic format compliant with HHSC requirements, including the HHSC companion guides and business rules. The MCO must provide HHSC with information from the ISP upon request, in the format prescribed by HHSC. The MCO must retain all previous versions of the ISP in the Member's file for a period of no less than 5 years. HHSC may use information collected in the ISP to measure the quality of Service Coordination and overall care.

8.1.38.4 Service Coordination Structure

Through Service Coordination and other methods determined appropriate by the MCO, the MCO must implement a systematic process to coordinate Non-capitated Services and, if determined advantageous to the Member, enlist the involvement of community organizations providing non-covered services that are important to the health and well-being of Members. The MCO also must also seek to establish relationships with state and local programs and community organizations, such as the following, to make referrals for Members who need community services.

1. Peer supports and Family Partners for Behavioral Health conditions;
2. Community Resource Coordination Groups (CRCGs);
3. Early Childhood Intervention (ECI) Program;
4. Local school districts (Special Education);
5. HHSC Medical Transportation Program;

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6. Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program;
7. Department of State Health (DSHS) services, including community mental health programs, the Title V Maternal and Child Health, Case Management for Children and Pregnant Women, Children with Special Health Care Needs (CSHCN) Programs, and Youth Empowerment Services (YES) HCBS Waiver;
8. Supplemental Nutrition Assistance Program (SNAP), the Women, Infants, and Children's (WIC) Program, and Head Start;
9. Department of Aging and Disability Services (DADS) HCBS Waivers, including Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and Home and Community-based Services (HCS);
10. Civic and religious organizations and consumer and advocacy groups, such as Easter Seals and the Arc, that also work on behalf of specific Member populations; and
11. Texas Department of Family and Protective Services (DFPS) Nurse Family-Partnership (NFP).

To assure coordination between programs for all STAR Kids Members who are enrolled in DADS or DSHS HCBS Waivers, the named STAR Kids Service Coordinator must communicate regularly with the DADS or DSHS staff members or contractors responsible for overseeing the Member's HCBS Waiver services.

All STAR Kids MCOs must provide dedicated toll-free service coordination phone numbers. These numbers, if not regional, must have the capabilities of warm transferring to the MCO's regional office. These numbers must have the capability for a Member, their family, or a Provider to leave a message between 5 p.m. and 8 a.m. Central Time on weekdays and on weekends. Any messages must be returned within two Business Days. If the number transfers to another MCO hotline after normal business hours, the caller must be able to leave a message for the service coordination team and the message must be returned within two Business Days.

As described in **Attachment A, Section 4.04.1**, an integrated Health Home may perform Service Coordination functions, and serve as an identified Service Coordinator.

8.1.38.5 Service Coordination Teams

Service Coordination teams are Member-centered support networks designed to enhance services provided by the Service Coordinator. Service Coordination team members must be individually selected based on the needs and preferences of the Member. The MCO will provide a Service Coordination team when the MCO or a Provider determines the Member could benefit from a multidisciplinary approach to Service Coordination or determines specific expertise is necessary to address needs identified in the Member's ISP. Service Coordination teams must be led by at least one Service Coordinator employed by the MCO, or appropriate Health Home employee, if the Member receives Service Coordination through their Health Home. If a Member has a named Service Coordinator, the named Service Coordinator must lead the Service

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Coordination team. Service Coordination teams must have access to individuals with expertise or access to identified subject matter experts in the following areas:

1. Behavioral health
2. Co-occurring behavioral health conditions and IDD
3. Medically complex conditions
4. Substance use disorder
5. Local resources (e.g., basic needs like housing, food, utility assistance)—MCOs are encouraged to use certified Community Health Workers to support individuals in local areas
6. Pediatrics
7. Long Term Services and Supports (LTSS), including HCBS Waiver programs
8. Durable Medical Equipment (DME)
9. End of life/advanced illness
10. Curative treatment or palliative care
11. Acute care
12. Preventive care
13. Cultural competency based on National Standards for Culturally and Linguistically Appropriate Services (CLAS)
14. Pharmacology
15. Nutrition
16. Consumer Directed Services
17. Texas Promoting Independence strategies such as diversion and relocation
18. Person-Centered Planning
19. Family Partners
20. Peer Supports
21. Positive behavior support
22. Assistive Technology including augmentative communication and seating and positioning
23. Supported employment
24. Permanency planning
25. School transition

A Member’s interaction with a Service Coordination team must be tied to the level and frequency of coordination desired by the Member and the Member's LAR and appropriate to the Member's needs. The named Service Coordinator responsible for leading the Service Coordination team must work with the team to ensure the team addresses objectives identified in the Member's ISP.

All Members who receive LTSS through a Nursing Facility, the ICF/IID program, or through Non-capitated HCBS Waiver programs must be offered access to a Service Coordination team that includes representatives from the Member's STAR Kids MCO, and at least one coordinator representing the Member’s non-capitated LTSS. All STAR Kids MCO representatives on a Service Coordination team must work in collaboration with other members of the Service Coordination team to ensure the Member receives adequate and appropriate Covered and non-covered services.

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8.1.38.6 Service Coordination Levels

The MCO must furnish a named Service Coordinator to all Members who request one. The MCO must also furnish a named Service Coordinator to a Member when the MCO determines one is required through an assessment of the Member's health and support needs.

The MCO must notify in writing, unless the Member/LAR specifies another medium, the Member of:

1. The name of the Member's Service Coordinator;
2. The phone number of the Member's Service Coordinator;
3. The minimum number of contacts the Member will receive every year; and
4. The types of contacts the Member will receive.

As specified in **Sections 8.1.38.6.1** and **8.1.38.6.2** below, Members receiving Level 1 or Level 2 Service Coordination must have a single, identified person as their assigned Service Coordinator. The MCO must notify a Member within five Business Days in writing of the name and phone number of the Member's new Service Coordinator, if their Service Coordinator changes. The MCO must also post the new Service Coordinator's information on the MCO portal within the same time period.

The MCO will have three tiers of Service Coordination and will assign Members to the appropriate tier based on the Member's level of need. The MCO may use a Health Home employee as the named Service Coordinator.

Each MCO must develop and submit a Service Coordination plan to HHSC during Readiness Review. The Service Coordination plan must address service planning for Members from all Service Coordination levels. If the MCO fails to meet the Service Coordination performance standards in **Attachment B-3**, HHSC may impose liquidated damages as provided in that matrix.

MCOs must provide the following for all STAR Kids Members:

1. A description of Service Coordination;
2. A phone number to contact if the Member needs Service Coordination or is experiencing problems with Service Coordination;
3. The name of the Member's Service Coordinator, if applicable;
4. The phone number and electronic method of contract, such as a portal or secure email, of the Member's named Service Coordinator or information on how to reach a Service Coordinator if the Member does not have a named Service Coordinator;
5. The minimum number of contacts the Member will receive every year;
6. The types of contacts the Member will receive and instructions on how to request additional Service Coordination assistance at any time; and
7. How to access a Member Advocate if the Member has complaints about a Service Coordinator.

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If the named Service Coordinator changes, the MCO must notify Members within five Business Days of the name and phone number of their new Service Coordinator. Within the same time period, the MCO must also post the new Service Coordinator's information on the portal or website Members use to obtain plan information.

The MCO must determine the level of Service Coordination for each Member based on findings from communication with the Member, the Member's LAR, and the relevant service Providers. The MCO, once such determination has been made, will provide the level of Service Coordination based on the following guidelines:

8.1.38.6.1 Level 1 Members

Level 1 Members include the following Member types:

1. MDCP STAR Kids Members
2. Members with Complex Needs or a history of developmental or behavioral health issues (multiple outpatient visits, hospitalization, or institutionalization within the past year)
3. Members with SED or SPMI.
4. Members at risk for institutionalization.

All Level 1 Members must receive a minimum of four face-to-face Service Coordination contacts annually, in addition to monthly phone calls, unless otherwise requested by the Member or Member's LAR.

If an MDCP STAR Kids Member does not utilize an MDCP service for one month, the MCO must make contact with the Member or Member's LAR by the end of the following month to ensure the Member is receiving any medically necessary services. This contact can serve as the required monthly telephonic contact. The MCO must document the contact and any action taken with regard to either waiver or State Plan Medicaid services including referrals, service changes, or other follow-up resulting from the contact in the Member's case file.

The minimum utilization of an MDCP service required to maintain MDCP eligibility is dependent upon the Member's Medicaid eligibility and whether they utilize Community First Choice (CFC) as described in the STAR Kids Handbook.

MCOs must provide a Level 1 Member with a named Service Coordinator.

8.1.38.6.2 Level 2 Members

Level 2 Members include the following Member types:

1. Members who do not meet the requirements for Level 1 classification but receive Personal Care Services (PCS), Community First Choice (CFC), or Nursing Services, including PDN and PPECC.

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2. Members the MCO believes would benefit from a higher level of service coordination based on results from the STAR Kids SAI and additional MCO findings.
3. Members with a history of substance use disorder (multiple outpatient visits, hospitalization, or institutionalization within the past year).
4. Members without SED or SPMI, but who have another behavioral health condition that significantly impairs function.

All Level 2 Members must receive a minimum of two face-to-face and six telephonic Service Coordination contacts annually, unless otherwise requested by the Member or Member's LAR.

MCOs must provide a Level 2 Member with a named Service Coordinator.

8.1.38.6.3 Level 3 Members

Level 3 Members include those who do not qualify as Level 1 or Level 2. The MCO must provide access to Service Coordination services to all Level 3 Members.

All Level 3 Members must receive a minimum of one face-to-face visit annually and make at least three telephonic Service Coordination outreach contacts yearly.

At the Member's request, the MCO must provide Level 3 Members with a named Service Coordinator. In addition, the MCO must provide a named Service Coordinator for Members who qualify for Level 3 who reside in a NF or community-based ICF-IID, or are served by one of the following 1915(c) waivers: CLASS, DBMD, HCS, or TxHmL.

8.1.38.7 Service Coordinator Roles and Responsibilities

The purpose of a Service Coordinator is to maximize a Member's health, wellbeing, and independence. Service Coordination should consider and address the Member's situation as a whole, including his or her medical, behavioral, social, and educational needs. The Service Coordinator must work with the Member's PCP to coordinate all Covered Services, Non-capitated Services, and non-covered services available through other sources. This requirement applies regardless of whether the PCP is in the MCO's Network. In order to integrate the Member's care while remaining informed of the Member's needs and condition, the Service Coordinator must actively involve the Member's primary and specialty care Providers, including Behavioral Health Service Providers, and Providers of Non-capitated Services and non-covered services. When families request information regarding a referral to a Nursing Facility or other long-term care facility, the MCO must inform the Member and family about options available through home and community-based service programs, in addition to facility-based options.

The MCO may allow a Member to receive Service Coordination through an integrated Health Home if the individual providing Service Coordination and the Service Coordination structure meet STAR Kids program requirements. The MCO must reimburse a Health Home that provides Service Coordination to its Members through an

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enhanced rate structure, a per-member-per-month fee, or other reasonable methodology agreed to between the MCO and Health Home. The MCO must employ Service Coordinators who are experienced in meeting the needs of vulnerable populations who have Chronic or Complex Conditions. Service Coordination personnel and management must have expertise in pediatric care and pediatric developmental challenges, in addition to physical and behavioral health challenges. Service Coordinators that serve STAR Kids Members must be solely dedicated to serving STAR Kids Members. The MCO must pair a Member with a Service Coordinator who has appropriate experience relating to the individual Member's needs. Service Coordinator managers are Key MCO Personnel as described in **Attachment A**.

The MCO must maintain a sufficient number of Service Coordination personnel and management to ensure the timely completion of assessments and Individualized Service Plans and the successful coordination of services as required by **Sections 8.1.38.1** and **8.1.38.2**. The MCO must ensure that Service Coordinator-to-Member ratios are clinically appropriate and evidence-informed. A named Service Coordinator must attend at least 75 percent of face-to-face meetings between the MCO and the Member. For each Member to whom the Service Coordinator is assigned and no less than twice per year, the named Service Coordinator must review the Member's ISP to determine if updates are required. A named Service Coordinator must return Member phone calls and e-mails within two Business Days. If a named Service Coordinator is unavailable due to illness or personal leave, the MCO must ensure Members who attempt to contact the named Service Coordinator are provided with the name and contact information of an alternate Service Coordinator.

If a STAR Kids Member does not have a named Service Coordinator, the MCO must ensure a Service Coordinator reviews the Member's ISP no less than twice per year in order to determine if updates are appropriate. The MCO must ensure a Service Coordinator returns a phone call received on behalf of a Member seeking service coordination within two Business Days.

The MCO must continuously monitor the staff's ability to complete these functions in a timely and thorough nature and will take corrective action as necessary. Member and Provider feedback must also be measured by the MCO in reviewing Service Coordination outcomes.

The MCO must maintain a sufficient number of regional offices in which Service Coordinators 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. All STAR Kids MCOs must provide dedicated toll-free Service Coordination phone numbers. If the caller requests to speak to a named Service Coordinator, this number must warm transfer callers to the named Service Coordinator.

The MCO must provide access to ongoing training and continuing education for Service Coordinators. Service Coordinator training should include focus on evidence-based best practices in case management for children and young adults with disabilities; Person-Centered Planning; and Cultural Competency.

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As described in **Sections 8.1.38.6.1**, **8.1.38.6.2**, and **8.1.38.6.3**, all STAR Kids Members must receive a minimum of one face-to-face annual visit. The timing of the annual visit, other required visits, and other required telephonic contacts, as determined by the Member's Service Coordination level, may be counted from the date the MCO completes the initial assessment. A face-to-face visit may be coordinated to coincide with the annual STAR Kids Reassessment, as described in **Section 8.1.39.1**. For Level 1 and Level 2 Members, the MCO must ensure that the named Service Coordinator attends the annual STAR Kids Reassessment. The named Service Coordinator must attend at least 75 percent of face-to-face visits.

During the face-to-face visit, the Service Coordinator must:

1. Review the Member's current short-term and long-term goals and objectives, as documented in the ISP;
2. Acknowledge and document goals and objectives that the Member has achieved or with which the Member has made progress;
3. Acknowledge and document goals and objectives that may need to be adjusted;
4. Develop new goals and objectives with input from the Member, Member's family, and Member's providers;
5. Update the Member's ISP;
6. Educate the Member and Member's LAR about their rights regarding acts that constitute Abuse or Neglect (CPS) and Abuse, Neglect, or Exploitation (APS);
7. Review Member rights and MCO processes for service authorization, appeals, and complaints; and
8. Provide information to the Member and the Member's parent or LAR regarding nursing service options (e.g., private duty nursing and PPECC), when the Member requires ongoing skilled nursing.

Service Coordinators, must meet the following requirements:

1. A Service Coordinator for a Level 1 Member must be a registered nurse (RN), nurse practitioner (NP), a physician's assistant (PA), a licensed social worker, or licensed professional counselor if the Member's service needs are primarily for behavioral health.
2. A Service Coordinator for a Level 2 Member must be a RN, NP, PA, have an undergraduate or graduate degree in social work or a related field, or be a licensed vocational nurse (LVN) with previous service coordination or case management experience.
3. A Service Coordinator for a Level 3 Member must have a minimum of a high school diploma or GED and direct experience working with children and young adults with similar conditions or behaviors in three of the last five years.
4. Service Coordinators must possess knowledge of the principles of most integrated settings, including federal and state requirements.
5. Service Coordinators must complete a minimum of 16 hours of service coordination training every two years, unless otherwise specified. MCOs must administer the training, which must include:
    a. Information related to the population served;
    b. How to assess Members' medical, behavioral health, and social needs and concerns;

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c. How to assess and provide information to Members related to Employment Assistance and Supported Employment;
d. How to provide Targeted Case Management for Members receiving Mental Health Rehabilitative Services;
e. Consumer Directed Services;
f. Person-Centered Planning;
g. Trauma-informed care;
h. Permanency planning;
i. Behavioral supports;
j. Identifying and reporting Critical Events or Incidents including Abuse, Neglect, or Exploitation and Unexplained Deaths and educating Members regarding protections;
k. For Service Coordinators working with Members receiving STAR Kids MDCP Community Based Long Term Services and Supports (LTSS), this training must be provided before contact with Members served, but no later than 30 days after the date of hire and annually thereafter;
l. Cultural competency based on National Standards for Culturally and Linguistically Appropriate Services (CLAS);
m. Refresher of available local and statewide resources;
n. Refresher of the, standards of documentation, and licensure requirements per Texas Occupational Code, Tex. Admin. Code, and scope of practice requirements as applicable to the LTSS setting;
o. How to complete the nursing facility level of care assessment designated by HHSC per form instructions;
p. How to perform a thorough investigation of third-party resources; and
q. Education for Service Coordinators regarding how to determine Medicare versus Medicaid coverage and how to access internal MCO resources to assist Service Coordinators with determining coverage.

6. Service Coordinators working with Members receiving Community-Based Services, including CFC and STAR Kids MDCP services, must complete within six months of the Service Coordinator's hire date, an HHSC-approved training on Person-Centered practices and Person-Centered plan Facilitation using a trainer certified by the Learning Community for Person-Centered Practices or an HHSC-approved curriculum and trainer. This training is in addition to current Service Coordinator training requirements. Service Coordinators must also receive an HHSC-approved or HHSC-offered Person Centered training refresher course every two years.
7. All Service Coordinators must complete any HHSC-required training.

Service Coordinators are responsible for helping to connect the Member to an extended service network to meet the Member's needs, which may include:

1. Mental health services;
2. Natural support networks;
3. Advocacy groups;
4. Support groups;
5. Recreational services;

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6. Substance use disorder services;
7. Health services;
8. Educational services;
9. Social services;
10. Long-Term Services and Supports;
11. Support services for families;
12. Transition planning for aging out of STAR Kids;
13. Home modification and housing resources;
14. Transportation programs;
15. Vocational services;
16. Juvenile justice system; and
17. THSteps Comprehensive Care Program services.

Members who receive LTSS through a Nursing Facility, the ICF/IID program, or Non-capitated HCBS Waiver programs administered through DADS or DSHS must be provided with access to Service Coordinators that are trained in effectively working with individuals with intellectual or developmental disabilities. For the purposes of coordinating with waiver service providers, Members enrolled in DADS waiver programs must be provided with a named Service Coordinator. STAR Kids Members who receive services through the YES Waiver must be assigned a named Service Coordinator, as described in **Section 8.1.38.6**, with training and experience in serving children and young adults with SED. For all Members also enrolled in a HCBS Waiver program, except MDCP STAR Kids Members, the MCO must provide all Medicaid Covered Services not otherwise approved through an HCBS program. The STAR Kids Service Coordinator must engage with other entities and individuals involved with a Member's HCBS Waiver program. As part of this process, the STAR Kids Service Coordinator must facilitate an ongoing exchange of information with individuals or entities responsible for coordinating, implementing, and monitoring HCBS Waiver services. To help facilitate this process HHSC will furnish MCOs with initial service plan information for members who receive HCBS Waiver services within 90 Days of the STAR Kids Operational Start Date. Additional information on individuals and entities involved with each HCBS waiver program is available in the Procurement Library.

In accordance with the requirements in **UMCM Chapter 16.1.15.1**, the MCO must share and integrate care coordination and services authorization data internally and, if applicable, between the MCO and the third party or subsidiary contracted with the MCO to manage Behavioral Health Services. MCOs must implement joint rounds for physical health and Behavioral Health Services Network Providers, or implement another effective means for sharing clinical information. MCOs must, to the extent feasible, co-locate physical health and behavioral health care coordination staff and must ensure warm call transfers between physical health and behavioral health care coordination staff.

8.1.38.7.1 CDS Information Sharing

The Service Coordinator is responsible for annually providing any Member who receives PCS, respite services, or Supported Employment or Employment Assistance with information regarding the Consumer Directed Services (CDS) model including the option

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to choose between the CDS, SRO, and Agency option. The Service Coordinator must inform the Member or the Member's LAR about the responsibilities of the employer and FMSA under the CDS model. The Service Coordinator must present the Member or the Member's LAR with a list of contracted FMSA providers. The Service Coordinator must document the Member or Member's LAR's decision on whether to use the CDS option in the ISP and, if elected, provide required materials to the selected FMSA. The Service Coordinator must also provide the FMSA with the authorized schedule of applicable services.

8.1.38.8 Adult Transition Planning

The MCO must help to assure that teens and young adult Members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. Each MCO is responsible for conducting ongoing transition planning starting when the Member turns 15 years old. The MCO must provide transition planning services as a team approach through the named Service Coordinator, if applicable, and with a Transition Specialist within the Member Services division. Transition Specialists must be an employee of the MCO and wholly dedicated to counseling and educating Members and others in the Members' support network about considerations and resources for transitioning out of STAR Kids. Transition Specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the Member in the transition process. Transition planning must include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service.
2. Prior to the age of 10, **the MCO must inform** the Member and the Member's LAR regarding LTSS programs offered through the Department of Aging and Disability Services (DADS) and, if applicable, provide assistance in completing the information needed to apply. DADS LTSS programs include CLASS, DBMD, TxHmL, and HCS.
3. Beginning at age 15, the MCO must regularly update the ISP with transition goals.
4. Coordination with DARS to help identify future employment and employment training opportunities.
5. If desired by the Member or the Member's LAR, coordination with the Member's school and Individual Education Plan (IEP) to ensure consistency of goals.
6. Health and wellness education to assist the Member with self-management.
7. Identification of other resources to assist the Member, the Member's LAR, and others in the Member's support system to anticipate barriers and opportunities that will impact the Member's transition to adulthood.
8. Assistance applying for community services and other supports under the STAR+PLUS program after the Member's 21st birthday.
9. Assistance identifying adult healthcare providers.

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8.1.38.9 Referral to Community Organizations

The MCO must provide information about, and refer the Member to, community organizations that may not be providing Covered Services, but are otherwise important to the health and well-being of Members. These organizations include the following:

1. State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance use disorder, mental health/intellectual or developmental disabilities, rehabilitation, income support, nutritional assistance, family support);
2. Social service agencies (e.g., residential support agencies, disability groups, centers for independent living, supported employment agencies, Aging and Disability Resource Centers, local intellectual disability authorities);
3. City and county agencies (e.g., welfare departments, housing programs);
4. Civic and religious organizations;
5. Family support agencies; and
6. Consumer groups, advocates, and councils (e.g., legal aid offices, consumer or family support groups, permanency planning).

8.1.38.10 Discharge Planning

The MCO must provide discharge planning, transition care, and other education programs to Network Providers regarding all available long-term care settings and options. The MCO must have a protocol for quickly assessing the needs of Members discharged from a Hospital or other care or treatment facility, including inpatient psychiatric facilities. On behalf of STAR Kids Members who are hospitalized, the MCO's Service Coordinator must work with the Member's PCP, the Hospital or inpatient psychiatric facility discharge planner(s), the attending physician, the Member, and the Member's family to assess and plan for the Member's discharge. The MCO must ensure that both physical and behavioral health needs, including substance use disorder treatment, are assessed. Upon receipt of notice of a Member's discharge from an inpatient psychiatric facility, Service Coordinators must contact the Member within one Business Day. To the extent feasible, the MCO must ensure discharge planning begins before the Member's discharge. Discharge planning must include establishing appropriate service authorizations. When long-term care is needed, the MCO must ensure that the Member's discharge plan includes arrangements for receiving Community-Based Services as appropriate. The MCO must ensure that the Member, the Member's family, and the Member's PCP are well informed of all service options available to meet the Member's needs in the community.

The MCO must also have a protocol for quickly assessing the needs of Members who have or will soon be discharged from a Nursing Facility or ICF-IID. The MCO's assessment must include both physical and behavioral health needs, including substance use disorder treatment. The MCO must assure timely access to Service Coordination and arrange for Medically Necessary or Functionally Necessary PCS or Nursing Services immediately upon the Member's transition from a Nursing Facility or ICF/IID to the community.

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8.1.38.11 Documentation for New STAR Kids Members

Within their system, the MCO must document the services newly enrolled Members are receiving, and upon request report what services Members were receiving upon transition into the MCO. Documentation must include:

1. The Member's history;
2. A summary of current medical, Behavioral Health, and social needs and concerns;
3. Immediate and short-term needs;
4. A list of services required, their frequency; and
5. A description of who will provide these services.

This documentation may include information for services outside the scope of Covered Services, such as how to access affordable, integrated housing.

This documentation process must include the following:

1. Review of existing care plans, ISPs, and covered services received, in addition to the service plan (Individual Plan of Care (IPC)/ISPs) for Members enrolled in MDCP;
2. Preparation of documentation that ensures continuous care under the Member’s existing treatment plan while the STAR Kids MCO conducts appropriate assessments and completes a new or updated ISP;
3. If durable medical equipment or supplies were ordered prior to enrollment but have not been received by the time of enrollment, coordination and follow-through to ensure that the Member receives the necessary supportive equipment and supplies without undue delay;
4. Payment to the existing provider(s) of service under any existing authorization, care plan, or service plan for up to 6 months, until the MCO has completed the STAR Kids Screening and Assessment Process and issued a new authorization and ISP; and

For those already enrolled in the Medicaid program, HHSC or the Member’s previous Medicaid MCO contractor will provide, upon enrollment in STAR Kids, the Member's STAR Kids MCO with information on existing care plans and names of current Providers. HHSC or DADS will also provide the MCO with information concerning Members who will be enrolled through manual processes and will need expedited access to services.

Except as provided below, the MCO must review any existing care plan or ISP and include this information in their system services of care if not received at the time of enrollment. For existing care plans and for ISPs received prior to the Operational Start Date, the MCO will have additional time to complete this process, not-to-exceed 30 Days after the Member’s enrollment or receipt of the plan of care if not received at the time of enrollment.

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Once the Member is enrolled, the STAR Kids MCO must ensure that current Providers are paid for Medically Necessary Covered Services that are delivered in accordance with the Member's existing care plan.

Prior to the Operational Start Date, MCOs must develop a plan that identifies how the MCO will identify and reach out to Members with the most immediate service needs. The plan must outline procedures the MCO will follow to ensure timely assessments for potential enrollees and incoming Members and to provide continuity of care for incoming Members. HHSC will also provide the MCO with information concerning Members who will be enrolled through manual processes and will need expedited access to services.

8.1.38.12 Centralized Medical Record and Confidentiality

The Service Coordinator is responsible for maintaining a centralized record related to Member contacts, assessments, and service authorizations. The MCO must ensure that the centralized Member record meets all applicable professional standards ensuring confidentiality of Member records, referrals, organization, and documentation of information.

The MCO must have a systematic process for generating and receiving referrals and sharing confidential medical, treatment, and planning information across Providers.

8.1.38.13 Participation in Texas Promoting Independence Initiative

The MCO must participate in the Texas Promoting Independence Initiative. The goal of the Texas Promoting Independence Initiative (PI) is to help aged and disabled individuals live in the most integrated setting possible. PI is Texas' response to the U.S. Supreme Court ruling in *Olmstead v. L.C.* 527 U.S. 581 (1999) that requires states to provide Community-Based Services for persons with disabilities who would otherwise be entitled to institutional services, when:

1. The state's treatment professionals determine that the placement is appropriate;
2. The affected persons do not oppose the treatment; and
3. The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported disability services.

In accordance with Section 531.0244, Texas Government Code, the MCO must designate a point of contact to receive referrals for Nursing Facility residents who may be able to return to the community through the use of MDCP or another HCBS Waiver program. To be eligible for this option, an individual must reside in a Nursing Facility until the individual meets the eligibility criteria for entry into MDCP STAR Kids. This will include the development and approval of a written plan of care for safely moving back into a community setting. If a Member chooses to remain in the Nursing Facility and meets Nursing Facility level of care as identified in the Minimum Data Set, the MCO must honor this choice.

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A STAR Kids Member who enters a Nursing Facility or an ICF/IID will remain enrolled in their STAR Kids MCO for the provision of any Covered Services, including those provided through the Comprehensive Care Program, not provided through the facility as part of the daily rate. See **Section 8.1.15** for further information.

When a STAR Kids Member enters a Nursing Facility or an ICF/IID the MCO must:

1. Determine the Member's assigned permanency planner;
2. Contact the Member's assigned permanency planner within seven Days of the Member's facility admission;
3. Collaborate with the Member, the Member's LAR, and the assigned permanency planner to develop a plan of care to transition the Member back to the community;
4. Contact and assess the Member no less than every 90 Days while the Member remains in the facility. As part of the quarterly assessment process the MCO must collaborate with HHSC or an HHSC contracted family-based alternatives provider to work with the Member and the Member's family to review community-based options;
5. Work with the Member, the Member's LAR, and the assigned permanency planner in the development of a transition plan when a Member is discharged from the facility. The transition plan must include the Member's applicable service needs, including their physical and behavioral health (e.g., both mental health and substance use disorder services).

The MCO will provide these services as part of the PI. The MCO must maintain documentation of the assessments completed as part of this PI and make them available for state review at any time.

8.1.38.14 STAR Kids Coordination of Services for Dual Eligibles

The STAR Kids program is intended to coordinate program services for Dual Eligible recipients. To facilitate coordination, HHSC encourages the MCO to contract with CMS and operate as a MA Dual SNP in the most populous counties in the Service Area(s) or as a Dual Eligible Medicare-Medicaid Plan (MMP) in the designated demonstration counties. STAR Kids MCOs that are not MA Dual SNPs or an MMP must coordinate care for Dual Eligibles to the fullest extent possible. Additional requirements regarding certain categories of Dual Eligibles are described in **Section 8.2**.

8.1.38.15 Section 811 Project Rental Assistance

The MCO Service Coordinator must coordinate with the Section 811 Project Rental Assistance (PRA) Program point of contact on an ongoing basis, as needed, in accordance with their role as the Section 811 Service Coordinator for Members with disabilities exiting a Nursing Facility and receiving services from the Section 811 PRA program.

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8.1.38.16 Community First Choice Eligibility

Recipients of Community First Choice services must meet level of care criteria for participation and must have a plan of care at initial determination of eligibility. Members needing services provided through Community First Choice must be tested for eligibility before those services are provided through other STAR Kids Community LTSS.

8.1.38.16.1 For Members with Physical Disabilities

To be eligible for the Community First Choice services, the Member must be eligible for Medicaid and meet Medical Necessity/Level of Care criteria.

The MCO must complete the STAR Kids Screening and Assessment Instrument, and submit the form to HHSC's Administrative Services Contractor. The MCO is also responsible for completing the assessment documentation, and preparing a service plan identifying the needed Community First Choice services, as well as any additional services the Member may benefit from, including the STAR Kids MDCP waiver. The MCO must complete these activities within the timeframe specified by HHSC at a later date.

8.1.38.16.2 For Members with an Intellectual or Developmental Disability

To be eligible for Community First Choice services, the Member must be eligible for Medicaid and meet an institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF-IID). The MCO must review and consider the level of care assessment Local IDD Authority when determining eligibility. The MCO is also responsible for completing the assessment documentation, and preparing a service plan identifying the needed Community First Choice services. The MCO must complete these activities within the timeframe specified by HHSC.

8.1.38.16.3 For Members with Severe and Persistent Mental Illness or Severe Emotional Disturbance

To be eligible for the Community First Choice services, the Member must be eligible for Medicaid and meet an IMD level of care, which is determined by CANS, ANSA LOC 4, or membership in the Youth Empowerment Services (YES) waiver.

The MCO must coordinate with a provider of mental health rehabilitation 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 Community First Choice services, as well as any additional services the Member may benefit from, including the MDCP waiver. The MCO must complete these activities within the timeframe specified by HHSC.

8.1.38.16.4 Eligibility

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The MCO will notify the Member of the eligibility determination, which will be based on results of the assessments. If the STAR Kids Member is eligible for Community First Choice services, the MCO will notify the Member of the effective date of eligibility. If the Member is not eligible for Community First Choice services, the MCO will provide the Member information on the right to appeal the determination, including access to HHSC's State Fair Hearing process. The MCO is responsible for preparing any requested documentation regarding its assessments and service plans and attending the State Fair Hearing.

8.1.38.16.5 Annual Reassessment

The MCO is responsible for tracking the renewal dates to ensure all Member reassessment activities are completed. Before the end date of the annual STAR Kids Screening and Assessment Instrument; before the end of the 12th month after the previous assessment was completed for Members with intellectual or developmental disabilities; or members with severe and persistent mental illness or severe emotional disturbance, the MCO must initiate an annual reassessment to determine and validate continued eligibility for Community First Choice services for each Member receiving these services. As part of the assessment, the MCO must inform the Member about Consumer Directed Services options. The MCO will complete the same activities for each annual reassessment as required for the initial eligibility determination.

8.1.39 STAR Kids Initial Screening and Assessment Process

The MCO must conduct an initial telephonic Member screening for all new Members. The telephonic screening must be used to help the MCO prioritize which Members require the most immediate attention. The MCO must also review claims data to prioritize Members who may need the most immediate assistance. For all Members who are new to the STAR Kids MCO on the Operational Start Date of the STAR Kids program, the STAR Kids MCO may take up to 15 Business Days for the initial telephonic Member screening unless notified by the Member, LAR, or Member's PCP by phone or in writing of a more urgent need. Members who enroll in STAR Kids six months after the Operational Start Date or later must receive the initial telephonic Member screening within ten Business Days from the day the Member is enrolled with the MCO.

The MCO must make at least three efforts to contact new Members telephonically. If an MCO is unable to reach a Member or a Member’s LAR by telephone, the MCO must mail written correspondence to the Member and Member’s LAR explaining the need to contact the MCO and requesting that the Member or Member’s LAR contact the MCO as soon as possible.

As a part of the telephonic communication with the Member or Member’s LAR, or through written materials provided by the MCO to the Member, the MCO must inform the Member about the STAR Kids Screening and Assessment Process and include the following details:

1. Information on the purpose and goals of the STAR Kids Screening and Assessment Process;

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2. The estimated timeframe it will take to complete the STAR Kids Screening and Assessment Instrument (SAI);
3. Information the family should be prepared to discuss as a part of STAR Kids Screening and Assessment Process including medication information, diagnoses, current services, and general questions and concerns.

In addition to the initial telephonic Member screening, all STAR Kids MCOs are responsible for conducting a comprehensive, holistic, and evidence-based service needs assessments for all Members. This process will be known as the "STAR Kids Screening and Assessment Process" and must help to inform or identify:

1. Service Coordination Level;
2. Service preferences and goals for the Member and the Member's LAR;
3. Natural strengths and supports such as Member abilities or helpful family members;
4. Non-capitated services and community supports that the Member already receives or that would be beneficial to the Member;
5. Members requiring immediate attention;
6. Members who need LTSS;
7. Members with behavioral health needs;
8. Members who need physical, occupational, speech, or other specialized therapy services;
9. Members who require durable medical equipment and medical supplies;
10. Members who currently receive and those who meet functional criteria to receive MDCP STAR Kids or HCBS Waiver services;
11. Members who need Personal Care Services;
12. Members who need Nursing Services, including Home Health Skilled Nursing, Private Duty Nursing, and Nursing Services offered through a Prescribed Pediatric Extended Care Center.

The MCO must prioritize how quickly individual Members receive the STAR Kids SAI based on urgency identified through the initial telephonic screening and claims data. The initial telephonic screening must include HHSC-approved screening questions to determine if the Member has historical or potential nursing needs that would necessitate the STAR Kids SAI to be conducted by an RN. If the Member or the Member's LAR declines the SAI process, the MCO must document this in the Member's case file. The MCO must explain that Member refusal to participate in the SAI process may impair the MCO's ability to identify and provide Covered Services that the Member does not currently access for which the Member has a need. The MCO will not be required to meet timelines outlined below for Members who have refused the SAI if the Member Refusal is documented or if the MCO is unable to reach the Member. A Member is determined unable to reach when an MCO has completed all required attempts to contact or locate a Member or Member's LAR but has been unable to contact or locate the Member or the Member's LAR. All attempts to contact or locate a Member or Member's LAR must be documented by the MCO. Immediately following the STAR Kids Operational Start Date, and for those enrolled within the first 6 months, Members must receive the face-to-face STAR Kids SAI within the following timelines:

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The MCO must assess all Priority 1 Members within seven Business Days of requesting services. The MCO must assess all Priority 2, Priority 3, and Priority 4 Members within six months of the Operational Start Date. Within that six-month period, the MCO must schedule assessments according to priority level, assessing Priority 2 Members first and Priority 4 Members last.

1. Priority 1: Members who become STAR Kids Members after the Operational Start Date and request immediate services.
2. Priority 2: Members with the most urgent or unmet needs for services or service.
3. Priority 3: Members with few unmet needs who are currently receiving the services they require to remain.
4. Priority 4: Members receiving MDCP services, other LTSS, or non-capitated waiver services (including CLASS, DBMD, HCS, TxHmL, and YES services).

Notwithstanding the Member's assigned priority level, the MCO must assess any Member who has experienced a significant change in condition and contacts the MCO to request assessment within 15 Business Days. A change in condition is defined as any physical or mental change that results in either an improvement or decline in the Member's overall health status or level of function. Examples include: inpatient hospitalization; increase or decrease in need of services (nursing, therapies, PCS, etc.); changes in enteral feeding (change from continuous to bolus; bolus to continuous, becomes oral feeding only); change in need for ventilator; new or removal of tracheostomy; need for IV therapy; or change in Member's ability to complete ADLs at age and condition appropriate level.

For all Members enrolled six months after the Operational Start Date, the MCO must attempt to schedule the STAR Kids SAI within 15 Business Days of a new Members' enrollment for Level 1 Members, and within 30 Business Days of a new Member's enrollment for Level 2 and Level 3 Members.

The MCO must ensure:

1. the Member and the Member's LAR are involved in the STAR Kids Screening and Assessment Process;
2. the Member and the Member's LAR are included in the development of the ISP;
3. the Member and the Member's LAR understand and, to the greatest extent possible, are in agreement with the completed ISP; and
4. the Member and the Member's LAR receives a completed copy of the STAR Kids SAI.

As a critical component of the STAR Kids Screening and Assessment Process, the MCO or the MCO's Subcontractor must administer the HHSC designated STAR Kids SAI in an electronic format that will be determined by HHSC. The STAR Kids SAI includes four modules:

1. The Core Module
2. The Personal Care Assessment Module (PCAM)
3. The Nursing Care Assessment Module (NCAM)

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4. The MDCP Module

The MCO must provide the Core Module to all STAR Kids Members. The Core Module will be used to:

1. determine Member preferences;
2. trigger for the PCAM, NCAM, or both;
3. identify follow-up assessment needs;
4. help determine Service Coordination Level; and
5. inform the development of the Member's ISP.

The STAR Kids SAI must be provided in the Member's place of residence, unless otherwise requested by the Member or the Member's LAR. The Member and Member's LAR must be present when the STAR Kids SAI is administered. The STAR Kids SAI will include certain information that must be relayed to the Member and Member's LAR. This information will include information concerning Member rights and responsibilities and Covered Services. More information about the SAI Modules is included in the **Procurement Library.**

Needs identified through the STAR Kids SAI must inform the types of follow-up assessments that must be administered. If determined through the STAR Kids Core Module that PCS or Nursing Services may be appropriate, the MCO must administer the STAR Kids SAI's PCAM module, NCAM module or both the PCAM and the NCAM module.

A registered nurse (RN), advance practice nurse (APRN), physician assistant (PA) social worker (MSW, LCSW, or LBSW), Licensed Professional Counselor if the Member's service needs are primarily for behavioral health, or LVN (with a minimum of one year previous service coordination or case management experience and experience with pediatric clients), must administer the STAR Kids SAI Core Module and PCAM, if needed, and these modules may not be administered by any contracted entity that is or will be providing direct services to the Member. An RN or APRN must administer the STAR Kids 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 have completed the HHSC-approved SKSAI training, and must be certified through the state-approved RUG training found at the Texas State website under "Continuing Education." For quality monitoring purposes, the MCO must submit data collected through the SAI to the HHSC Administrative Services Contractor in the format prescribed by HHSC. The MCO must provide any requested data to HHSC or its Administrative Services Subcontractor in accordance with the terms of this Contract.

The Personal Care Assessment Module (PCAM) must be used to assess Member's need for Functionally Necessary Personal Care Services. MCOs may adapt the PCAM to reflect the MCO's name or distribution instructions, but all other elements must be the same. Instructions for completion must be followed exactly as stated. MCOs will not complete the PCAM for members enrolled in IDD waiver programs.

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The Nursing Care Assessment Module (NCAM) is a module included in the STAR Kids SAI that collects clinical information on a Member's physical condition in order to inform potential Nursing Service needs. MCOs may adapt the NCAM to reflect the MCO's name or distribution instructions, but all other elements must be the same. Instructions for completion must be followed exactly as stated.

If the PCP of a STAR Kids Member submits an order for services to the STAR Kids MCO before the Member has been assessed in-person by the MCO, the MCO must initiate a short-term plan of care for services until the STAR Kids Screening and Assessment Process is complete.

If a current STAR Kids Member is considered by HHSC for entry into the MDCP STAR Kids program, the MCO must use the STAR Kids SAI, including the MDCP Module, for the purposes of gathering and submitting medical information to HHSC or its designee for Medical Necessity determinations.

The STAR Kids SAI will indicate if further screening or evaluation is needed for behavioral health services, physical therapy, occupational therapy, and speech therapy. The MCO may use additional evidence-based assessments or promising practices to further inform these specific behavioral health and therapy services, as well as DME, medical supplies, or any other need identified during the STAR Kids Screening and Assessment Process. The MCO, a Subcontractor, a Local IDD Authority, or a Provider may complete additional assessment instruments, but the MCO remains responsible for the data recorded. To the extent appropriate, MCOs must ensure additional assessment tools administered are either evidence or research-based.

The MCO must coordinate the assessment and gathering of any required documentation in a manner that ensures that the authorization and initiation of a Member's services are in no way delayed and that the Member's access to care is in no way delayed or limited. Failure of the MCO to obtain information required by HHSC or to obtain any additional information that may be requested by the MCO in a particular case, shall not result in any lapse in service, service authorization, or delay in the initiation of any services. The MCO must not require any additional information or documentation that has the effect of creating a delay in, or barrier to, the Member receiving timely and appropriate care or has the effect of depriving any Member of access to such care.

For Members with a physical disability seeking or needing Community First Choice services, the MCO must use the STAR Kids Screening and Assessment Instrument and supply current medical information for Medical Necessity determinations. After the initial service plan is established, it must be completed on an annual basis. The STAR Kids Screening and Assessment Instrument must be completed annually at reassessment. The MCO is responsible for tracking the renewal dates to ensure all Member reassessment activities have been completed and submitted to the HHSC Administrative Services Contractor 30 Days prior to the expiration date of the STAR Kids Screening and Assessment Instrument for Members who are physically disabled. The MCO cannot submit a renewal of the STAR Kids Screening and Assessment Instrument earlier than 90 Days prior to the expiration date of the ISP.

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For all Members who receive Behavioral Health Services, the MCO must encourage participation of both the Member's PCP and Behavioral Health Providers in the assessment and treatment planning process.

If the Member or the Member's LAR indicates an immediate need for Covered Services the MCO must provide appropriate authorizations prior to administering the face-to-face STAR Kids Screening and Assessment Instrument. If at any time prior to conducting the STAR Kids SAI the MCO is notified or becomes aware of an increase in the Member's needs, the MCO must initiate the change based on the urgency of the Member's condition, but no longer than ten Days of becoming aware of the increase in the Member's needs.

Following completion of the STAR Kids SAI, the MCO must review the information populated in the assessment with the Member or Member's LAR for verification and make edits, as appropriate, prior to submitting to the HHSC Administrative Service Contactor. The Service Coordinator must notify the Member or Member's LAR that the STAR Kids SAI will be available on the Member's portal and that they may also request and receive a copy of the SAI. Upon request, the MCO must provide the Member or Member's LAR with a printed or electronic copy of the SAI within seven Days of the request. The MCO must post the results of the STAR Kids SAI to the Member's portal within seven Days of submitting the assessment to the HHSC Administrative Services Contractor. The MCO must provide a summary document on significant findings from the STAR Kids SAI and STAR Kids Screening and Assessment Process to the Member's PCP, if requested. For all Members receiving CFC services, the MCO must provide the CFC provider with a copy of the SAI and ISP in order to comply with person-centered planning requirements.

Based on the functional assessment of a Member's needs, appropriate community-based LTSS must be authorized no later than three Business Days from the date of the assessment. The date on an authorization for community-based LTSS must be no earlier than the date the authorization is sent to a Provider, unless the Provider gives the MCO written consent for an earlier authorization date. The Provider's written consent must be maintained in the Member's case file. Community-based LTSS must be initiated within the timeframes specified in **Section 8.1.3.1**, Appointment Accessibility.

8.1.39.1 STAR Kids Reassessment

No less than once per year, the MCO must re-administer the STAR Kids SAI and make necessary adjustments to the Member's ISP. The MCO may not conduct the SAI earlier than 90 Days prior to the one-year anniversary of the previous SAI. If the MCO determines the Member's health and support needs have not changed significantly within a calendar year of completing the STAR Kids SAI based on utilization records, Member reports, and Provider input, the MCO may administer an abbreviated version of the STAR Kids SAI approved by HHSC. The MCO may not administer the abbreviated STAR Kids SAI more than once every other calendar year and may not administer the abbreviated SAI without previously completing the full STAR Kids SAI. For Members who receive PCS, the MCO must complete reassessments using the PCAM every twelve months and as requested by the Member or the Member's LAR. The PCAM must

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also be completed at any time the MCO determines the Member may require a change in the number of authorized Personal Care Service hours.

Following completion of the STAR Kids SAI, the MCO must review the information populated in the assessment with the Member or Member's LAR for verification and make edits, appropriate, prior to submitting to the HHSC Administrative Service Contactor. The Service Coordinator must notify the Member or Member's LAR that the STAR Kids SAI will be available on the Member's portal and that they may also request and receive a copy of the SAI. Upon request, the MCO must provide the Member or Member's LAR with a printed or electronic copy of the STAR Kids SAI within seven Days of the request. The MCO must post the results of the STAR Kids SAI to the Member's portal within seven Days of submitting the assessment to the HHSC Administrative Services Contractor. The MCO must provide a summary document on significant findings from the STAR Kids SAI and STAR Kids Screening and Assessment Process to the Member's PCP, if requested. For all Members receiving CFC services, the MCO must provide the CFC provider with a copy of the SAI and ISP in order to comply with person-centered planning requirements.

To ensure continuity of care, the MCO must ensure that the Member is reassessed using the STAR Kids SAI prior to the expiration date of the Member's ISP. The MCO must ensure that the reassessment is timed to prevent any lapse in service authorization or program eligibility.

For Members receiving services through the MDCP STAR Kids, the MCO must reassess eligibility annually as described in **Section 8.3.1**.

The MCO must also review and update a Member's ISP under the following circumstances:

1. Upon discharge from an inpatient stay;
2. Upon discharge from a long-term care facility;
3. Upon a significant change in the Member's condition that results in a need for additional or reduced services;
4. Upon notification of a significant change in life circumstance such as a change in family structure, a physical move or death in the family; and
5. Within seven Days of the Member's request.

8.1.39.2 STAR Kids Screening and Assessment Instrument Electronic Application

The MCO must develop and deploy an electronic application to facilitate administration of the STAR Kids Screening and Assessment Instrument (SAI). The application must be optimized for use on a mobile device such a smart phone or tablet. The MCO must design and implement its electronic SAI application in accordance with technical specifications as defined by HHSC. In implementing the electronic application, the MCO must not alter the content of the SAI, including specific wording, item order, algorithms, and question logic.

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8.1.39.3 Change in Condition

Upon notice by a Member, the Member's Authorized Representative, Member's caregiver, Provider, or Service Coordinator of a Change in Condition, the MCO must reassess the Member and authorize appropriate services as soon as possible but no later than 21 Days from notification. The MCO must document the date, and source of notification and any action taken. The MCO must then notify the Member and the Provider delivering the impacted service(s) within 2 Business Days of any determination, including a change in service(s) or denial of service(s) following the reassessment and determination. If the MCO is unable to reach the Member or the Member prefers a later date, the MCO must document the attempts to contact the Member or the Member's preference in the Member's case file. If the Member's Change in Condition jeopardizes the Member's ability to remain safely in the community, the MCO must reassess and authorize necessary services as soon as possible but no later than 7 Days following notification. The MCO must document the date, and source of notification and any action taken. The MCO must then notify the Member and the Provider delivering the impacted service(s) within 2 Business Days of any determination, including a change in service(s) or denial of service(s) following the reassessment and determination. If the MCO is unable to reach the Member or the Member prefers a later date, the MCO must document the attempts to contact the Member or the Member's preference in the Member's case file. If the Member's Change in Condition relates to a medical condition, the MCO may complete the SK-SAI. If the Change in Condition relates to the Member's functional ability, the MCO must complete the appropriate functional assessment modules. If the Change in Condition relates to a Member's caregiver support, and does not impact the result of the original assessment, the MCO must authorize appropriate services and note the change in the Member's case file. The MCO must then notify the Member and the Provider delivering the impacted service(s) of any determination, including a change in service(s) or denial of service(s) within 2 Business Days following the reassessment.

8.1.40 Community-Based Service Providers

8.1.40.1 Training

The MCO must comply with **Section 8.1.4.4** regarding Provider Manual and Provider Training specific to the STAR Kids Program. The MCO must train all Community-Based Service Providers regarding the requirements of the Contract and needs of STAR Kids Members. The MCO must establish ongoing Provider training addressing the following issues at a minimum:

1. Covered Services and the Provider’s responsibilities for providing services to Members and billing the MCO for those services. The MCO must place special emphasis on Community-based LTSS and STAR Kids requirements, policies, and procedures that vary from Medicaid Fee-for-Service and commercial coverage rules, including payment policies and procedures.
2. The transition process of up to 6 months for the continuation of Community-based LTSS for Members receiving those services at the time of program implementation, including provider billing practices for these services and who to contact at the MCO for assistance with this process.

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3. Inpatient Stay Hospital services and the authorization and billing of those services for STAR Kids Members.
4. Relevant requirements of the STAR Kids Contract, including the role of the Service Coordinator;
5. Processes for making referrals and coordinating Non-capitated Services;
6. The MCO's quality assurance and performance improvement program and the Provider's role in the programs; and
7. The MCO's STAR Kids policies and procedures, including those relating to Network and Out-of-Network referrals.

8.1.40.2 Long-Term Care Provider Billing

Long Term Care (LTC) Providers are not required to utilize the billing systems that most medical facilities use on a regular basis. For this reason, the MCO must make accommodations to the claims processing system for these Providers to allow for a smooth transition from traditional Fee-for-Service Medicaid to Managed Care Medicaid. HHSC also encourages MCOs to provide a no-cost alternative for providers to allow billing without the use of a clearinghouse and to include attendant care payments as part of the regular claims payment process.

All STAR Kids MCOs are required to utilize the standardized method of long-term care billing described in the STAR Kids Handbook.

MCOs must require agencies that provide attendant care to conduct unannounced home visits to validate services are being rendered and billed correctly. MCOs must maintain written documentation of these requirements and make available upon request.

8.1.40.3 Rate Enhancement Payments for Day Activity and Health Services

All MCOs participating in the STAR Kids program must allow their Day Activity and Health Services (DAHS) Providers to participate in the STAR Kids Attendant Care Enhancement Program.

The **UMCM** will explain the methodology that the MCO will use to implement and pay the enhanced payments, including a description of the timing of the payments, in accordance with 1 Tex. Admin. Code Chapter 355. In addition to the requirements in **UMCM Chapter 2.1.3**, the MCO must apply vendor holds to participating Providers in accordance with 1 Tex. Admin. Code § 355.101 and recoup enhancement payments made to Providers at HHSC's direction. Additionally, upon HHSC's request, the MCO must provide HHSC with a current list of Network Providers of DAHS.

8.1.40.4 Cost Reporting for LTSS Providers

MCOs must require that LTSS Providers submit periodic cost reports and supplemental reports to HHSC in accordance with 1 Tex. Admin. Code Chapter 355, including Subchapter A (Cost Determination Process), and 1 Tex. Admin. Code § 355.403 (Vendor Hold). If an LTSS Provider fails to comply with these requirements, HHSC will

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notify the MCO to hold payments to the LTSS provider until HHSC instructs the MCO to release the payments.

8.1.41 Substance Use Disorder Benefit

8.1.41.1 Substance Use Disorder and Dependency Treatment Services

Substance use disorder includes substance use disorder and dependence as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

8.1.41.2 Providers And Referrals

MCOs must follow provider requirements at Sections 8.1.3.2, and 8.1.4 for substance use disorder outpatient and residential services, respectively.

MCOs must maintain a Provider education process to inform substance use disorder treatment Providers in the MCO's Network on how to refer Members for treatment.

8.1.41.3 Substance Use Disorder Service Coordination

MCOs must provide specialized Service Coordination to Members with a substance use disorder. MCOs 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. MCOs must also coordinate services with appropriate state agencies, including the HHSC and DFPS and their designees for Members requiring Non-capitated Services. Non-capitated Services include without limitation, services that are not available for coverage under this Contract, state plan, or waiver that are available under the Federal Substance Use Disorder and Prevention and Treatment block grant when provided by a HHSC-funded provider or covered by the DFPS under direct contract with a treatment provider. MCOs must work with appropriate state agencies, including HHSC and DFPS, and providers to ensure payment for Covered Services is available to Out-of-Network providers who also provide related Non-capitated Services when the Covered Services are not available through Network Providers.

8.1.41.4 Member Education and Self-Referral for Substance Use Disorder Treatment Services

MCOs must maintain a Member education process, including hotlines, manuals, policies and other Member Materials, to inform Members of the availability of and access to substance use disorder treatment services, including information on self-referral.

8.1.41.5 Requirements for Medication Assisted Treatment

The MCO must comply with Texas Human Resources Code §32.03115.

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8.1.42 STAR Kids Handbook

The STAR Kids Handbook contains HHSC-approved policies and procedures related to the STAR Kids Program, including policies and procedures relating to the Texas Healthcare Transformation and Quality Improvement Program 1115 waiver. The STAR Kids Handbook includes additional requirements regarding the STAR Kids Program and guidance for the MCOs, the STAR Kids Support Units at DADS, and HHSC staff for administrating and managing STAR Kids Program operations. The STAR Kids Handbook is incorporated by reference into this Contract.

8.1.43 Required Contact with STAR Kids Members

The MCO is required to contact each STAR Kids Member a minimum of four times per calendar year unless the Member or Member's LAR requests less frequent contact and the MCO documents that request. This contact can be done telephonically or in-person depending upon the Member's level of need and preferences. The MCO must document the mechanisms, number and method of contacts, and outcomes within the MCO's Service Coordination system. During at least one of the annual contacts the MCO must remind the Member or the Member's LAR about timeframes and deadlines applicable to filing complaints and appeals.

If a MDCP STAR Kids Member does not utilize an MDCP service for one month, the MCO must make contact with the Member or Member's LAR by the end of the following month to ensure the Member is receiving any medically necessary services. This contact can service as the monthly telephonic contact required in **Section 8.1.38.6**. The MCO must document the contact and any action taken with regard to either waiver or State Plan Medicaid services including referrals, service changes, or other follow-up resulting from the contact in the Member's case file.

The minimum utilization of an MDCP service required to maintain MDCP eligibility is dependent upon the Member's Medicaid eligibility and whether they utilize Community First Choice (CFC) as described in the STAR Kids Handbook.

No later than four weeks following the ISP start date, the Service Coordinator must follow up with the Member or Member's LAR, either face-to-face or telephonically, to ensure that necessary services are in place. The MCO must document the visit. This contact is in addition to required Service Coordination contacts as described in **Section 8.1.38.6**. However, if the Service Coordinator is able to document completion of this required contact, it may be counted as the required Service Coordination contacts as described in Section **8.1.38.6.**

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8.1.45 Facility-Based Care

A STAR Kids Member who enters a Nursing Facility or ICF/IID will remain a STAR Kids Member.

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The MCO will not be responsible for the cost of care provided in a Nursing Facility or ICF/IID.

The MCO must provide Service Coordination and any Covered Services that occur outside of the Nursing Facility or ICF/IID when a STAR Kids Member is a Nursing Facility or ICF/IID resident. Throughout the duration of the Nursing Facility or ICF/IID stay, the STAR Kids MCO must work with the Member and the Member's LAR to identify Community-Based Services and LTSS programs to help the Member return to the community.

HHSC reserves the right to amend the scope of the Contract to include Nursing Facility and Intermediate Care Facility services for STAR Kids Members. If these services are added to the scope of the Contract, HHSC will provide advance written notice and conduct appropriate Readiness Review.

8.1.46 This Section Intentionally Left Blank
8.1.47 Abuse, Neglect, or Exploitation

8.1.47.1 Member Education on Abuse, Neglect, or Exploitation

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.

8.1.47.2 Abuse, Neglect, and Exploitation Email Notifications

The MCO must provide HHSC with an email address to receive and respond to Adult Protective Services (PCS) notifications involving Abuse, Neglect or Exploitation notifications. The MCO must respond to emails received by this email address by providing the information requested by APS within 24 hours of delivery seven Days a week to the MCO’s email address.

8.1.47.3 MCO Training on Abuse, Neglect, and Exploitation

By date of STAR Kids implementation, the 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** regarding Policy Guidance. All newly hired staff who have direct contact with a Member must be trained no later than 30 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.

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8.1.48 Carve-in Readiness

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.

8.1.49 Responsibilities in the Event of a Federal Emergency Management Agency or Governor-Declared Disaster, or Other Emergencies

In the event of a Federal Emergency Management Agency (FEMA) or State of Texas Governor-declared disaster, or other emergencies that are internal, man-made, or natural, the MCO must ensure the care of Members in compliance with the MCO's continuity of Member care emergency response plan (COMCER plan), particularly the care of Members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Covered Services are disrupted or interrupted. Requirements for the COMCER plan and other disaster-related requirements are described in **UMCM Chapter 16**.

The MCO must have a COMCER plan based on a risk assessment for each of the Service Areas in which Services are provided under the Contract, using an "all hazards" approach to respond. An "all hazards" approach focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies, man-made emergencies, or natural disasters. As part of the plan, the MCO must describe the method to ensure that Members are able to see Out-of-Network Providers if Members have a permanent address in FEMA or State of Texas Governor-declared disaster areas, or areas in which internal, man-made, or natural disasters have occurred, and are unable to access Covered Services from Network Providers. The MCO must also describe the method it will use to ensure that prior authorizations are extended and transferred without burden to new Providers if directed by HHSC, and the method by which the MCO will identify the location of Members who have been displaced. Annually, the MCO must conduct exercises carrying out the plan's provisions, evaluate its performance and make necessary updates.

The MCO must coordinate with local emergency management departments or agencies prior to an event to understand local emergency management plans and processes, identify plans to escalate needs through local emergency management departments or agencies, and identify mechanisms for assistance at the local level.

Additionally, the MCO must maintain a continuity of operations business plan which includes a collection of resources, actions, procedures, and information that is developed, tested, and held in readiness for use to continue operations in the event of a major disruption of operations due to a FEMA or State of Texas Governor-declared disaster, or other emergencies that are internal, man-made, or natural. The continuity of operations business plan must address emergency financial needs, essential functions for Member services, critical personnel, and the return to normal operations as quickly as possible.

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During a FEMA or State of Texas Governor-declared disaster, or other emergency that is internal, man-made, or natural, the MCO is required to report to HHSC daily or at an interval determined by HHSC, when requested, on the status of Members and issues regarding Member access to Covered Services.

The MCO/PBM claims system must have the capability to waive edits or allow override of edits by at least ZIP code and county for specific date ranges.

The MCO or its PBM may not use circumstances described in Texas Health and Safety Code § 483.047(b-1) as a justification for rejecting a claim provided the pharmacy or pharmacist meets Texas Health and Safety Code § 483.047(b-1)'s requirements.

8.1.50 CMS Interoperability and Patient Access

Effective January 1, 2021, MCOs are required by federal law to implement and maintain a Patient Access Application Programming Interface (API) and a Provider Directory API using the required Health Level 7 Fast Healthcare Interoperability Resources -based standards.

The MCO must comply with the Patient Access API requirements in 42 C.F.R. § 438.242(b)(5) and the Provider Directory API requirements in 42 C.F.R. § 438.242(b)(6), including the provider directory information specified in 42 C.F.R. § 438.10(h)(1) and (2). More detailed information regarding the federal compliance requirements can be found in the CMS Interoperability and Patient Access Final Rule in the May 1, 2020 issue of the Federal Register (85 FR 25510-01). Additional guidance can also be found in the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program in the May 1, 2020 issue of the Federal Register.

8.1.50.1 Payer–to–Payer Data Exchange

Effective January 1, 2022, the MCO must comply with an individual's request to have the individual's health data transferred from payer to payer.

The rule finalizes the requirements in 42 CFR § 438.62(b)(1)(vi) and (vii) for the creation of a process for the electronic exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 CFR § 170.213.

8.2 Integrated Healthcare Services for Dual-Eligible Members

8.2.1 Medicaid Wrap-Around Services

The STAR Kids MCO may be required to supplement Medicare coverage for STAR Kids Members by providing services, supplies, and outpatient drugs and biologicals that are available under the Texas Medicaid program. There are three categories of Medicaid wrap-around services:

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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 Medicare benefit limitation; and
3. Medicare Services that become a Medicaid expense due to coinsurance (true cross-over claims).

Section 8.2.1.1 includes requirements for Medicaid wrap-around services for outpatient drugs and biological products. **Section 8.2.1.2** includes requirements for Medicaid wrap-around services for LTSS. HHSC will provide advance written notice to the MCOs identifying other types of Medicaid wrap-around services that will become Covered Services, and the effective date of coverage.

8.2.1.1 Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products

STAR Kids 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 STAR Kids Members under a non-risk, cost settlement basis, as described in **Attachment A, Section 10.15**, "Supplemental Payments for Medicaid wrap-around Services for Outpatient Drugs and Biological Products." Refer to **UMCM Chapter 2** for additional information regarding the claims processing requirements for these Medicaid wrap-around services.

8.2.1.2 Long-term Services and Supports

STAR Kids MCOs will supplement the Medicare coverage for STAR Kids members by providing LTSS as Medicaid wrap-around services, including:

1. Community First Choice (CFC) services for qualified members, as specified in **Section 8.1.36.1,** Community First Choice Services Available to Qualified Members
2. Day Activity and Health Services
3. MDCP services for qualified members, as specified in **Section 8.3.** Additional Requirements Regarding the Medically Dependent Children Program (MDCP) STAR Kids
4. Personal Care Services
5. Prescribed Pediatric Extended Care Centers
6. Private Duty Nursing

MCOs may not require a provider to obtain a denial or explanation of benefits from Medicare prior to covering these services.

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8.3 Additional Requirements Regarding the Medically Dependent Children Program STAR Kids

The purpose of Medically Dependent Children Program (MDCP) STAR Kids is to prevent unnecessary placement of an individual in a long-term care facility and to support de-institutionalization of individuals who reside in nursing facilities by providing them with support services in the community. The programmatic goals for MDCP STAR Kids are to:

1. enable children and young adults who are medically dependent to remain safely in their homes;
2. offer cost-effective alternatives to placement in nursing facilities and hospitals; and
3. support families in their role as the primary caregiver for their children and young adults who are medically dependent.

8.3.1 Program Eligibility

MDCP STAR Kids 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. Total enrollment in MDCP is limited to the number of individuals and the amount of state funding approved by the Texas Legislature. For additional information regarding MDCP STAR Kids eligibility MCOs may refer to the STAR Kids Handbook. Individuals may be considered for program entry through an interest list process or following an institutional stay. If an individual being considered by HHSC for MDCP entry is not already a STAR Kids Member, HHSC will provide the individual and the individual's LAR with a list of STAR Kids MCOs in the individual's Service Area. Individuals identified by HHSC will select a MCO. HHSC will provide the selected MCO authorization to perform the STAR Kids SAI, including the MDCP Module. MCOs must schedule and complete the STAR Kids SAI, including the MDCP Module, within 30 Days of notice from HHSC. Once the STAR Kids SAI and MDCP module are complete, the MCO must successfully submit and confirm receipt of results from the SAI to the HHSC Administrative Services Contractor (ASC) within 72 hours. The MCO must submit the ISP no later than 60 Days following the initial notice from HHSC.

If a current STAR Kids Member is considered by HHSC for MDCP entry, the MCO must schedule and complete the STAR Kids SAI, including the MDCP module, within 30 Days of notice from HHSC. Once the STAR Kids SAI and MDCP Module are complete, the MCO must successfully submit and confirm receipt of the results from the SAI to the HHSC ASC within 72 hours. The MCO must submit the ISP no later than 60 Days following the initial notice from HHSC.

To be eligible for MDCP STAR Kids services, an individual must meet disability and medical necessity criteria and other program requirements determined by HHSC or its designee. A determination of medical necessity must be based on information collected as part of the STAR Kids SAI and MDCP Module. A medical necessity determination must be authorized through HHSC or its designee.

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Once enrolled in MDCP STAR Kids, the MCO must ensure medical necessity is reviewed for each Member on an annual basis. Annual assessments for MDCP eligibility must occur at the same time as annual reassessment with the STAR Kids 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 reassess the Member using the STAR Kids SAI and MDCP module 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 STAR Kids MDCP program eligibility. The MCO must submit the ISP Tracking Tool no later than 30 Days prior to the end date of the current ISP on file.

The MCO must provide HHSC ASC with all necessary information needed to determine medical necessity. Refer to the STAR Kids Handbook for additional information regarding MCO expectations related to the medical necessity determination process.

8.3.2 MDCP STAR Kids Covered Services

The MCO must provide MDCP STAR Kids Covered Services, **Attachment B-2**, "Covered Services," to eligible Members. The MCO must contract with Providers with the following qualifications, consistent with any effective MDCP HCBS Waiver. A list of current MDCP Providers is also included in the **Procurement Library**. HHSC may also require the MCO to enroll certain MDCP Providers who agree to the MCO's terms and conditions and are identified by HHSC in its Provider Network, such as Camps for Respite Care. For additional information, see 40 Tex. Admin. Code Chapter 51.

Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	**Licensure and Certification Requirements**
Respite Care	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 early childhood intervention program.

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Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	**Licensure and Certification Requirements**
	Specific licensure requirements apply based on the place of service for respite care. These requirements are as follows. **In-home Respite** HCSSA—licensed by DADS under 26 Tex. Admin. Code Chapter 558 **Nurse**: Skilled care must be performed by a registered nurse or licensed vocational nurse or delegated by a registered nurse. Non-licensed individuals providing delegated skilled tasks must be supervised by a registered nurse. Any delegated skilled care must meet the requirements of the Texas Nursing Practice Act Attendant: The home and community support services agency must employ a respite attendant who must meet the following requirements: 1. Be at least 18 years of age; 2. Have a high school diploma, certificate of high school equivalency (GED credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks; 3. Be trained in CPR and first-aid; 4. Pass criminal history checks; 5. Not be on the Employee Misconduct Registry or Nurse Aide Registry; 6. Not be on the state and federal lists of excluded persons and entities; 7. Be familiar with individual's specific tasks; 8. Not be the individual's spouse; and 9. Must not be the caregiver whether or not the provider is related to the individual. **Out-of-home Respite** **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 (26 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 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.

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Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	**Licensure and Certification Requirements**
	Child Day Care Facilities-licensed by HHSC under 26 Tex. Admin. Code Chapter 746 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. Registered nurses and licensed vocational nurses must have current licenses under Texas Occupations Code Chapter 301. Child Day Care Facilities- licensed by HHSC. Children with special healthcare needs must receive the care recommended by a healthcare professional or qualified professional affiliated with the local school district or early childhood intervention program. **Special Care Facilities**-licensed byHHSC under 26 Tex. Admin. Code Chapter 506 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. Registered nurses and licensed vocational nurses must have current licenses under Occupations Code, Chapter 301. **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. Registered nurses and licensed vocational nurses must have current licenses under Texas Occupations Code Chapter 301. **Nursing Facility**-licensed by DADS under 40 Tex. Admin. Code Chapter 19 The nursing facility respite provider must employ staff who must: 1. Be at least 18 years of age;

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Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	**Licensure and Certification Requirements**
	2. 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; 3. Be trained in CPR and first-aid; 4. Pass criminal history checks; 5. Not be on the Employee Misconduct Registry or Nurse Aide Registry list; 6. Be familiar with the individual's tasks; 7. Not be on the state and federal lists of excluded individuals and entities; **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. Registered nurses and licensed vocational nurses must have current licenses under Texas Occupations Code Chapter 301. These camps must be accredited by the American Camping Association.
Supported Employment	**HCSSA**-licensed by HHSC under 26 Tex. Admin. Code Chapter 558 The Provider of supported employment services must meet all of the criteria in one of these three options. Option 1: 1. a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and 2. six months of documented experience providing services to people with disabilities in a professional or personal setting. Option 2: 1. an associate's degree in rehabilitation, business, marketing, or a related human services field; and 2. one year of documented experience providing services to people with disabilities in a professional or personal setting. Option 3: 1. a high school diploma or GED; and 2. two years of documented experience providing services to people with disabilities in a professional or personal setting.

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Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	**Licensure and Certification Requirements**
Financial Management Services	Private entities furnish financial management services. These entities, called financial management services agencies, 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 Medicaid provider agreement on behalf of HHSC. A financial management service agency 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; financial management service agency responsibilities; consumer/employer responsibilities; DADS case manager/service coordinators responsibilities; enrollment, transfer, suspension and termination of the consumer directed services option; employer budgets; reporting abuse, neglect and exploitation allegations; oversight of consumer directed services; 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 consumer directed services option, located at 40 Tex. Admin. Code Chapter 41, require financial management services agencies to act as vendor fiscal/employer agents along with describing responsibilities such as the revocation of IRS Form 2678 if the individual terminates the consumer directed services option or transfers to another financial management service agency. The financial management services agency must not be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.
Adaptive Aids	Be a durable medical equipment supplier or be a manufacturer of items not supplied through durable medical equipment suppliers.
Employment Assistance	**HCSSA** - licensed by HHSC under 26 Tex. Admin. Code Chapter 558 The Provider must meet all of the criteria in one of these three options. Option 1: 1. a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and

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Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	**Licensure and Certification Requirements**
	2. six months of documented experience providing services to people with disabilities in a professional or personal setting. Option 2: 1. an associate's degree in rehabilitation, business, marketing, or a related human services field; and 2. one year of documented experience providing services to people with disabilities in a professional or personal setting. Option 3: 1. a high school diploma or GED; and 2. two years of documented experience providing services to people with disabilities in a professional or personal setting.
Flexible Family Support Services	**HCSSA**-licensed by HHSC under 26 Tex. Admin. Code Chapter 558 **Nurse**: Skilled care must be performed by a registered nurse or licensed vocational nurse or delegated by a registered nurse. Non-licensed individuals providing delegated skilled tasks must be supervised by a registered nurse. Any delegated skilled care must meet the requirements of the Texas Nursing Practice Act **Attendant**: The HCSSA must employ a respite attendant who must meet the following requirements: 1. Be at least 18 years of age; 2. Have a high school diploma, certificate of high school equivalency (General Educational Development credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks; 3. Be trained in CPR and first-aid; 4. Pass criminal history checks; 5. Not be on the Employee Misconduct Registry or Nurse Aide Registry; 6. Not be on the state and federal lists of excluded persons and entities; 7. Be familiar with individual's specific tasks; 8. Not be the individual's spouse; and 9. Must not be the caregiver whether or not the provider is related to the individual.
Minor Home Modifications	A minor home modification program 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;

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Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	**Licensure and Certification Requirements**
	2. Three references from previous contractor clients; and 3. Current General Comprehensive Liability coverage for Errors & Omissions.
Transition Assistance Services	The Transition Assistance Services (TAS) provider must comply with the requirements for delivery of TAS, which include requirements regarding allowable purchases, costs limits, and time frames for delivery. TAS providers must demonstrate knowledge of, and history in, successfully serving individuals who require home and community - based services.

The MCO must offer and make available the consumer directed services (CDS) option for Respite Care, Supported Employment, Employees Assistance, Flexible Family Support Services, Adaptive Aids, and Minor Home Modifications.

8.3.3 Additional Service Coordination Requirements for MDCP STAR Kids Members

The MDCP Module of the STAR Kids SAI 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. As a part of the ISP planning process, the MCO must establish an MDCP plan of care as a part of the STAR Kids ISP that does not exceed the Member's cost limit. 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 his or her cost limit. The MCO must also adopt a methodology to track each Member's MDCP-related expenditures on a monthly basis and provide an update on the progress to the Member and the Member's LAR no less than once per month.

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 ISP.

The MCO must prioritize MDCP reassessments to ensure they occur on schedule. If a STAR Kids MDCP Member changes MCOs prior to annual reassessment, the previous MCO must supply the new MCO with the results from the previous MDCP Module, and the new MCO must honor the previous assessment findings until the MDCP Module is provided again upon annual review.

If a Member or a Member's LAR notifies the MCO that the Member has experienced a significant change in condition that may warrant an adjustment to their cost limit, the

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MCO must use an HHSC-approved assessment to confirm if an adjustment is needed. If the assessment validates a change in cost limit, the MCO must work with the Member and the Member's LAR to update the Member's ISP accordingly.

For all MDCP STAR Kids Members, the MCO must consult with the Member and the Member's LAR to determine if the Member needs Minor Home Modifications and Adaptive Aids as part of the annual STAR Kid Screening and Assessment Process or if the Member experiences a change in condition or requests assistance. The MCO must obtain vendors to provide Minor Home Modifications or Adaptive Aids for MDCP STAR Kids Members with a need.

As referenced in **Section 8.1.38.6**, any Member who receives services through MDCP STAR Kids must receive Level 1 Service Coordination. Additionally, named Service Coordinators who provide services to Members enrolled in MDCP STAR Kids must be trained and proficient in the following:

1. The full STAR Kids and MDCP service array;
2. Provider requirements for each service;
3. The CDS option;
4. Eligibility and assessment requirements; and
5. Monitoring and reporting requirements.

On the date of the MDCP assessment or reassessment, the MCOs are required to ensure that the Service Coordinator in the STAR Kids program reviews the information gathered in the STAR Kids Screening and Assessment Instrument (SK-SAI) with the Member or LAR. The Service Coordinator must attempt to obtain the signature of the Member/LAR to verify that the Member/LAR has reviewed the information gathered in the SK-SAI. If the Member/LAR disagrees with the information gathered in the SK-SAI and refuses to sign, the Service Coordinator must document the refusal. The review of the results by the Member/LAR must not delay the determination of the services to be provided to the Member or the ability to authorize or initiate services. The MCOs must provide a paper or electronic copy of the SK-SAI within seven Business Days of the request as outlined in Section 8.1.39. The MCO must monitor the TMHP portal and upon notification of a preliminary denial of medical necessity, must contact the Member/LAR and offer an opportunity to hold a peer-to-peer review with the treating physician of the Member/LAR's choice and the MCO medical director. The MCO is required to ensure that the peer-to-peer review does not affect Member rights to appeal an initial assessment or reassessment through the MCO Internal Appeal process or the State Fair Hearing process. In addition, the MCO must monitor the TMHP portal through the final medical necessity determination and must follow the guidelines stated in the STAR Kids handbook section 6250.

8.3.4 Additional ISP Requirements for MDCP STAR Kids Members

In addition to the requirements in **Section 8.1.38.3**, the MCO must use the Person-Centered Planning process described in 42 C.F.R. § 441.301(c)(1) to develop an ISP for

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an MDCP STAR Kids Member. The MDCP STAR Kids Member's ISP must include the components of a person-centered service plan described in 42 C.F.R. § 441.301(c)(2).

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	October 1, 2015	Initial version of Attachment B-1, RFP Section 9, "Turnover Requirements" that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2016	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.2	November 1, 2016	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.3	March 1, 2017	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.4	June 1, 2017	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.5	September 1, 2017	Section 9.5 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement.
Revision	1.6	March 1, 2018	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.7	September 1, 2018	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.8	January 1, 2019	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.9	March 1, 2019	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.10	September 1, 2019	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.11	March 1, 2020	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.12	September 1, 2020	Section 9.1 Introduction is modified to clarify language to include expectations required of contracted MCO' should they terminate, merger, or acquire new business.

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Revision	1.13	March 1, 2021	Contract amendment did not revise Attachment B-1, RFP Section 9, “Turnover Requirements.”

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

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9 Turnover Requirements

9.1 Introduction

This section presents the Turnover Phase. The MCO is required to perform all required activities prior to, upon, and following termination, expiration, merger, or acquisition of the Contract in accordance with the HHSC-approved Turnover Plan.

9.2 Turnover Plan

Twelve months after the 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 9.2 of the Contract. HHSC must approve the Turnover Plan.

9.3 Transfer of Data and Information

The MCO must transfer to HHSC or a subsequent contractor all data and information necessary to transition operations, including: data and reference tables; data entry software; license agreements for third-party software and modifications if required by HHSC; documentation relating to software and interfaces; functional business process flows; and operational information, including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operational information regarding Subcontractors. For purposes of this provision, "documentation" means all operations, technical, and user manuals used in conjunction with the software, Services, and Deliverables, in whole or in part, that HHSC determines are necessary to view and extract application data in a proper format. The MCO must provide the documentation in the formats in which the 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 MCO Program data from the MCO's system(s) to the replacement system(s) of HHSC or a successor contractor, including a comprehensive data dictionary as defined by HHSC.
2. The MCO must provide all necessary data, information, and services will be provided 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,

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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. 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

Six months prior to the end of the Initial Contract Period, the MCO must propose a Turnover Plan. Twelve months prior to the end of any extension in the Contract Period, the MCO must update its Turnover Plan and submit it to HHSC. 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 than twelve 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 must describe the MCO's policies and procedures that guarantee the following.

1. The least disruption in the delivery of Healthcare Services to 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.
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.
3. The MCO's approach to training HHSC or a subsequent contractor's staff in the operation of its business processes.

HHSC is not limited or restricted in the ability to require additional information from the MCO or modify the Turnover Plan as necessary.

9.5 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.

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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 must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) to carry out inspection, audit, review, analysis, reproduction, and transfer functions at the location(s) of any necessary records; and attorneys' fees and costs. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement. This section does not limit HHSC's ability to impose remedies or damages as set forth in the Contract.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	October 1, 2015	Initial version of Attachment B-2, "STAR Kids Covered Services" that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2016	Services included under the MCO capitation payment is modified to add Day Activity and Health Services (DAHS) and to remove the NorthSTAR exception under Behavioral Health Services.
Revision	1.2	November 1, 2016	"Services included under the MCO capitation payment" is modified to include private duty nursing, PPECC, certified respiratory care practitioner services, and therapies as part of medical checkups and CCP services. In addition, Mental Health Rehabilitative Services is corrected.
Revision	1.3	March 1, 2017	Contract amendment did not revise Attachment B-2, "STAR Kids Covered Services."
Revision	1.4	June 1, 2017	Contract amendment did not revise Attachment B-2, "STAR Kids Covered Services."
Revision	1.5	September 1, 2017	The modified language better organizes the section of "covered services" to ensure all behavioral health services are grouped under the Behavioral Health Services heading by including Mental Health Rehabilitative Services and Mental Health Targeted Case Management services in the list of Behavioral Health Services. The modified language also correctly references the population eligible for covered services.
Revision	1.6	March 1, 2018	Contract amendment did not revise Attachment B-2, "STAR Kids Covered Services."
Revision	1.7	September 1, 2018	Attachment B-2 "Covered Services" is modified to comply with home health requirements in 42 C.F.R § 440.70.
Revision	1.8	January 1, 2019	Contract amendment did not revise Attachment B-2, "STAR Kids Covered Services."
Revision	1.9	March 1, 2019	Contract amendment did not revise Attachment B-2, "STAR Kids Covered Services."
Revision	1.10	September 1, 2019	Attachment B-2 "Covered Services" is modified to add the term "habilitation.

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Revision	1.11	March 1, 2020	Contract amendment did not revise Attachment B-2, "STAR Kids Covered Services."
Revision	1.12	September 1, 2020	Contract amendment did not revise Attachment B-2, "STAR Kids Covered Services."
Revision	1.13	March 01, 2021	Attachment B.2 is modified to comply with SB 1177, 86th Legislature, amended Texas Government Code § 533.005 updating contract requirements to include the provisions of this bill.

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

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STAR Kids Covered Services

The following is a non-exhaustive, high-level listing of Covered Services included under the STAR Kids Medicaid managed care program.

Medicaid MCOs are responsible for providing a benefit package to STAR Kids Members that includes all Medically Necessary services covered under the traditional, fee-for-service Medicaid programs, except for Non-capitated Services provided to Medicaid Members outside of the MCO capitation and listed in **Section 8.1.24.8**. In accordance with **Section 8.1.24.8**, Nursing Facility Services are examples of services that are excluded from the capitation payment to STAR Kids MCOs and are paid through HHSC's Administrative Contractor responsible for payment of Traditional Medicaid fee-for-service claims. The MCO must coordinate care for STAR Kids Members for these Non-capitated Services so that STAR Kids Members have access to a full range of medically necessary Medicaid services, both capitated and non-capitated. 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 list of limitations and exclusions that apply to each Medicaid benefit category. This 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.

Services included under the MCO capitation payment

- Emergency and non-emergency ambulance services
- Audiology services, including hearing aids
- Behavioral Health Services including:
  - Inpatient mental health services.
  - Mental Health Rehabilitative Services and Mental Health Targeted Case Management for individuals who are not dually eligible in Medicare and Medicaid
  - Outpatient mental health services
  - Psychiatry services
  - Substance use disorder treatment services, including
    - Outpatient services, such as:
      - Assessment
      - Detoxification services
      - Counseling treatment
      - Medication assisted therapy
    - Residential services, which may be provided in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting, including
      - Detoxification services
      - Substance use disorder treatment (including room and board)
- 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

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- Birthing services provided by a physician and CNM in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment service
- Chiropractic services
- Day Activity and Health Services (DAHS)
- Dialysis
- Drugs and biologicals provided in an inpatient setting
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency Services
- Family planning services
- Home health care services provided in accordance with 42 C.F.R. § 440.70, and as directed by HHSC
- Hospital services, inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
    - inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care 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 through the Texas Health Steps Program (EPSDT), including private duty nursing, Prescribed Pediatric Extended Care Center (PPECC) services, certified respiratory care practitioner services, and therapies (speech, occupational, physical)
- 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;
- Optometry, glasses, and contact lenses, if medically necessary
- Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Personal Care Services (PCS)
- Podiatry
- Prescribed pediatric extended care center (PPECC) services
- Primary care services
- Private Duty Nursing (PDN) services
- Radiology, imaging, and X-rays
- Specialty physician services
- Telemonitoring
- Telehealth
- Therapies – physical, occupational, and speech
- Transplantation of organs and tissues

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- Vision services

Community First Choice services for those Members who qualify for these services

The state provides an enriched array of services to Members who would otherwise qualify for care in a Nursing Facility, an ICF/IDD, or an Institution for Mental Diseases (IMD).

- Personal Care Services - CFC - All qualified Members may receive medically and functionally necessary Personal Assistance Services under CFC.
- Habilitation, acquisition, maintenance and enhancement of skills - All qualified Members may receive this service to enable the Member to accomplish ADLs, IADLs and health-related tasks.
- Emergency Response Services - CFC - (Emergency call button) - All qualified Members may receive necessary Emergency Response Services under CFC.
- Support Management - All qualified Members may receive voluntary training on how to select, manage and dismiss attendants.

Services included under the MCO capitation payment for MDCP STAR Kids

The following is a list of Covered Services for Members who qualify for MDCP STAR Kids services. The MCO must provide Medically and Functionally Necessary services to Members who meet the functional and financial eligibility for MDCP STAR Kids.

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.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	October 1, 2015	Initial version of Attachment B-3, “Deliverables/Liquidated Damages Matrix” that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2016	Item 3.1 is added. Item 3.2 is added. Item 3.3 is added. Item 16 is modified. Item 16.1 is added. Item 39 is modified. Item 43.1 is added.
Revision	1.2	November 1, 2016	Item 34.4 is added. Item 38 subsections (d) (e) and (f) are deleted. Item 43.2 is added.
Revision	1.3	March 1, 2017	Item 9 is modified to correct the Service/Component reference and to add "per county" to the Measurement Assessment and Liquidated Damages. Item 43.1 is added and subsequent items are renumbered.
Revision	1.4	June 1, 2017	Contract amendment did not revise Attachment B-3, “Deliverables/Liquidated Damages Matrix.”
Revision	1.5	September 1, 2017	Item 15 is modified to apply LDs to any appeal timeframe. Item 16.2 is added. Item 30.1 is added.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Item 33.1 is added. Item 36 is modified to change the report from quarterly to monthly and to remove Service Areas from the measurement assessment. Item 38 is modified to remove one deliverable and include an existing deliverable which is currently not included on the matrix.
Revision	1.6	March 1, 2018	Changes were made throughout the attachment for consistency purposes. Item 4.1 is modified to make the LD amount consistent with all managed care contracts. Item 37 is modified to replace Report with Referral and change from quarterly to monthly submission. Item 40 is modified to remove instruct and add allow.
Revision	1.7	September 1, 2018	Items 33 and 43 are modified to update language for new reporting requirements.
Revision	1.8	January 1, 2019	Contract amendment did not revise Attachment B-3, “Deliverables/Liquidated Damages Matrix.”
Revision	1.9	March 1, 2019	Contract amendment did not revise Attachment B-3, “Deliverables/Liquidated Damages Matrix.”
Revision	1.10	September 1, 2019	Contract amendment did not revise Attachment B-3, “Deliverables/Liquidated Damages Matrix.”
Revision	1.11	March 1, 2020	Contract amendment did not revise Attachment B-3, “Deliverables/Liquidated Damages Matrix.”

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.12	September 1, 2020	Attachment B-3, "Deliverables/Liquidated Damages Matrix" was reorganized for programming into TexConnect. Items were moved under categories and item numbers changed. The crosswalk and modifications for previous and current LD items are as follows: Items OR-1 to OR-3 were Items 5, 6, and 7 respectively. Items GA-1 to GA-4 were Items 1, 2, 4, and 4.1 respectively. Items GA-3 and GA-4 were modified to add monthly and annual to the reporting timeframes. Items PS-1 and PS-2 were in Item 3.1, and PS-3 and PS-4 were Items 3.2 and 3.3 respectively. Items MS-1 to MS-4 were in Item 3. Items CL-1 to SKCL-5 were Items 36, 43, 33.1, 32, and 33. Items CL-4 and CL-7 were in Item 32, and Items CL-5, CL-6, CL-8, CL-9, and SKCL-2 to SKCL-5 were in Item 33. The performance standards for CL-2, CL-3, CL-5, CL-6, CL-8, CL-9 and SKCL-2 to SKCL-5 were clarified. Items CL-2, CL-4 to CL-9, and SKCL-2 to SKCL-5 were modified to change the reporting timeframe to monthly. SKCL-1 was added. Items ED-1 to SKED-1 were the Items 30, 30.1, and 43.1. Items ED-1 and ED-4 were in Item 30.1. Items ED-2, ED-3, ED-5, and ED-6 were in Item 30. Item HL-1 was in Items 11 and 13. Item HL-2 is a new item. Item HL-3 to HL-5 were in Items 11, 13, and 17. HL-6 and HL-7 were in Item 17. SKHL-1 was added. Call pickup rate and busy signal performance standards were removed, the reporting time was modified to monthly, and measurement by Service Area was removed. The liquidated damages amount for Item HL-7 was modified to match with the amount in the new Item HL-2. Items CA-1 and CA-2 were in Item 14. Items CA-3 to SKCA-1 were Items 15, 35, and 43.2 respectively. Items CA-1 to CA-3 were modified to change the reporting time to monthly and remove measurement by Service Area.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Items PN-1 and PN-2 were Items 9 and 16.2 respectively. Items PN-3 to PN-5 were in Item 10. PN-6 is a new item. Items MM-1 to MM-3 were Items 16, 16.1, and 12 respectively. Item MM-3 was modified to clarify performance standard. Items MI-1 and MI-2 were Items 29 and 31 respectively. Items FR-1 to FR-4 were Items 18, 20, 22, and 27 respectively. Items FR-5, FR-11, and FR-12 were in Item 28. Items FR-6 to FR-10 were Items 21, 23, 24, 25, and 26 respectively. Item SKFR-1 was Item 19. Items FR-4 and FR-6 were modified to update deliverable due date information. Items IG-1 to IG-3 were Items 8, 34.4, and 34 respectively. Items IG-4 and IG-5 were in Item 37. Items IG-6 to IG-8 were Items 34.1, 34.3, and 34.2 respectively. Items SKFW-1 to SKFW3 were in Item 38. Items TO-1 to TO-3 were Items 46, 45, and 44 respectively. Items PH-1, PH-2, and PH-5 were Items 39, 39.1, and 41 respectively. Items PH-3 and PH-4 were in Item 40. Items PH-6 to PH-11 are new items. Items PH-1, PH-2, and PH-5 were modified to clarify the performance standard, and Item PH-2 was modified to change the liquidated damage information. In addition, the previous Item 42 was removed. Item SKMD-1 was Item 43.3. The following changes were made throughout the amendment for consistency among columns: Capitalized defined terms. Modified Service/Component column to remove “RFP” reference, update contract amendment sections as applicable, and change UMCM chapter reference to section heading level.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Modified the Measurement Assessment and Liquidated Damages columns to match criteria assessed.
Revision	1.13	March 1, 2021	Contract amendment did not revise Attachment B-3, "Deliverables/Liquidated Damages Matrix."

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Operations Readiness (OR)					
OR-1	Contract Attachment B-1, §7.3 Transition Phase Schedule and Tasks Contract Attachment B-1, §7.3.1 Transition Phase Planning Contract Attachment B-1, §8.1 General Scope of Work	The MCO must be operational no later than the agreed upon Operational Start Date. HHSC, or its agent, will determine when the MCO is considered operational based on the requirements in Sections 7 and 8 of Attachment B-1.	Operational Start Date	Each Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $10,000 per Day of noncompliance and per MCO's Service Area for each Day beyond the Operational Start Date that the MCO is not operational until the Day that the MCO is operational, including all systems.
OR-2	Contract Attachment B-1, §7.3.5 System Readiness Review	The MCO must submit to HHSC or to the designated Readiness Review Contractor the following plans for review, no later than 120 Days prior to the Operational Start Date: 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	Transition Phase	Each Day of noncompliance, per report, per MCO's Service Area.	HHSC may assess up to $1,000 per Day of noncompliance, per report, and per MCO's Service Area for each Day a Deliverable is not submitted or is late, inaccurate, or incomplete.

[1] Derived from the Contract, General Terms & Conditions, or HHSC's Uniform Managed Care Manual.
[2] Standard specified in the Contract. Note: Where the due date states 30 days, the MCO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the MCO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.
[3] Period during which HHSC will evaluate service for purposes of tailored remedies.
[4] Measure against which HHSC will apply remedies.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
OR-3	Contract Attachment B-1, §7.3.7 Operations Readiness	Final versions of the Provider Directory must be submitted to the HHSC Administrative Services Contractor no later than 95 Days prior to the Operational Start Date.	Transition Phase	Each Day of noncompliance, per directory, per MCO's Service Area.	HHSC may assess up to $1,000 per Day of noncompliance, per directory, and per MCO's Service Area for each Day the directory is not submitted or is late, inaccurate, or incomplete.
General/ Administrative (GA)					
GA-1	General Requirement: Failure to Perform an Administrative Service Contract Attachment A, "STAR Kids Contract Terms and Conditions" Contract Attachment B-1, §§ 6, 7, 8 and 9	The MCO fails to timely perform an MCO Administrative Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, the 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	Per Day, per each incident of noncompliance, per MCO's Service Area.	HHSC may assess up to $5,000 per Day for each incident of noncompliance per MCO's Service Area.
GA-2	General Requirement: Failure to Provide a Covered Service Contract Attachment A, "STAR Kids Contract Terms and Conditions" Contract Attachment B-1, §§ 6, 7, 8 and 9	The MCO fails to timely provide a Covered Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, this failure results in actual harm to a Member or places a Member at risk of imminent harm.	Ongoing	Each Day of noncompliance, per each incident of noncompliance.	HHSC may assess up to $7,500 per Day of noncompliance for each incident of noncompliance.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
GA-3	Contract Attachment B-1, §§ 6, 7, 8 and 9 UMCM	All reports and Deliverables as specified in Sections 6, 7, 8, and 9 of Attachment B-1 must be submitted according to the timeframes and requirements stated in the Contract (including all attachments) and the UMCM. (Specific reports or Deliverables listed separately in this matrix are subject to the specified liquidated damages.)	Transition Phase and Operations Phase	Per each Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $250 per Day of noncompliance and per MCO's Service Area if the monthly, quarterly, or annual report/Deliverable is not submitted or is late, inaccurate, or incomplete.
GA-4	Contract Attachment B-1, §§ 6, 7, 8 and 9 UMCM	All reports as specified in Sections 6, 7, 8 and 9 of Attachment B-1 must be submitted according to the requirements stated in the Contract (including all attachments) and the UMCM.	Transition Phase and Operations Phase	Per incident of noncompliance, per MCO's Service Area.	HHSC may assess up to $1,000 per incident of noncompliance and per MCO's Service Area if either the monthly, quarterly, or annual report is not submitted in the format/template required by HHSC.
Privacy/ Security (PS)					
PS-1	Contract Attachment A, "STAR Kids Contract Terms and Conditions," Section 7.06 HIPAA and Article 11 Disclosure & Confidentiality of Information	The MCO must meet all privacy standards under applicable state or federal law, rule, regulation and HHSC contract requirement.	Transition Phase and Quarterly during Operations Phase	Per quarterly reporting period, per violation.	HHSC may assess up to $5,000 per quarterly reporting period for each privacy violation of applicable federal or state law or the HHSC privacy standards in the Contract.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PS-2	Contract Attachment A, "STAR Kids Contract Terms and Conditions," Section 7.06 HIPAA and Article 11 Disclosure & Confidentiality of Information	The MCO must meet all security standards under applicable state or federal law, rule, regulation and HHSC contract requirement.	Transition Phase and Quarterly during Operations Phase	Per quarterly reporting period, per violation.	HHSC may assess up to $1,000 per quarterly reporting period for each security violation of security requirements under federal or state law or the HHSC security standards in the Contract.
PS-3	Contract Attachment A, "STAR Kids Contract Terms and Conditions," Section 7.06 HIPAA and Article 11 Disclosure & Confidentiality of Information	The MCO must meet all confidentiality standards under applicable state or federal law, rule, regulation and HHSC contract requirement.	Transition Phase and Quarterly during Operations Phase	Per quarterly reporting period, per privacy/security incident.	HHSC may assess up to $5,000 per quarterly reporting period for each breach by MCO scenario as required by HHSC.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PS-4	Contract Attachment A, "STAR Kids Contract Terms and Conditions," Section 7.06 HIPAA and Article 11 Disclosure & Confidentiality of Information	The MCO must meet the privacy breach notification and/or breach response standard required by applicable federal and state law and HHSC contract requirements.	Transition Phase and Quarterly during Operations Phase	Per Day, per violation of breach notification and/or response standards of an actual or suspected privacy breach which may or actually requires notification to HHSC, an individual, the press and/or a federal regulatory body or may require appropriate mitigation and/or remediation activity.	HHSC may assess up to $1,000 per Day for each MCO violation of breach notice, breach response standard for each violation and/or for each privacy violation impacting an individual according to applicable federal or state breach notification law or the HHSC breach notification and response standards in the Contract.
Material Subcontractors (MS)					
MS-1	Contract Attachment A, “STAR Kids Contract Terms and Conditions,” Section 4.08 Subcontractors and Agreements with Third Parties	Unless otherwise provided in this Contract, the MCO must provide HHSC with written notice no later than three Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Subcontract.	Transition Phase; Quarterly during the Operations Phase	Each Day of noncompliance, per MCO’s Service Area.	HHSC may assess up to $5,000 per Day of noncompliance and per MCO’s Service Area.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
MS-2	Contract Attachment A, "STAR Kids Contract Terms and Conditions," Section 4.08 Subcontractors and Agreements with Third Parties	Unless otherwise provided in this Contract, the MCO must provide HHSC with written notice no later than 180 Days prior to the termination date of a Material Subcontract for MIS systems operation or reporting.	Transition Phase; Quarterly during the Operations Phase	Each Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $5,000 per Day of noncompliance and per MCO's Service Area.
MS-3	Contract Attachment A, "STAR Kids Contract Terms and Conditions," Section 4.08 Subcontractors and Agreements with Third Parties	Unless otherwise provided in this Contract, the MCO must provide HHSC with written notice no later than 90 Days prior to the termination date of a Material Subcontract for non-MIS MCO Administrative Services.	Transition Phase; Quarterly during the Operations Phase	Each Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $5,000 per Day of noncompliance and per MCO's Service Area.
MS-4	Contract Attachment A, "STAR Kids Contract Terms and Conditions," Section 4.08 Subcontractors and Agreements with Third Parties	Unless otherwise provided in this Contract, the MCO must provide HHSC with written notice no later than 30 Days prior to the termination date of any other Material Subcontract.	Transition Phase; Quarterly during the Operations Phase	Each Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $5,000 per Day of noncompliance and per MCO's Service Area.
Claims (CL)					
CL-1	Contract Attachment B-1, §8.1.22.2 Reports UMCM Chapter 5	Claims Summary Report: The MCO must submit monthly Claims Summary Reports to HHSC by the last Day of each month following the reporting period.	Operations Phase	Per Day of noncompliance, per claim type.	HHSC may assess up to $1,000 per Day of noncompliance and per claim type the report is not submitted or is late, inaccurate, or incomplete.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-2	Contract Attachment B-1, §8.1.27.2 Provider Appeal of MCO Claims Determinations UMCM Chapter 2	The MCO must resolve at least 98% of appealed claims within 30 Days from the date the appealed claim is filed with the MCO.	Operations Phase and Turnover Phase	Per month, per claim type.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO's monthly performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO's monthly performance percentages fall below the performance standards.
CL-3	Contract Attachment B-1, §8.1.20.5.1 Claims Project UMCM Chapters 2 and 5	The MCO must complete all claims projects within 60 Days of the claims project's start date unless the MCO enters into a written agreement with the Provider before the initial expiration of the 60 Days to establish the claims projects agreed upon timeframe. MCOs may not include Nursing Facility Daily/Unit Rate claims as part of the claims project.	Operations Phase	Per incident of noncompliance.	HHSC may assess up to $5,000 per incident of noncompliance. A claim's project incident of noncompliance is considered any claims project not completed within 60 Days of the claims project's start date or any claims project that includes Nursing Facility Daily/Unit Rate claims.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-4	Contract Attachment B-1, §8.1.20.5 Claims Processing Requirements UMCM Chapter 2	For a Clean Claim not adjudicated within 30 Days of receipt by the MCO, the MCO must pay the provider interest at 18% per annum, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 30-Day claims processing deadline. Interest owed to the provider must be paid on the same date as the claim.	Operations Phase	Per month, per claim.	HHSC may assess up to $1,000 per month and per claim if the MCO fails to pay interest timely.
CL-5	Contract Attachment B-1, §8.1.20.5 Claims Processing Requirements UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Section 8.1.20.5 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 98% of acute, vision, and behavioral health Clean Claims within 30 Days of the claim being submitted to the MCO.	Operations Phase	Per month, per claim type.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-6	Contract Attachment B-1, §8.1.20.5 Claims Processing Requirements UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Section 8.1.20.5 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 99% of acute, vision, and behavioral health Clean Claims within 90 Days of the claim being submitted to the MCO.	Operations Phase	Per month, per claim type.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards.
CL-7	Contract Attachment B-1, §8.1.20.5 Claims Processing Requirements Contract Attachment B-1, §8.1.17.14 Pharmacy Claims and File Processing UMCM Chapter 2	For a Clean Claim for outpatient pharmacy benefits not adjudicated within (1) 18 Days after receipt by the MCO if submitted electronically or (2) 21 Days after receipt by the MCO if submitted non-electronically, the MCO must pay the provider interest at 18% per annum, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 18-Day or 21-Day claims processing deadline. Interest owed to the provider must be paid on the same date as the claim.	Operations Phase	Per month, per claim.	HHSC may assess up to $1,000 per month and per claim if the MCO fails to pay interest timely.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-8	Contract Attachment B-1, §8.1.20.5 Claims Processing Requirements Contract Attachment B-1, §8.1.17.14 Pharmacy Claims and File Processing UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Sections 8.1.20.5 and 8.1.17.14 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 98% of electronic pharmacy Clean Claims within 18 Days of the claim being submitted to the MCO.	Operations Phase	Per month, per claim type.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards.
CL-9	Contract Attachment B-1, §8.1.20.5 Claims Processing Requirements Contract Attachment B-1, §8.1.17.14 Pharmacy Claims and File Processing UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Sections 8.1.20.5 and 8.1.17.14 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 98% of non-electronic pharmacy Clean Claims within 21 Days of the claim being submitted to the MCO.	Operations Phase	Per month, per claim type.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SKCL-1	Contract Attachment B-1, §8.1.20.5 Claims Processing Requirements UMCM Chapter 2	For a Nursing Facility Unit Rate or coinsurance Clean Claim not adjudicated within ten Days of receipt by the MCO, the MCO must pay the provider interest at 18% per annum, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 10-Day claims processing deadline. Interest owed to the provider must be paid on the same date as the claim.	Operations Phase	Per month, per claim.	HHSC may assess up to $1,000 per month and per claim if the MCO fails to pay interest timely.
SKCL-2	Contract Attachment B-1, §8.1.20.5 Claims Processing Requirements UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Section 8.1.20.5 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 98% of long term services & supports Clean Claims within 30 Days of the claim being submitted to the MCO.	Operations Phase	Per month, per claim type.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SKCL-3	Contract Attachment B-1, §8.1.20.5 Claims Processing Requirements UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Section 8.1.20.5 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 99% of long term services & supports Clean Claims within 90 Days of the claim being submitted to the MCO.	Operations Phase	Per month, per claim type.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards.
SKCL-4	Contract Attachment B-1, §8.1.20.5 Claims Processing Requirements UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Section 8.1.20.5 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 98% of Nursing Facility Clean Claims within 10 Days of the claim being submitted to the MCO.	Operations Phase	Per month, per claim type.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards.

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TX-AG-22-0325-A-000475

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SKCL-5	Contract Attachment B-1, §8.1.20.5 Claims Processing Requirements UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in Section 8.1.20.5 of Attachment B-1 and in UMCM Chapter 2. The MCO must pay or deny 99% of Nursing Facility Clean Claims within 90 Days of the claim being submitted to the MCO.	Operations Phase	Per month, per claim type.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards.
Encounter Data (ED)					
ED-1	Contract Attachment B-1, § 8.1.20.1 Encounter Data	The MCO must submit complete and accurate non-pharmacy Encounter Data transmissions in accordance with Section 8.1.20.1.	Measured Quarterly during Operations Phase	Per Day, per incident of noncompliance, per MCO's Service Area.	For the initial quarter: HHSC may assess up to $500 per Day, per incident of noncompliance, and per MCO's Service Area that the MCO fails to submit complete and accurate non-pharmacy Encounter Data in a quarter. For each subsequent quarter: HHSC may assess up to $1,000 per Day, per incident of noncompliance, and per MCO's Service Area for each quarter the MCO fails to submit complete and accurate non-pharmacy Encounter Data.

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TX-AG-22-0325-A-000476

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
ED-2	Contract Attachment B-1, §8.1.20.1 Encounter Data	The MCO will be subject to liquidated damages if the Quarterly Encounter Reconciliation Report (which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Vision 21 Data Warehouse) includes more than a 2% variance for non-pharmacy Encounter Data.	Operations Phase	Per quarter, per incident of noncompliance, per MCO's Service Area.	HHSC may assess up to $2,500 per quarter, per incident of noncompliance, and per MCO's Service Area if the MCO is not within the 2% variance for non-pharmacy Encounter Data. HHSC may assess up to $5,000 per quarter, per incident of noncompliance, and per MCO's Service Area for each additional quarter that the MCO is not within the 2% variance for non-pharmacy Encounter Data.
ED-3	Contract Attachment B-1, §8.1.20.1 Encounter Data	The MCO must submit non-pharmacy Encounter Data transmissions and include all Encounter Data and Encounter Data adjustments processed by the MCO on a monthly basis, not later than the 30th Day after the last day of the month in which the claim(s) are adjudicated.	Quarterly during Operations Phase	Per month, per incident of noncompliance, per MCO's Service Area.	For the initial quarter: HHSC may assess up to $2,500 per month, per incident of noncompliance, and per MCO's Service Area if the MCO fails to submit monthly non-pharmacy Encounter Data in a quarter. For each subsequent quarter: HHSC may assess up to $5,000 per month, per incident of noncompliance, and per MCO's Service Area for each month in any subsequent quarter that the MCO fails to submit monthly non-pharmacy Encounter Data.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
ED-4	Contract Attachment B-1, § 8.1.20.1 Encounter Data	The MCO must submit complete and accurate pharmacy Encounter Data transmissions in accordance with Section 8.1.20.1.	Measured Quarterly during Operations Phase	Per Day, per incident of noncompliance.	For the initial quarter: HHSC may assess up to $1,000 per Day and per incident of noncompliance that the MCO fails to submit complete and accurate pharmacy Encounter Data in a quarter. For each subsequent quarter: HHSC may assess up to $2,000 per Day and per incident of noncompliance for each quarter the MCO fails to submit complete and accurate pharmacy Encounter Data.
ED-5	Contract Attachment B-1, §8.1.20.1 Encounter Data	The MCO will be subject to liquidated damages if the Quarterly Encounter Reconciliation Report (which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Vision 21 Data Warehouse) includes more than a 2% variance for pharmacy Encounter Data.	Operations Phase	Per quarter, per incident of noncompliance.	HHSC may assess up to $2,500 per quarter and per incident of noncompliance if the MCO is not within the 2% variance for pharmacy Encounter Data. HHSC may assess up to $5,000 per quarter and per incident of noncompliance for each additional quarter that the MCO is not within the 2% variance for pharmacy Encounter Data.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
ED-6	Contract Attachment B-1, §8.1.20.1 Encounter Data	Pharmacy Encounter Data must be submitted no later than 25 Days after the date of adjudication and include all Encounter Data and Encounter Data adjustments.	Operations Phase	Per quarter, per incident of noncompliance.	For the initial quarter: HHSC may assess up to $10,000 per quarter and per incident of noncompliance that the MCO fails to submit pharmacy Encounter Data in a timely manner. For each subsequent quarter: HHSC may assess up to $15,000 per quarter and per incident of noncompliance if the MCO fails to submit pharmacy Encounter Data in a timely manner.
SKED-1	Contract Attachment B-1, §8.1.40.2 Long-Term Care Provider Billing	All STAR Kids MCOs are required to utilize the standardized method as found in the STAR Kids Handbook.	Operations Phase	Per Encounter	HHSC may assess up to $100 per Encounter that is not compliant with the standardized method found in the STAR Kids Handbook.
Hotlines (HL)					
HL-1	Contract Attachment B-1, §8.1.5.6.2 Member Hotline Contract Attachment B-1, §8.1.4.5 Provider Hotline	The MCO must operate toll-free Member and Provider hotlines from 8 AM – 5 PM local time for each MCO's Service Area, Monday through Friday, excluding State-approved holidays.	Operations Phase and Turnover Phase	Per month, per each incident of noncompliance, per hotline.	HHSC may assess up to $100 per month, per each incident of noncompliance, and per hotline for each hour, or portion thereof, that appropriately staffed hotlines are not operational. If the MCO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
HL-2	Contract Attachment B-1, §8.1.5.6 Nurse and Member Hotline Requirements Contract Attachment B-1, §8.1.16.2 Behavioral Health Services Hotline	Call hold rate: At least 80% of calls must be answered by hotline staff within 30 seconds.	Operations Phase and Turnover Phase	Per each percentage point below the standard, per hotline, per monthly reporting period.	HHSC may assess up to $100 for each percentage point below the standard per hotline that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated hotlines.
HL-3	Contract Attachment B-1, §8.1.5.6 Nurse and Member Hotline Requirements Contract Attachment B-1, §8.1.4.5 Provider Hotline Contract Attachment B-1, §8.1.16.2 Behavioral Health Services Hotline	Call abandonment rate: The call abandonment rate must be 7% or less.	Operations Phase and Turnover Phase	Per each percentage point above the standard, per hotline, per monthly reporting period.	HHSC may assess up to $100 for each percentage point above the standard per hotline that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated hotlines.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
HL-4	Contract Attachment B-1, §8.1.5.6 Nurse and Member Hotline Requirements Contract Attachment B-1, §8.1.4.5 Provider Hotline Contract Attachment B-1, §8.1.16.2 Behavioral Health Services Hotline	The average hold time must be two minutes or less.	Operations Phase and Turnover Phase	Per month, per hotline for each 30-second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time.	HHSC may assess up to $100 per month and per hotline for each 30-second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time.
HL-5	Contract Attachment B-1, §8.1.16.2 Behavioral Health Services Hotline	The MCO must have an emergency and crisis Behavioral Health Services Hotline available 24 hours a Day, 7 Days a week, throughout the MCO's Service Area(s).	Operations Phase and Turnover Phase	Per month, per each incident of noncompliance.	HHSC may assess up to $100 per month and per each incident of noncompliance for each hour, or portion thereof, that appropriately staffed hotlines are not operational. If the MCO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan.
HL-6	Contract Attachment B-1, §8.1.16.2 Behavioral Health Services Hotline	Crisis hotline staff must include or have access to qualified Behavioral Health Services' professionals to assess behavioral health emergencies.	Operations Phase and Turnover Phase	Per each incident of noncompliance.	HHSC may assess up to $1000 per each incident of noncompliance for each occurrence that HHSC identifies through its recurring monitoring processes that hotline staff were not qualified or did not have access to qualified professionals to assess behavioral health emergencies.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SKHL-1	Contract Attachment B-1, §8.1.5.6.1 Nurse Hotline	The MCO must operate a toll-free Nurse hotline that Providers and Members can call 24 hours a Day, 7 Days a week.	Operations Phase and Turnover Phase	Per month, per each incident of noncompliance.	HHSC may assess up to $100 per month and per each incident of noncompliance for each hour, or portion thereof, that appropriately staffed hotlines are not operational. If the MCO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan.
Complaints/ Appeals (CA)					
CA-1	Contract Attachment B-1, §8.1.5.9 Member Complaint and Appeal Process	The MCO must resolve at least 98% of Member Complaints within 30 Days from the date the Complaint is received by the MCO.	Operations Phase	Per monthly reporting period.	HHSC may assess up to $250 per monthly reporting period if the MCO fails to meet the performance standard.
CA-2	Contract Attachment B-1, §8.1.27.1 Provider Complaints	The MCO must resolve at least 98% of Provider Complaints within 30 Days from the date the Complaint is received by the MCO.	Operations Phase	Per monthly reporting period.	HHSC may assess up to $250 per monthly reporting period if the MCO fails to meet the performance standard.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CA-3	Contract Attachment B-1, §8.1.5.9 Member Complaint and Appeal Process Contract Attachment B-1, §8.1.29.2 Medicaid Member MCO Internal Appeal Process Contract Attachment B-1, §8.1.29.3 Expedited MCO Internal Appeals	The MCO must resolve at least 98% of Member appeals within the specified timeframes for standard and expedited appeals.	Operations Phase	Per monthly reporting period.	HHSC may assess up to $500 per monthly reporting period if the MCO fails to meet the performance standard.
CA-4	Contract Attachment B-1, §8.1.27.1 Provider Complaints Contract Attachment B-1, §8.1.29 Member Complaint and Appeal System UMCM Chapter 3	MCOs must resolve Provider and Member Complaints received by HHSC and referred to the MCOs no later than the due date indicated on HHSC's notification form unless an extension is granted by HHSC. The MCO response must be submitted according to the timeframes and requirements stated within the MCO notification correspondence (letter, e-mail, etc.).	Quarterly during the Operations Phase	Per Day, per each incident of noncompliance, per MCO's Service Area.	HHSC may assess up to $250 per Day, per each incident of noncompliance, and per MCO's Service Area for each Day beyond the due date specified within the MCO notification correspondence.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SKCA-1	Contract Attachment B-1, §8.1.29.4 Access to Fair Hearing and External Medical Record Review (EMR) for Medicaid Members	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 Phase, Operations Phase	Per quarter, per incident of noncompliance.	HHSC may assess up to $1000 per quarter and per incident of noncompliance for each State Fair Hearing that the MCO fails to attend as required by HHSC.
Provider Networks (PN)					
PN-1	Contract Attachment B-1, § 8.1.3 Access to Care Contract Attachment B-1, §8.1.3.1 Appointment Accessibility Contract Attachment B-1, §8.1.3.2 Access to Network Providers Contract Attachment B-1, §8.1.3.3 Monitoring Access	The MCO must comply with the contract's mileage and/or time standards and benchmarks for Member access.	Quarterly	Per quarter, per incident of noncompliance, per plan code, per county, and per Provider type.	HHSC may assess up to $1,000 per quarter, per incident of noncompliance, per plan code, per county, and per Provider type.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages

PN-2	Contract Attachment B-1, §8.1.7.9.2 MCO Alternative Payment Models with Providers (APMs)	The MCO must meet minimum APM ratios as follows:
		• CY2018:
		  ○ Overall APM Ratio: >=25%
		  ○ Risk Based APM Ratio: >=10%
		• CY2019: 125% of CY2018 Minimum Target APM Ratios
		• CY2020: 125% of CY2019 Minimum Target APM Ratios
		• CY2021:
		  ○ Overall APM Ratio: >=50%
		  ○ Risk Based APM Ratio: >=25%
			Measured on July 1 of each calendar year for the previous calendar period.	Per Member per month (PMPM), per period of measurement.	Failure to meet calendar year target for overall APM, and not eligible for exception, based on HHSC's exception criteria:
					
					up to $0.10 per Member per month (PMPM) for period of measurement.
					
					Failure to meet target for Risk Based APM, and not eligible for exception:
					
					up to $0.10 per Member per month (PMPM) for period of measurement.

PN-3	Contract Attachment B-1, §8.1.4 Provider Network UMCM Chapter 5	No more than 20% of total dollars billed to an MCO for “other outpatient services” may be billed by Out-of-Network providers.	Quarterly	Per quarter.	HHSC may assess up to $25,000 per quarter.
PN-4	Contract Attachment B-1, §8.1.4 Provider Network UMCM Chapter 5	No more than 15% of an MCO’s total hospital admissions, by Service Area, may occur in Out-of-Network facilities.	Quarterly	Per quarter.	HHSC may assess up to $25,000 per quarter.
PN-5	Contract Attachment B-1, §8.1.4 Provider Network UMCM Chapter 5	No more than 20% of an MCO’s total emergency room visits, by Service Area, may occur in Out-of-Network facilities.	Quarterly	Per quarter.	HHSC may assess up to $25,000 per quarter.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PN-6	Contract Attachment B-1, §8.1.4 Provider Network UMCM Chapter 5	No more than 20% of total dollars billed to an MCO for residential substance use disorder (SUD) treatment may be billed by Out-of-Network residential SUD treatment providers.	Quarterly	Per quarter.	HHSC may assess up to $25,000 per quarter.
Marketing and Member Materials (MM)					
MM-1	Contract Attachment B-1, §8.1.6 Marketing and Prohibited Practices UMCM Chapter 4	The MCO must meet all Marketing and Member Materials policy requirements and may not engage in prohibited marketing practices.	Transition Phase, Quarterly during the Operations Phase	Per quarter, per incident of noncompliance.	HHSC may assess up to $1,000 per quarter per incident of noncompliance.
MM-2	Contract Attachment B-1, §8.1.6 Marketing & Prohibited Practices UMCM Chapter 4	The MCO must meet all Social Media policy requirements and may not engage in any prohibited Social Media practices.	Ongoing	Per Business Day, per incident of noncompliance.	HHSC may assess up to $500 per Business Day for each incident of noncompliance.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
MM-3	Contract Attachment B-1, §8.1.5.1 Member Materials	No later than the 5th Business Day following the receipt of the enrollment file from the HHSC Administrative Services Contractor, the MCO must mail a Member's ID card and Member Handbook to the Account Name or Case Head for each new Member. When the Account Name or Case Head represents two or more new Members, the MCO is only required to send one Member Handbook.	Transition Phase, Operations Phase, and Turnover Phase	Per each incident of noncompliance.	HHSC may assess up to $500 per each incident of the MCO's failure to mail Member Materials to the Account Name or Case Head for each new Member.
Management Information Systems (MI)					
MI-1	Contract Attachment B-1, §8.1.20 Management Information System (MIS) Requirements	The MCO's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.	Quarterly during the Operations Phase	Per Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $5,000 per Day of noncompliance and per MCO's Service Area.
MI-2	Contract Attachment B-1, §8.1.20.3 System-wide Functions	The MCO's MIS system must meet all requirements in Section 8.1.20.3 of Attachment B-1.	Quarterly during the Operations Phase	Per Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $5,000 per Day of noncompliance and per MCO's Service Area.
Financial Reporting (FR)					

AMERICAN OVERSIGHT

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-1	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements UMCM Chapter 5	Financial Statistical Reports (FSR): For each MCO's Service Area, the MCO must file quarterly and annual FSRs. Quarterly reports are due no later than 30 Days after the conclusion of each State Fiscal Quarter (SFQ). The first annual report is due no later than 120 Days after the end of each Contract Year and the second annual report is due no later than 365 Days after the end of each Contract Year.	Quarterly during the Operations Phase	Per Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $1,000 per Day of noncompliance and per MCO's Service Area a quarterly or annual report is not submitted or is late, inaccurate, or incomplete.
FR-2	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements UMCM Chapter 5	Claims Lag Report must be submitted by the last Day of the month following the reporting period.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-3	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements UMCM Chapter 5	Affiliate Report must be submitted on an as-occurs basis and annually by September 1 of each year in accordance with the UMCM. The "as-occurs" update is due within 30 Days of the event triggering the change.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.

AMERICAN OVERSIGHT

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-4	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements UMCM Chapter 5	Report of Legal and Other Proceedings and Related Events: The MCO must comply with UMCM requirements regarding the disclosure of certain matters involving the MCO, its Affiliates, or its Material Subcontractors, as specified. This requirement is both on an as-occurs basis and an annual report due by September 1. The as-occurs report is due no later than 30 Days after the event that triggered the notification requirement.	Transition Phase and Operations Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-5	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements	Third Party Liability and Recovery (TPL/TPR) Reports: The MCO must submit reports quarterly by the MCO's Service Area as described in UMCM Chapter 5.3.4 Third Party Liability and Recoveries (TPL/TPR).	Operations Phase	Per Day of noncompliance, per TPL/TPR report.	HHSC may assess up to $500 per Day of noncompliance and per TPL/TPR report that is not submitted or is late, inaccurate, or incomplete.
FR-6	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements	MCO Disclosure Statement: The MCO must submit an annual submission no later than September 1st each year and a change notification after a certain specified change, no later than 30 Days after the change.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-7	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements	TDI Examination Report: The MCO must furnish HHSC with a full and complete copy of any TDI Examination Report issued by TDI no later than ten Days after receipt of the final version from TDI.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-8	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements	TDI Financial Filings: The MCO must submit copies to HHSC of reports submitted to TDI no later than ten Days after the MCO's submission to TDI.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-9	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements	Filings with Other Entities and Other Existing Financial Reports: The MCO must submit an electronic copy of the reports or filings pertaining to the MCO, or its parent, or its parent's parent no later than 30 Days after such report is filed or otherwise initially distributed.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-10	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements UMCM Chapter 5	Audit Reports: The MCO must comply with UMCM requirements regarding notification or submission of audit reports.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-11	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements	Employee Bonus and/or Incentive Payment Plan must be submitted no later than 30 Days after the Effective Date of the Contract.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-12	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements	Registration Statement (aka "Form B") must be submitted by ten Days after the MCO's submission of the item to TDI.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
SKFR-1	Contract Attachment B-1, §8.1.19.2 Financial Reporting Requirements UMCM Chapter 5	Medicaid Disproportionate Share Hospital (DSH) Reports: The MCO must submit, on an annual basis, preliminary and final DSH reports. The preliminary report is due no later than June 1 after each reporting year, and the final report is due no later than July 1 after each reporting year. Any claims added after July 1 must include supporting claim documentation for HHSC validation.	Measured during the 4th Quarter of the Operations Phase (6/1–8/31)	Per Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $1,000 per Day of noncompliance and per MCO's Service Area for each Day the report is not submitted or is late, inaccurate, or incomplete.
HHSC Office of the Inspector General (IG)					
IG-1	Contract Attachment B-1, §7.3.7 Operations Readiness Contract Attachment B-1, §8.1.21 Fraud, Waste, and Abuse	The MCO must submit or comply with the requirements of the HHSC-approved Fraud, Waste, and Abuse Compliance Plan.	Transition Phase, Operations Phase, and Turnover Phase	Per Day, per each incident of noncompliance.	HHSC may assess up to $1,000 per Day for each incident of noncompliance.
IG-2	Contract Attachment B-1, §8.1.21 Fraud, Waste, and Abuse	The MCO must perform pre-payment review for identified providers as directed by HHSC OIG within ten Business Days after notification.	Transition Phase, Operations Phase, and Turnover Phase	Per Day, per each incident of noncompliance.	HHSC may assess up to $1,000 per Day and per each incident of noncompliance.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
IG-3	Contract Attachment B-1, §8.1.21.2 General requests for and access to data, records, and other information	The MCO must respond to HHSC OIG requests for information in the manner and format requested.	Transition Phase, Operations Phase, and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance that the information is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per Day of noncompliance for the fourth and each subsequent occurrence within a 12-month period.
IG-4	Contract Attachment B-1, §8.1.22.2 Reports UMCM Chapter 5	The MCO must submit a Fraudulent Practices Referral to the HHSC OIG within 30 Business Days of receiving a report of possible Fraud, Waste, or Abuse from the MCO's Special Investigative Unit (SIU).	Transition Phase, Operations Phase, and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance that the referral is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per Day of noncompliance for the fourth and each subsequent occurrence within a 12-month period.
IG-5	Contract Attachment B-1, §8.1.21.4 Payment Holds and Settlements UMCM Chapter 5	The MCO must submit monthly MCO Open Case List Reports.	Transition Phase, Operations Phase, and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance that the report is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per Day of noncompliance for the fourth and each subsequent occurrence within a 12-month period.
IG-6	Contract Attachment B-1, §8.1.21.4 Payment Holds and Settlements	The MCO must respond to HHSC OIG requests for payment hold amounts accurately and in the manner and format requested.	Transition Phase, Operations Phase, and Turnover Phase	Per incident of noncompliance.	HHSC may assess, per incident of noncompliance, up to the difference between the amount required to be reported by the MCO under UMCM Chapter 5.5 and the amount received by the HHSC OIG.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
IG-7	Contract Attachment B-1, §8.1.21 Fraud, Waste, and Abuse	The MCO fails to submit claims data as prescribed by the HHSC OIG.	Transition Phase, Operations Phase, and Turnover Phase	Per Day, per each incident of noncompliance.	HHSC may assess up to $1,000 per Day and per each incident of noncompliance that the data is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per Day and per each incident of noncompliance for the fourth and each subsequent occurrence within a 12-month period.
IG-8	Contract Attachment B-1, §8.1.21.4 Payment Holds and Settlements	The MCO must impose payment suspensions or lift payment holds as directed by the HHSC OIG.	Transition Phase, Operations Phase, and Turnover Phase	Per incident of noncompliance, per MCO.	HHSC may assess up to the amount not held or released improperly per incident of noncompliance and per MCO.
Frew (FW)					
SKFW-1	Contract Attachment B-1,§8.1.22.2 Reports UMCM Chapter 12	*Frew* Quarterly Monitoring Report – The MCO must submit the report as described in UMCM Chapter 12.	Quarterly	Per Day of noncompliance, per MCO.	HHSC may assess up to $1,000 per Day of noncompliance and per MCO the reports are not submitted or are late, inaccurate, or incomplete.
SKFW-2	Contract Attachment B-1, §8.1.22.2 Reports UMCM Chapter 12	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 as described in UMCM Chapter 12.	Annually	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the reports are not submitted or are late, inaccurate, or incomplete.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SKFW-3	Contract Attachment B-1, §8.1.22.2 Reports UMCM Chapter 12	Farmworker Child Annual Report and Farmworker Child Annual Report Log – The MCO must submit an annual report and an annual log as described in UMCM Chapter 12.	Annually	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the reports are not submitted or are late, inaccurate, or incomplete.
Turnover (TO)					
TO-1	Contract Attachment B-1, §9.5 Post-Turnover Services	The MCO must provide the 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 Phase	Per Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $250 per Day of noncompliance and per MCO's Service Area the report is not submitted or is late, inaccurate, or incomplete.
TO-2	Contract Attachment B-1, §9.4 Turnover Services	Twelve months prior to the end of the Contract Period or any extension thereof, unless otherwise specified by HHSC, the MCO must propose a Turnover Plan covering the possible turnover of the records and information maintained to either the HHSC or a successor MCO.	Measured at twelve months prior to the end of the Contract Period, or any extension thereof, and ongoing until satisfactorily completed	Each Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $1,000 per Day of noncompliance and per MCO's Service Area the Turnover Plan is not submitted or is late, inaccurate, or incomplete.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
TO-3	Contract Attachment B-1, §9.3 Transfer of Data and Information	The MCO must transfer all data regarding the provision of Covered Services to Members to HHSC or a new MCO at the sole discretion of HHSC and as directed by HHSC. All transferred data must comply with the Contract requirements, including HIPAA.	Measured at time of transfer of data and ongoing after the transfer of data until satisfactorily completed	Per Day, per incident of noncompliance (failure to provide data and/or failure to provide data in required format), per MCO's Service Area.	HHSC may assess up to $10,000 per Day, per incident of noncompliance, and per MCO's Service Area the data is not submitted or is late, inaccurate, or incomplete.
Pharmacy (PH)					
PH-1	Contract Attachment B-1, §8.1.17.1 Formulary and Preferred Drug List (PDL) Contract Attachment B-1, §8.1.17.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies	The MCO must allow Network Providers free access to a point-of-care web-based application accessible to smart phones, tablets, or similar technology. The application must be operational, identify preferred/non-preferred drugs Clinical PAs, and any preferred drugs that can be substituted for non-preferred drugs, updated at least weekly. If the MCO has Clinical PAs that are identical to HHSC VDP's Clinical PAs, then the MCO can reference VDP's Texas Medicaid formulary on Epocrates.	Ongoing	Per incident of noncompliance.	HHSC may assess up to $10,000 for an incident of noncompliance if the web-based application is not operational, does not identify preferred/non-preferred drugs, or Clinical PAs, and any preferred drugs that can be substituted for non-preferred drugs, is not updated at least weekly.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PH-2	Contract Attachment B-1, §8.1.17.1 Formulary and Preferred Drug List (PDL) Contract Attachment B-1, §8.1.17.10 Specialty Drugs	The MCO must adhere to HHSC's formularies and the Specialty Drug List (SDL) for drugs provided through selective specialty pharmacy contracts.	Ongoing, Quarterly during Operations Phase	Per incident of noncompliance.	For the initial quarter of noncompliance, HHSC may assess up to $5,000 per incident of noncompliance. For each subsequent quarter of noncompliance, HHSC may assess up to $10,000 per incident of noncompliance.
PH-3	Contract Attachment B-1, §8.1.17.2 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.	Ongoing	Per incident of noncompliance.	HHSC may assess up to $5,000 per incident of noncompliance.
PH-4	Contract Attachment B-1, §8.1.17.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies	The MCO must allow a pharmacy to dispense a 72-hour emergency supply of the prescription as outlined in this section or must make a prior authorization determination within 24 hours of the request.	Ongoing	Per incident of noncompliance.	HHSC may assess up to $5,000 per incident of noncompliance.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PH-5	Contract Attachment B-1, §8.1.17.5 Pharmacy Rebate Program UMCM Chapter 2	The MCO must include rebatable National Drug Codes (NDCs) on all encounters for outpatient drugs and biological products, including clinician-administered drugs. Encounters containing clinician-administered drugs must include, in addition to a CMS-rebate-eligible NDC, the correctly matched HCPCS code and billing units per the applicable date of service according to HHSC NDC-to-HCPCS Crosswalk.	Ongoing	Per month, per each incident of noncompliance.	HHSC may assess up to $500 per month and per each incident of noncompliance.
PH-6	Contract Attachment B-1, §8.1.17.1 Formulary and Preferred Drug List (PDL)	The MCO must maintain a minimum 95% utilization of preferred drugs in each therapeutic class on the PDL.	Ongoing, Quarterly during Operations Phase	Per incident of noncompliance, per therapeutic class.	HHSC may assess up to $1,000 for each incident of noncompliance and per therapeutic class in which the MCO does not meet the standard.
PH-7	Contract Attachment B-1, §8.1.17.1 Formulary and Preferred Drug List (PDL)	The MCO must submit its proposed medication synchronization plan to the HHSC for approval before the MCO may undertake any implementation activities.	Annually by September 1, Transition Phase, Operations Phase, and Turnover Phase	Each Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance.

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#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PH-8	Contract Attachment B-1, §8.1.17.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies	The MCO must provide access to a toll-free call center for prescribers to call to request a PDL PA for non-preferred drugs or drugs that are subject to Clinical PAs. The MCO must ensure at least 98% of PA requests received from prescriber calls to the MCO's PA call center for Medicaid are approved or denied immediately at the time of the call when necessary information is received to complete the review.	Ongoing, Quarterly during Operations Phase	Per each percentage point below the standard.	HHSC may assess up to $100 per each percentage point below the standard each quarter.
PH-9	Contract Attachment B-1, §8.1.17.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies	The MCO must ensure at least 98% of all other PA requests received by a prescriber's office are approved or denied no later than 24 hours after the MCO receives the request. This standard applies to Medicaid programs only.	Ongoing, Quarterly during Operations Phase	Per each percentage point below the standard.	HHSC may assess up to $100 per each percentage point below the standard each quarter.

AMERICAN OVERSIGHT

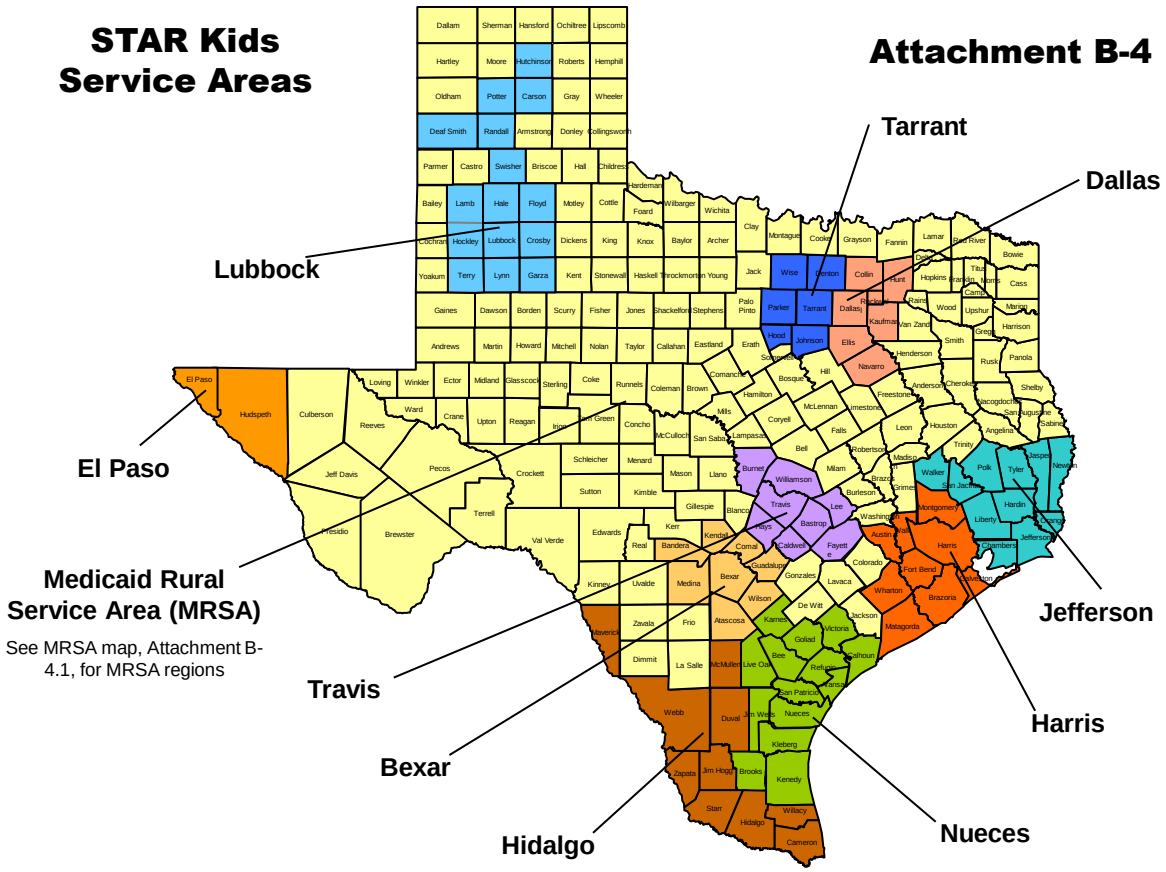
#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PH-10	Contract Attachment B-1, §8.1.17.11 Maximum Allowable Cost Requirements	The MCO must have a process for allowing Network pharmacies to challenge a MAC price, including Network pharmacies that are contracted with a Pharmacy Services Administrative Organization (PSAO). The MCO must ensure at least 98% of MAC challenge requests are resolved by the 15th Day after the MCO receives the request.	Ongoing, Quarterly during Operations Phase	Per incident of noncompliance below percentage rate.	HHSC may assess up to $1,000 per incident of noncompliance below the percentage rate each quarter.
PH-11	Contract Attachment B-1, §8.1.17.11 Maximum Allowable Cost Requirements	Once an MCO has developed a MAC list, the MCO must review and update the MAC list and prices at least once every seven Days to reflect any modifications of MAC pricing.	Ongoing, Quarterly during Operations Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance each quarter.
Medically Dependent Children Program (MD)					
SKMD-1	Contract Attachment B-1, §8.3 Additional Requirements Regarding the Medically Dependent Children Program STAR Kids	The MCO must complete and electronically submit the Screening and Assessment Instrument (SAI) to HHSC's Administrative Services Contractor in the specified format 1) within 60 Days from the date of initial notice from HHSC or 2) 30 Days prior to the annual ISP expiration date.	Operations Phase and Turnover Phase	Per Day of noncompliance, per Member.	HHSC may assess up to $500 per Day of noncompliance and per Member for each Day required documentation is not submitted or is late, inaccurate, or incomplete.

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STAR Kids Service Areas

Attachment B-4



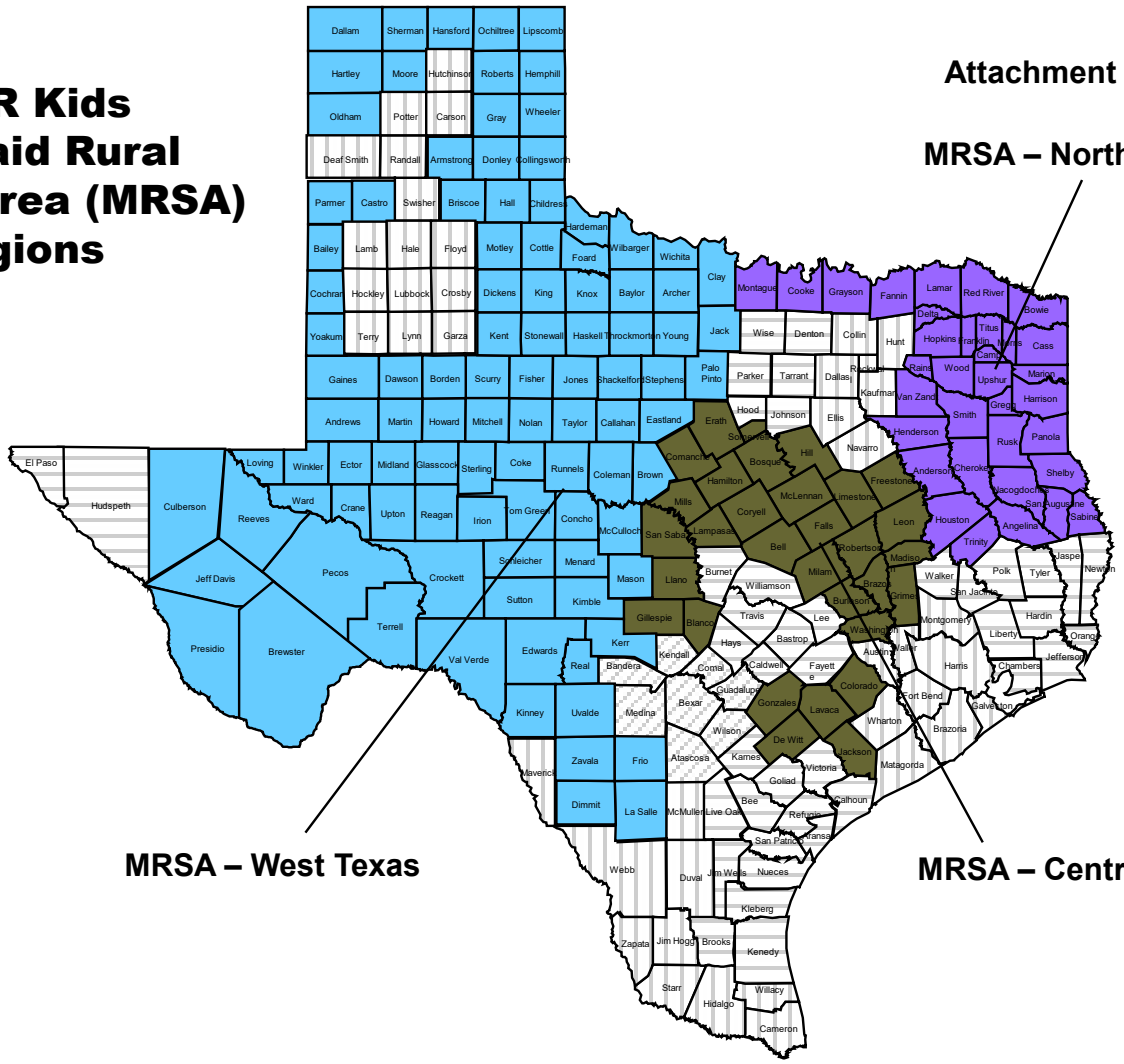
HHSC, Program Operations
November2013

Service Area	Counties Served
Bexar	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson
Dallas	Collin, Dallas, Ellis, Hurt, Kaufman, Navarro, Rockwall
El Paso	El Paso, Hudspeth
Harris	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton
Hidalgo	Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata
Jefferson	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker
Lubbock	Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry
Medicaid RSA	Anderson, Andrews, Angelina, Archer, Armstrong, Bailey, Baylor, Bell, Blanco, Borden, Bosque, Bowie, Brazos, Brewster, Briscoe, Brown, Burleson, Callahan, Camp, Cass, Castro, Cherokee, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Colorado, Comanche, Concho, Cooke, Coryell, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Delta, DeWitt, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Erath, Falls, Fannin, Fisher, Foard, Franklin, Freestone, Frio, Gaines, Gillespie, Glasscock, Gonzales, Gray, Grayson, Gregg, Grimes, Hall, Hamilton, Hansford, Hardeman, Harrison, Hartley, Haskell, Hemphill, Henderson, Hill, Hopkins, Houston, Howard, Irion, Jack, Jackson, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lamar, Lampasas, Lavaca, Leon, Limestone, Lipscomb, Llano, Loving, Madison, Marion, Martin, Mason, McCulloch, McLennan, Menard, Midland, Milam, Mills, Mitchell, Montague, Moore, Morris, Motley, Nacogdoches, Nolan, Ochiltree, Oldham, Palo Pinto, Panola, Parmer, Pecos, Presidio, Rains, Reagan, Real, Red River, Reeves, Roberts, Robertson, Runnels, Rusk, Sabine, San Augustine, San Saba, Schleicher, Scurry, Shackelford, Shelby, Sherman, Smith, Somervell, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Titus, Tom Green, Trinity, Upshur, Upton, Uvalde, Val Verde, Van Zandt, Ward, Washington, Wheeler, Wichita, Wilbarger, Winkler, Wood, Yoakum, Young, Zavala
Nueces	Aransas, Bee, Brooks, Calhoun, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria
Tarrant	Denton, Hood, Johnson, Parker, Tarrant, Wise
Travis	Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson

AMERICAN OVERSIGHT
TX-AG-22-0325-A-000501

STAR Kids Medicaid Rural Service Area (MRSA) Regions

Attachment B-4.1



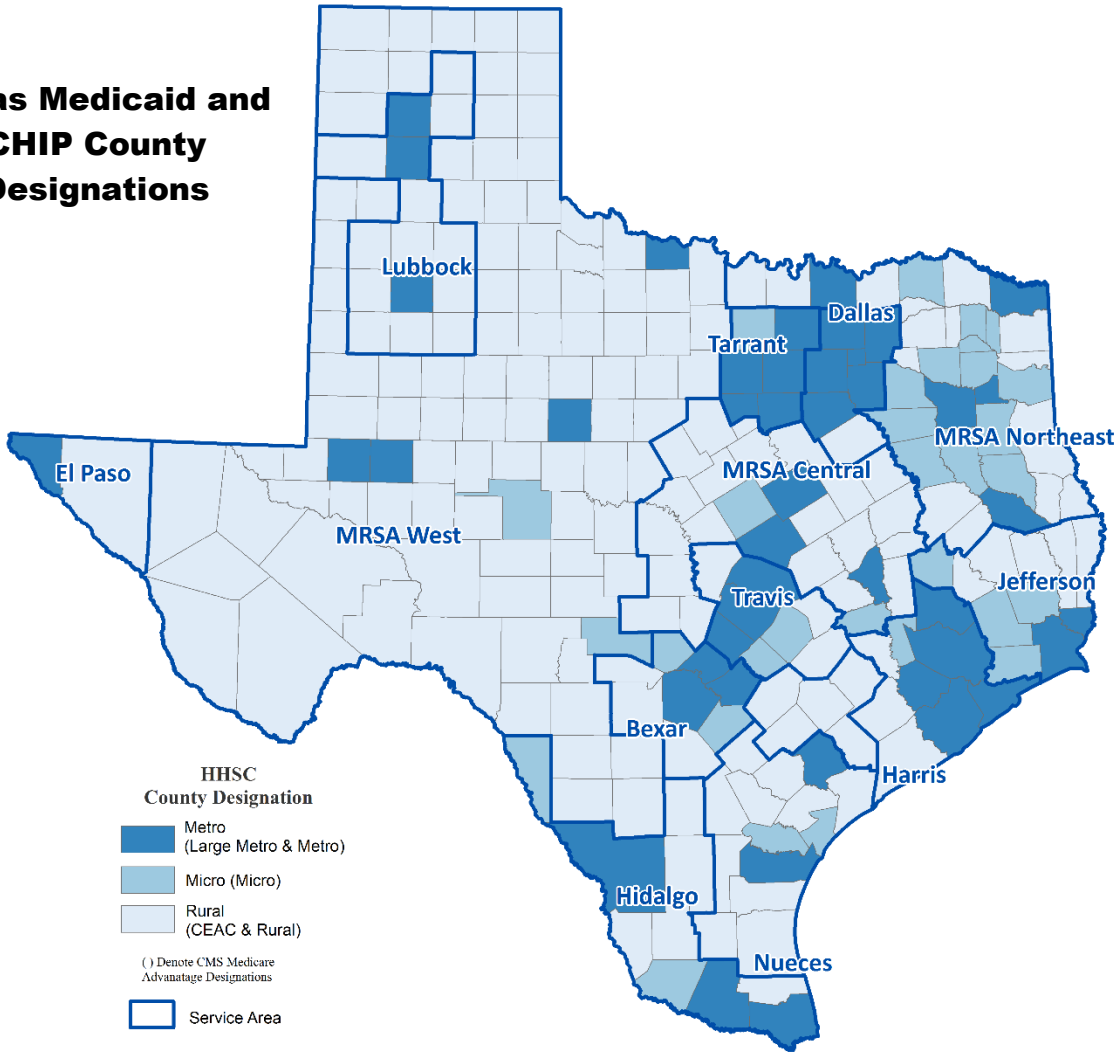
HHSC, Program Operations
November 2013

Service Area	Counties Served
Medicaid RSA – Central Texas	Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington
Medicaid RSA – Northeast Texas	Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt, Wood
Medicaid RSA – West Texas	Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Yoakum, Young, Zavala

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Attachment B-5

Texas Medicaid and CHIP County Designations



HHSC County Type	MA County Type	Population	Density
Metro	***Large Metro***	≥ 1,000,000	≥ 1,000/mi²
---	---	500,000 – 999,999	≥ 1,500/mi²
---	---	Any	≥ 5,000/mi²
---	***Metro***	≥ 1,000,000	10 – 999.9/mi²
---	---	500,000 – 999,999	10 – 1,499.9/mi²
---	---	200,000 – 499,999	10 – 4,999.9/mi²
---	---	50,000 – 199,999	100 – 4,999.9/mi²
---	---	10,000 – 49,999	1,000 – 4,999.9/mi²
Micro	***Micro***	50,000 – 199,999	10 – 99.9 /mi²
---	---	10,000 – 49,999	50 – 999.9/mi²
Rural	***Rural***	10,000 – 49,999	10 – 49.9/mi²
---	---	<10,000	10 – 4,999.9/mi²
---	***CEAC***	Any	<10mi²

A county must meet both the population and density thresholds for inclusion in a given designation.
Data Source: CMS Medicare Advantage

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Designation	Counties
Metro	Angelina, Bell, Bexar, Bowie, Brazoria, Brazos, Cameron, Collin, Comal, Dallas, Denton, Ector, El Paso, Ellis, Fort Bend, Galveston, Grayson, Gregg, Guadalupe, Harris, Hays, Hidalgo, Hood, Hunt, Jefferson, Johnson, Kaufman, Lubbock, McLennan, Midland, Montgomery, Nueces, Orange, Parker, Potter, Randall, Rockwall, Smith, Tarrant, Taylor, Travis, Victoria, Webb, Wichita, Williamson
Micro	Anderson, Aransas, Bastrop, Caldwell, Camp, Chambers, Cherokee, Coryell, Hardin, Harrison, Henderson, Kendall, Kerr, Lamar, Liberty, Maverick, Morris, Nacogdoches, Rusk, San Patricio, Starr, Titus, Tom Green, Upshur, Van Zandt, Walker, Waller, Washington, Wilson, Wise, Wood
Rural	Andrews, Archer, Armstrong, Atascosa, Austin, Bailey, Bandera, Baylor, Bee, Blanco, Borden, Bosque, Brewster, Briscoe, Brooks, Brown, Burleson, Burnet, Calhoun, Callahan, Carson, Cass, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Colorado, Comanche, Concho, Cooke, Cottle, Crane, Crockett, Crosby, Culberson, Dallam, Dawson, Deaf Smith, Delta, DeWitt, Dickens, Dimmit, Donley, Duval, Eastland, Edwards, Erath, Falls, Fannin, Fayette, Fisher, Floyd, Foard, Franklin, Freestone, Frio, Gaines, Garza, Gillespie, Glasscock, Goliad, Gonzales, Gray, Grimes, Hale, Hall, Hamilton, Hansford, Hardeman, Hartley, Haskell, Hemphill, Hill, Hockley, Hopkins, Houston, Howard, Hudspeth, Hutchinson, Irion, Jack, Jackson, Jasper, Jeff Davis, Jim Hogg, Jim Wells, Jones, Karnes, Kenedy, Kent, Kimble, King, Kinney, Kleberg, Knox, La Salle, Lamb, Lampasas, Lavaca, Lee, Leon, Limestone, Lipscomb, Live Oak, Llano, Loving, Lynn, Madison, Marion, Martin, Mason, Matagorda, McCulloch, McMullen, Medina, Menard, Milam, Mills, Mitchell, Montague, Moore, Motley, Navarro, Newton, Nolan, Ochiltree, Oldham, Palo Pinto, Panola, Parmer, Pecos, Polk, Presidio, Rains, Reagan, Real, Red River, Reeves, Refugio, Roberts, Robertson, Runnels, Sabine, San Augustine, San Jacinto, San Saba, Schleicher, Scurry, Shackelford, Shelby, Sherman, Somervell, Stephens, Sterling, Stonewall, Sutton, Swisher, Terrell, Terry, Throckmorton, Trinity, Tyler, Upton, Uvalde, Val Verde, Ward, Wharton, Wheeler, Wilbarger, Willacy, Winkler, Yoakum, Young, Zapata, Zavala

Notes

The County Designations in Attachment B-5 are for purposes of assessing access to network providers (excluding pharmacies). The designations build upon CMS Medicare Advantage (MA) designations. The table above lists the population and density parameters applied to county type designations. A county must meet both thresholds for inclusion in a given designation. In order to facilitate monitoring, HHSC has combined the Large Metro and Metro MA categories into one category for Metro. The categories for Counties with Extreme Access Considerations (CEAC) and Rural counties have been combined to create the Rural category.

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STAR Kids Managed Care Advisory Committee

January 6, 2021

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STAR Kids Managed Care Advisory Committee

AGENDA
January 6, 2020
9:30 a.m.

Meeting Site:
Due to the COVID-19 pandemic, this meeting will be conducted virtually using Microsoft Teams only. To join the meeting, go to https://texashhsmeetings.org/SKMCAC_Jan2021.

Closed captioning for this meeting is available. Viewers are asked to highlight the closed captioning symbol **"cc"** on the bottom of their viewing screen to enable this function.

There is not a physical location for this meeting.

Attendees who would like to provide public comment should see the **Public Comment** section below.

1. Welcome, introductions, and opening remarks

2. Review and approval of STAR Kids Managed Care Advisory Committee Legislative Report (Vote required)

3. Public comment

4. Review of action items and agenda for future meeting

5. Adjourn

Public Comment: The Texas Health and Human Services Commission (HHSC) welcomes public comments pertaining to topics related to eligibility, health and medical care services and policies that govern the administration of the Texas Medicaid program. Members of the public who would to provide public comment are asked to complete a Public Comment Form at https://texashhsmeetings.org/SKMCAC_PCReg_Jan2021. Members of the public are encouraged to participate in this process by providing written public comment to HHSC by emailing Caroline Sunshine at Caroline.Sunshine@hhs.texas.gov no later than 5:00 pm Monday, January 4, 2020. Please include your name and the organization you are representing, or state if you are speaking as a private citizen. Written comments are limited to three minutes and will be read during the meeting for consideration by the Committee.

If you would like to register to provide oral comments, please mark the correct box on the Public Comment form. Instructions for providing oral comment will be emailed to you. Registration should be completed no later than 5:00 p.m., Monday, January 4, 2020. Members of the public may also use the Microsoft Teams Live Event Q&A section to submit a request to provide public comment. The request must contain your name and either the organization you are representing or that you are speaking as a private citizen, and your direct phone number.

Public comment is limited to three minutes. Speakers must state their name and on whose behalf they are speaking. Public members who are using handouts are asked to provide an electronic copy in accessible pdf format that will be distributed by HHSC staff to members, state staff, and the public. Handouts are limited to two pages (paper size: 8.5" by 11", one

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TX-AG-22-0325-A-000506

side only). Handouts must be emailed to HHSC immediately after registering and include the name of the person who will be commenting.

Contact: Questions regarding agenda items, content, or meeting arrangements should be directed to Caroline Sunshine, Advisory Committee Coordinator, Medicaid and CHIP Services Department, 512-428-1948, Caroline.Sunshine@hhs.texas.gov.

This meeting is open to the public. No reservations are required, and there is no cost to attend this meeting.

People with disabilities who wish to attend the meeting and require auxiliary aids or services should contact Sunshine at 512-428-1948 or Caroline.Sunshine@hhs.texas.gov at least 72 hours before the meeting so appropriate arrangements can be made.

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STAR Kids Managed Care Advisory Committee Recommendations

As Required by

Title 1, Part 15, Texas Administrative Code, Section 351.823(d)

STAR Kids Managed Care Advisory Committee

January 2021

TX-AG-22-0325-A-000508

Recommendations

Subcommittee on Health Homes and Quality Measures

The ideal model of service delivery for children with complex healthcare needs is one where the Primary Care Physician (PCP) and parents engage in a person-centered process of goal setting and shared decision making to allow appropriate access to and allocation of resources and services. To achieve this in this population, we need to encourage close collaboration and integration of processes between providers, parents and MCOs. This was specifically stated as a desired goal by HHSC when STAR Kids was being designed and is the goal of this subcommittee's recommendations. We have reviewed the literature on examples of similar approaches to innovation.

As in previous reports, recommendations and updates, stakeholder input (especially that from families, public comment, work groups and the Star Kids Advisory Committee meetings) has been incredibly beneficial and successful in improving efficiency, access, and care for children in Star Kids. The committee recommends ongoing use of stakeholder feedback to continue to improve, adapt and ensure coordinated care.

In the past year, healthcare delivery systems were forced to make dramatic adaptations in response to COVID. We will draw from these experiences as we make our recommendations as it relates to health homes and quality measures.

1.1 Topic/Issue: Service fragmentation and potential opportunities from telemedicine

***Background**:*

Children served in the STAR Kids program, especially children with medical complexity receive services from multiple providers, subspecialists, home

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health agencies, durable medical equipment providers and personal care attendant services.

As these providers function as independent business entities, with no mechanism for data sharing; families are subjected to redundant assessments, evaluation and surveys necessitating additional layers (and time) and cost for care coordination and case management.

The COVID pandemic was particularly challenging for this population, but it has also allowed innovation - especially as it relates to efficiencies offered by telemedicine and the potential for telemedicine to enable true service integration and real-time multi-disciplinary collaboration in safe, timely way benefiting providers, families and MCOs.

The data from this experience is barely emerging around the country. Dr. Ricardo Mosquera – a member of our subcommittee has been a pioneer of telemedicine practices for this population and had performed a randomized controlled trial in the period just preceding the COVID pandemic (August 2018- April 2020). In a recent presentation to the Children's Policy Council, his team showed the cohort served by telemedicine had a higher probability of decreased emergency room visits, decreased hospital days and decreased total days of care.

There is anecdotal evidence that shows benefits that derive from decreased exposure to illnesses in the waiting room and decreased cost of ambulance transport and missed work for in-person visit.

In addition, in an on-going pilot at the Children's Comprehensive Care, the team is trying to leverage the virtual technology platform of telemedicine to have bi-annual health maintenance visit where all the care providers will participate in a virtual visit to allow for a coordinated assessment and care plan development.

Successful integration of service delivery and care plan development is dependent on three prerequisites.

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- a common data platform that allows data sharing between the different provider entities.
- a payment scheme that incentivizes integration (e.g., a bundled payment for all participating entities) and
- an evaluation schema that assesses the effectiveness of the model as a 'whole' instead of separate schemes for each entity.

Recommendation: We recommend HHSC incentivize efforts to make these three pre-requisites possible. Given the unique nature of the STAR Kids population, the opportunities offered by telemedicine need to be carefully evaluated and expanded, as appropriate, even after the COVID crisis resolves.

1.2 *Issue/Topic: Problems related to an unsustainable increase in* administrative paperwork and administrative costs to providers

Background*:* The process of delivering care as it exists is fraught with redundant assessments and evaluations by different entities; (See graphics below for a representation of some of the assessments a single individual may undergo over the course of a year.)

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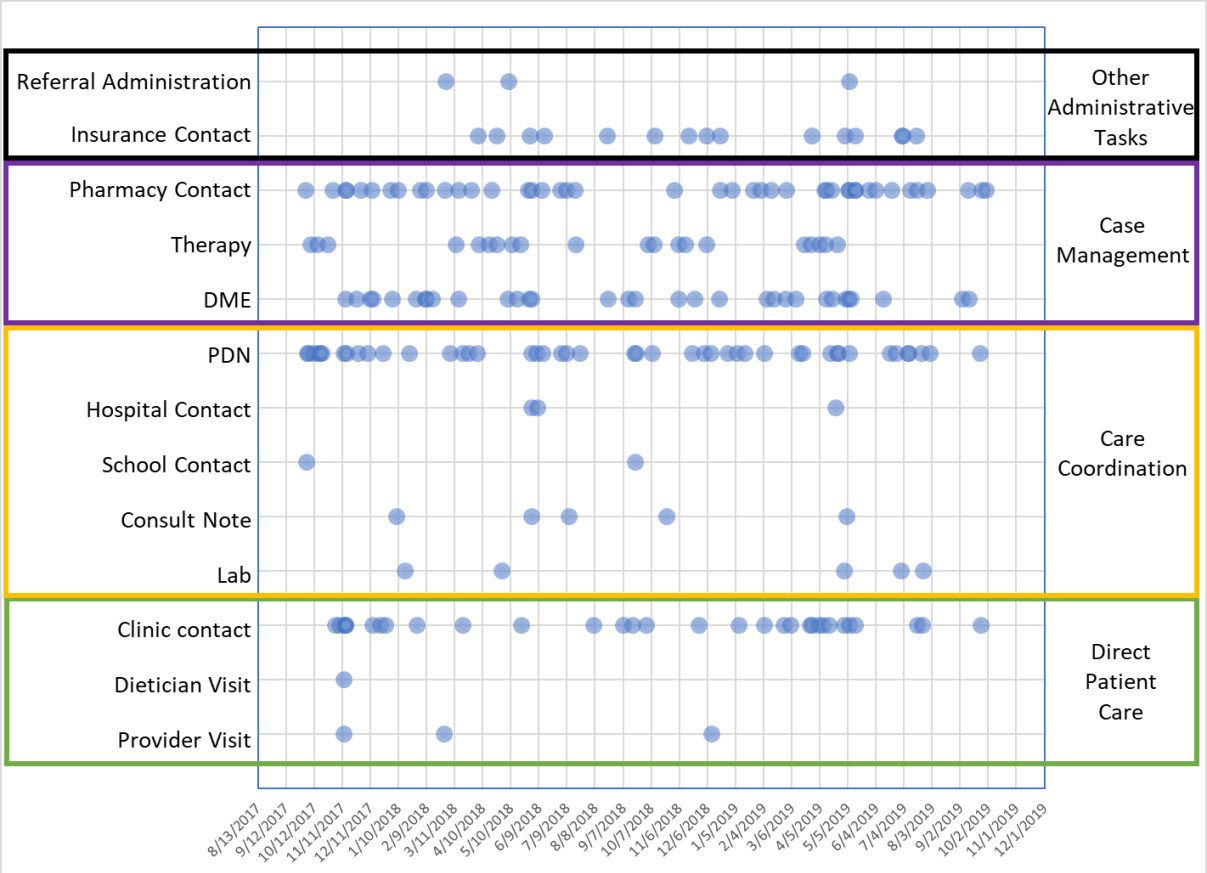
Assessment, Assessment, Assessment



Many of the assessments are done by disparate entities that operate as silos and have no mechanism for data sharing and operational integration.

In addition, repeated requests for justification of care and letters of medical necessity result in several hours a week of parent and provider time spent complying with these paperwork requirements. The following graph represents the contact points for a single patient receiving care at a comprehensive care clinic over the course of two years. As the graph indicates, of the more than 200 contact points, much of the time is spent on paperwork to justify care than actual care delivery.

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PCPs have experienced an overwhelming increase in paperwork dealing with multiple MCOs processes for prior authorization. In addition, many of the MCO's have subcontracted their prior authorization process to multiple outside entities which has led to a frustrating situation to providers. PCPs sometimes must do peer-to-peer consultations with MCO medical directors, many of whom do not have any specific expertise with this population.

Since the submission of our last report, several of our recommendations related to administrative simplification were initiated and are currently underway at HHSC. For example, HHSC is piloting with an MCO a mechanism to decrease administrative burdens related to medical supplies through a process of streamlined and longer prior authorization periods for children whose needs have not changed. See recommendation 1.2.i below. In addition, Senate Bills 1207 and 1096 as well as House Bill 3041 from the 86th Texas Legislature, Regular Session, 2019 required MCOs to annually review

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prior authorization requirements for relevance. See recommendation 1.2.iv below.

***Recommendation**:* We recommend HHSC encourage and facilitate simplification of administrative paperwork as it relates both from provider to MCO as well as MCO to HHSC and continue to include committee representation in the discussion. For example:

i. Use the SK-SAI to allow for the identification of children where certain services and supplies will be needed for the duration of the child's life. There should be a provision to auto-renew orders for incontinence supplies, supplies for enteral nutrition etc. without requirement for frequent paperwork and letters of medical necessity. Expand the medical supplies pilot currently underway at HHSC to other MCOs and regions.

ii. Similarly, for a child with progressive condition with tracheostomy/ventilator – if stable, and the clinical condition deemed unlikely to change within the next year, waive the requirement to submit the nursing plan of care every 60-90 days and space out the intervals. A pilot project with a Medicaid MCO and a comprehensive care clinic is currently underway to fast track authorizations and decrease administrative burden. The subcommittee will monitor the implementation and report to the full committee.

iii. HHSC should incentivize systems of care that allow for a coordinated review of needs at specified time points to streamline the approval and delivery of supplies and medications. Currently most authorizations for supplies, equipment and medications occur at desperate times in a very uncoordinated and haphazard manner. It is not unusual for a family to make a trip to the pharmacy every other day.

iv. HHSC, MCOs and Providers should review and revise prior authorization requirements for appropriateness for this population. Example: An MCO requires a hearing test and developmental screens before authorizing for speech therapy. This may be a reasonable requirement for the typical STAR population but for children who already have a diagnosis of moderate to severe cognitive impairment the screening is unnecessary. This recommendation is supported by SB 1207 which requires an annual review of prior authorization processes.

v. HHSC should require MCOs to engage provider groups in value-based arrangements where trusted providers will have their orders (for labs, imaging and hospitalization) fast tracked without the need for extra

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justification provided there are periodic audits to keep each party accountable.

1.3 *Issue/Topic:* Improved care coordination through the development of health homes for children with medical fragility and serious mental health care needs

***Background**:*

In communities where there are enhanced health homes – dedicated to the medically fragile children as defined as subgroup 1 of our first recommendation, (Austin, San Antonio, Dallas, Houston), the opportunities for better integration of care coordination services with the MCO have not been adequately explored, utilized and incentivized. These clinics have a longitudinal relationship with the families and provide care coordination, social services and are well networked with the local specialist panels and children's hospitals. However, there is no template on how to fold this existing resource into a viable center of excellence. These centers could serve as bright spots for evidence generation on best practices. Absent any template for collaboration and no direction or incentivization from the state, leaders of most of these clinics spend a lot of time and energy trying to craft contracts with multiple MCOs. Reimbursement from MCOs for services in these centers covers only a small fraction of the center's budget. As most are supported by a combination of grants and subsidies, their financial viability is tenuous and will likely jeopardize care for hundreds of members.

***Recommendations**:*

i. Incentivize the development of dedicated comprehensive service lines within FQHCs and large primary care practices and their collaboration with centers of excellence.
ii. Incentivize value-based payment arrangements that are designed to address the special effort required to meaningfully develop comprehensive person-centered care plans and adequately reimburses providers for non-encounter-based processes that lead to better outcomes.
iii. Incentivize MCOs to create fast tracking processes for trusted provider groups to certain service coordination and case management

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functions. Specifically, this may involve embedding service coordinators in health homes or delegating service coordination to health homes with adequate capacity.

iv. Pay providers a higher rate for caring for children with complex medical needs and children with serious and persistent mental illness. Some mechanisms for this payment may involve -designating consult level billing or an extra payment category for preparing and producing a detailed care plan. Care Plan preparation and discussion is largely a non-reimbursed service currently even though it takes more than two hours of time; a large part of it may not be a face-to-face encounter.

v. Promote this collaboration through statewide pilot projects; participating actively in national innovative projects and focusing PIPs to address some of these processes.

vi. HHSC should take full advantage and participate in the ACE Kids Act when it rolls out to states.

1.4 Issue/Topic: Limited pool of qualified direct service workforce

***Background**:* PCPs who have longitudinal relationships with families caring for children with complex needs recognize that health care outcomes are largely dependent on having quality home care services. Unfortunately, there is very little effort to improve the pool of qualified direct service workers. The two options offered to families are – Medicaid Private Duty Nursing which is expensive and increasingly limited or attendant care – which, while cheaper is difficult to access as there are very few qualified individuals willing to work for such low pay. PCPs and health homes can engage families in conversations about the most appropriate home health services, but this is not possible because the appropriate workforce is not available in most communities.

Many families of children with medical complexities would be amenable to delegation of nursing tasks to a direct service worker through personal care services or Community First Choice if they were provided attendant care that was reliable and qualified. The current rate of $8.11 an hour for a direct service worker is too low to support delegation. In addition, families of children with significant behavioral support needs had hoped that Community First Choice would provide opportunities for support and a decrease in episodes of crises that lead to hospitalization and institutionalization. However, it incredibly difficult to find someone who will provide the support

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needed for $8.11 an hour. Finally, the recent implementation of Electronic Visit Verification for families using Consumer Directed Services and for individuals in waiver services has led to further disruption to this incredibly important support for families who want to keep their children at home instead of institutions.

Recommendations:

i. HHSC should closely evaluate through data collection whether individuals are being assessed for Community First Choice and Personal Care Services.

ii. HHSC should closely evaluate through data collection whether individuals who are receiving CFC or PCS are receiving the number of hours they have been assessed as needing.

iii. HHSC should include the following recommendations as strategies for the recruitment, retention, and access to community attendants.

a. Facilitate/incentivize the creation of community attendant registry to help families find direct service workers.
b. Encourage value-based payment models that incentivize the development of specifically trained attendants to care for children who have medically complex conditions or who have behaviorally complex support needs by allowing for increased payment for individuals with more skills and certifications as well as increased administrative payments to home health agencies.
c. Increase the Medicaid fee schedule for Personal Care Services and Community First Choice.
d. Explore models that allow families to be providers of care such as Parents as Certified Nurse Assistants in Colorado.

1.5 Issue/ Topic: Measuring outcomes that matter

Background*:* The federal government mandates that State Medicaid Managed Care Programs be regularly evaluated by an External Quality Review Organization (EQRO). We appreciate the effort by HHSC and EQRO to come up with a set of outcome measures to track and assess the implementation of STAR Kids. Given the challenges in data collection, many of the measures rely on administrative and claims data and are focused on

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process measures derived from a universe of validated measures used in other populations.

Unfortunately, validated measures that are specific to this population are very limited. Understandably, measures used in the general population (HEDIS) have been used in this population. Some of the limitations of using HEDIS measures in this population include the following:

- Requirement for UTD immunization - Some children with medical complexity have an immune deficiency syndrome that prohibits the use of any live virus vaccines (e.g., DiGeorge's Syndrome). Some children are undergoing interventions that require delaying vaccination (e.g., children with complex congenital heart disease - delay immunizations for six weeks before and after bypass.
- Requirement for 'physical activity' and 'weight counseling - The verification of these measures does not take into consideration the possibility that the child may be on an exclusively gastrostomy tube feeds that may be managed by a dietitian. In some instances (such as for children with cerebral palsy), the degree of physical activity and weight bearing allowed is determined by the physical therapist. Therefore, counseling on physical activity may be inappropriate. The verification of these measures does not consider the dietitian visits that provide rich documentation of their involvement and management.
- Follow up visit after ADHD; Lab monitoring with antipsychotics - Many of the children with behavioral challenges due to organic brain syndrome, children on the spectrum etc. are started on stimulant medications to help manage behavior. The guidelines do not take into account the complex polypharmacy that may be involved. The blood test requirements also tend to be very rigidly applied. For some of these children, conscious sedation is required for any medical procedure (including blood work). This rigid time interval for monitoring - with no regard for the risk of metabolic syndrome, exposes these children to more harm than good.

Texas is unique among states in mandating a standardized comprehensive assessment of the health status of all children served under this program.

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The STAR Kids Screening and Assessment Instrument (SK-SAI) offers an opportunity for longitudinal tracking and the development of robust measures of the health status of children and families.

Recommendations:

i. HHSC should incorporate waivers for certain HEDIS measures to avoid unfairly penalizing practices that have a high proportion of children whose conditions do not comport with the HEDIS measures.
ii. Include measures that are more focused on Outcomes than Process. The National Core Indicators (NCI) that are based on Child Family Surveys of households with developmental disabilities is a good resource.
iii. HHSC should pay particular attention to include outcome measures that directly measure the capability/comfort/calm of members – in the next iteration of the SK-SAI. Collaboration with pilot projects such as COIIN (http://cahpp.org/project/CoIIN-CMC) and other groups working on improvement will be helpful
iv. HHSC should promote evidence generation as to the best approach to service delivery by sponsoring and incentivizing statewide and national pilot projects to identify best practices. Some examples of such opportunities include https://innovation.cms.gov/initiatives/integrated-care-for-kids-model/ and also http://cahpp.org/project/CoIIN-CMC.
v. HHSC should participate in the implementation of the ACE-KIDS act (https://www.congress.gov/bill/116th-congress/senate-bill/317) and use opportunities such as the 1115 waiver to jump start innovation. The state should use existing complex care programs and transition programs in large urban centers as laboratories for innovation and experimentation to test best practices and build an evidence base. HHSC should begin mapping out what is needed prior to the next legislative session to avoid missed opportunities.
vi. HHSC should investigate and sponsor pilots where the patient centered medical home is a community integrated "Behavioral Health Home" to bring together social services and behavioral health. This may require a collaboration with MCOs, local mental health authority and health homes. These health homes can utilize telemedicine to access psychiatric med management; utilize evidence-based family supports such as the Family Partner program by the National Alliance of Mental Illness (NAMI). Lessons from the two-year demonstration project for 'Certified Community Behavioral Health Clinics (CCBHC) can serve as a model around which to organize the pilot.

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Subcommittee on SK-SAI, Prior Authorizations, MDCP and IDD Waivers

The Texas Health and Human Services Commission contracted with Texas A&M University (TAMU) for a screening and assessment instrument to be used in STAR Kids. The STAR Kids Screening and Assessment (SK-SAI) instrument is divided into modules. All children must receive the core module. If triggered by the core, children are then assessed using one or more of the remaining modules; Personal Care Assessment Module (PCAM), Nursing Care Assessment Module (NCAM) and MDCP Module. The SK-SAI is intended to assess for eligibility for PCS, CFC for children who meet medical necessity for nursing facilities, PDN and the MDCP waiver. The assessment is also intended to serve as a trigger for referrals for additional services such as therapy, durable medical equipment (DME) and supplies, CFC for children with IDD or children with mental health conditions, IDD waiver services, and other mental health services.

HHSC has engaged in an optimization project to improve the SK-SAI with the goal of improving data integrity and reporting; creating a more actionable assessment; ensuring assessor accuracy; and reducing assessment burden on families. The committee has worked diligently with HHSC since August 2019 to offer feedback to proposed changes to the SK-SAI. HHSC is still reviewing our feedback, including recommendations from MCOs before the changes are finalized. Our subcommittee is interested and committed to improving the assessment and reassessment of children and reducing assessment burden on families. We are committed to working with HHSC on improvements to the process and offer the following recommendations regarding the SK-SAI.

2.1 Topic/Issue: SK-SAI Tool Improvements

Background: HHSC has embarked on an internal review of the SK-SAI for optimization and improvement. The STAR Kids Advisory Committee has offered numerous improvement recommendations to the assessment and is planning to work with HHSC on changes to the reassessment process.

Recommendations:

i. Continue to work with the committee on improvements to the SK-SAI.

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ii. Test the new assessment on a small sample of children, including children with medical complexities, children with intellectual and developmental disabilities and children with significant mental health needs prior to implementing the new tool. Include MCO assessors in the testing of the assessment and revise based on testing.
iii. Ensure the revised tool contains solid triggers for referrals for Community First Choice, durable medical equipment, Personal Care Services, and therapy.
iv. Provide guidance to the SK-SAI assessor directly on the tool for questions that require judgement such as questions that are those using a scaling system.
v. Work with the committee on a reassessment tool that limits questions based on no change in condition and which focuses on assessing for improved outcomes for children.
vi. The SK-SAI should account for medical intervention as a contributor to how one answers the questions. For example, is he in pain, no "because of medical intervention?" The same could be said for being "stable," due to medical intervention. The intervention must be accounted for because without it the child's condition could deteriorate. Families should be asked to what they attribute the change.
vii. Expand the HHSC Utilization Review Department's operational review of STAR Kids to include children who are not in MDCP such as children with IDD and MH conditions and evaluate whether changes are needed in the SK-SAI to capture a child's need for services.
viii. Monitor the testing of the new tool and make changes based on feedback from the families and MCOs.

2.2 Topic/Issue: MDCP SK-SAI

Background: Since the inception of STAR Kids on November 1, 2016, the number of children on the MDCP waiver who were reassessed using the new SK-SAI and lost waiver eligibility increased from 3.1% in 2016 to 14.1% in 2017 and 8.7% in 2018. Initial reports for the period of November 2018 to October 2019 show the number to be approximately 5% which is a substantial improvement over 2017 and 2018. Many of the children who lost eligibility during the early implementation of STAR Kids are children who have been on the waiver for years and have not experienced a change in condition. With the loss of eligibility children are not only losing access to MDCP waiver services but are losing access to critical long-term services and supports and for some access to their health insurance, Medicaid.

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Children who receive services under the MDCP waiver are required to meet the same medical necessity eligibility as children seeking admission to a nursing facility, adults seeking admission to a nursing facility, or adults seeking services under the STAR +Plus waiver. Prior to the implementation of STAR Kids, children in MDCP were assessed initially and reassessed annually using the Medical Necessity Level of Care (MN-LOC) tool. This is the same tool used for individuals over 21 years of age in the STAR + Plus nursing facility waiver. The MN-LOC tool was similar to the Minimum Data Set tool used to determine eligibility for adults and children in Texas nursing facilities. The new SK-SAI is a departure from the MN-LOC. The SK-SAI MDCP module only results in a determination of the MDCP budget based on the Resource Utilization Group. It does not determine nursing facility medical necessity. That determination is made using a variety of fields in other SK-SAI modules and is subject to interpretation by the state's third-party contractor. In addition, the nurse assessors with the MCOs who are completing the assessment are not allowed to do a physical nursing assessment of the child and are only going by information provided to them by the child's family or what is available through medical records.

Recommendations:

i. Consider alternative options for assessing children for eligibility for the MDCP waiver, including requiring the assessment be done by an assessor who can do a hands-on nursing assessment, not the MCO nurse assessor who is prohibited from doing a thorough nursing assessment.
ii. Continue to monitor the number of MDCP denials at the annual reassessment and consider reverting to the MN-LOC tool to determine MDCP eligibility as opposed to the SK-SAI if the number increases.
iii. Offer children who have lost eligibility for Medicaid due to loss of Medically Dependent Children Program eligibility in STAR Kids, access to another 1915(c) waiver such as Community Living Assistance and Support Services (CLASS) or Home and Community-based Services (HCS) with no wait.
iv. Amend the MDCP waiver to create reserved capacity for crisis diversion slots for a targeted group of children who are determined to be medically fragile and at imminent risk of nursing facility admission. Because the MDCP waiver waives off both a hospital level of care and/or a nursing facility level of care, a child who meets the medical fragility eligibility for MDCP and is at imminent risk of admission to a

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nursing facility should be able to access the waiver without a limited stay in a nursing facility. A child should not have to get discharged from a hospital setting to a nursing facility for a short stay and then to home. This is not good for the child's health and safety and leads to increased costs and administrative burdens.

v. Allow children enrolled in STAR Kids who have SSI and meet the MDCP waiver eligibility immediate access to waiver services with no wait.
    a. Create a similar allowance for children in STAR Health.

2.3 Topic/Issue: SK SAI and Improved Communication and Transparency for Families

Background: Families must be the drivers of their children's health. For families to be actively involved and to ensure children achieve optimal outcomes, there must be clear, ongoing communication between the Star Kids MCOs and the families. Based on recommendations in last year's report and legislative direction, HHSC added requirements in the STAR Kids contracts (8.1.39) that parents review the SK-SAI prior to submission. HHSC also instructed MCOs to train members in the navigation of member portals and required them to submit education materials to HHSC for review. We understand HHSC is embarking on a significant utilization review initiative of children receiving services through the Medically Dependent Children's Program. We recommend that during the review HHSC monitor whether training on portal access is occurring.

Recommendations:

i. HHSC should monitor the MCOs to ensure MCOs have offered individualized training to families on how to access the health portal to:
    a. See the SK-SAI
    b. Review the Individual Service Plan (ISP)
    c. Track authorizations, view claims and find information on the child's MDCP budget, and pending and final denials and reductions
    d. Request an internal appeal

ii. HHSC should require the MCOs to notify individuals via a text, email or call when a document has been uploaded to the member portal. Parent contact information including email addresses can be updated at every reassessment for accuracy.

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iii. HHSC should develop a document that can be sent from the MCO to the family 120 days prior to the annual assessment informing them:
   a. What to expect at the assessment
   b. What documents to have ready

2.4 Topic/Issue: Medical Necessity and Treating Physician

Background: Families and physicians in STAR Kids have voiced their concern about medical necessity determinations being made by the MCOs that are contrary to the determinations made by the child's physician. Some children have experienced a reduction in authorizations for PDN, MDCP waiver eligibility, therapies and other benefits. HHSC has a definition of medical necessity and when there is a dispute, the determination and standard of medical necessity should default to the child's physician.

Senate Bill 1207 required HHSC and the State Medicaid Managed Care Advisory Committee to develop a uniform process and timeline for reconsideration of an insufficient prior authorization request and allow for a peer-to-peer review. Two of our committee members are serving on the subcommittee charged with developing the recommendations. Senate Bill 1207 also requires an external medical review process when a family or their child's treating professional disagree with an adverse benefit determination.

Recommendations:

i. Continue to develop uniform process and timeline for reconsideration of prior authorization requests prior to denial.
ii. Monitor the implementation and provision of external medical reviews as required by SB 1207. Publicly post data related to external medical reviews including number of denials overturned and number sustained.

2.5 Topic/Issue: Preferred Provider

Recommendations: HHSC should retain the allowance in STAR Kids for a member to opt out of a preferred provider arrangement and choose a different provider. Members should continue to have a choice of providers for specialty services and DME, including non-preferred provider arranged services.

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i. HHSC should require in contract that MCO call center staff inform members of non-preferred providers along with preferred providers available in the network, to enable members to choose the most appropriate services, providers and equipment.
ii. HHSC should monitor to ensure the preferred provider opt out process is working and easy for families to access and use.

2.6 Topic/Issue: Notices of denials of services lack clarity and families need adequate notice of right to appeal

Background: Families and providers report issues with timeliness and clarity in Medicaid appeal notices. For services to continue during the appeal process, an individual must request the appeal within 10 days from the date of the action notification letter. By the time the families receive the letter some of the 10 days have passed, leaving the family with a very small window of time for the actual filing of the appeal. In some cases, families have received notices well past the 10-day time frame

It is imperative that the reasons cited in the appeal notice must be clear and written in plain language that is easily understood by families.

HHSC has undertaken several initiatives to improve notices of denials of benefits which were included in last year's report. We will continue to work with HHSC and the State Medicaid Managed Care Advisory Committee's subcommittees to ensure recommendations and on direction from the legislature

Recommendations:

i. Provide families timely notice of their right to seek an internal MCO appeal and a Medicaid fair hearing when Medicaid services, including waiver services, nursing, PCS and therapy are reduced or denied.
ii. Monitor whether denial notices are being sent out the same day the determination was made, and if there are significant violations, consider requiring the notice to be delivered via registered mail to ensure the time frame is followed.
iii. Require MCO service coordinators to contact families when an adverse determination is being sent and remind the family of their right to appeal the denial.

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iv. Ensure notices sent by HHSC and MCOs are written in plain language for families with detail on why the denial occurred, what is needed to meet medical necessity requirements, deadlines for the appeal, and information on maintaining the same level of service during the internal MCO appeal and Medicaid fair hearing process until a final determination is made.

v. Improve and coordinate MCO informal appeals and HHSC fair hearings, including consumer information that explains and assists with both processes and meets all state and federal due process requirements, such as proper notices and packets with complete and relevant information used to deny, suspend, or reduce services.

2.7 Topic/Issue: Transparency and timely response to member and provider complaints

Recommendations: Increase transparency and respond quickly, accurately and completely to issues generated through inquiries, complaints, conducting investigations, inspections and other contract compliance regulatory actions.

i. Require state agencies and MCOs to track all instances of access to care issues as a complaint.

ii. Improve data integration and transparency to include information across systems relating to inquiries, complaints, informal MCO appeals, and Medicaid Fair Hearings that is publicly available.

2.8 Topic/Issue: Coordination of Benefits, Continuity of Care, and Alternative service delivery model for children in Medically Dependent Children Program

Background: Some families of children in the STAR Kids MDCP waiver have reported a loss of providers, delays in authorizations, denials of service, inability to see physicians and specialists in other service delivery areas, and issues with the coordination of benefits with third-party insurers. Approximately 50% of children receiving services through MDCP have third-party insurance.

Recommendations:

i. Prioritize the development of clear and standard policies around coordination of benefits for those with third-party insurance.

ii. Define specialty providers broadly to include providers of therapy and durable medical equipment

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iii. HHSC should work to develop a list of services that are rarely provided via commercial insurance and allow MCOs to authorize services without waiting on Explanation of Benefit from a commercial carrier.
iv. Ensure the continuity of care provision is a minimum of 90 days.
v. Allow families to access out of network providers with no penalty to MCOs.
vi. Exempt the MDCP population from any out of network utilization benchmarks placed on MCOs.
vii. Improve access to single-case agreements and make the process easier for families to access and physicians to accept.
viii. Investigate alternative models of service delivery for children in MDCP such as Primary Care Case Management, Fee for Service, or an Accountable Care Organization.

2.9 Topic/Issue: Inclusion of IDD Waivers into STAR Kids

Background: The IDD System Redesign Advisory Committee created as part of SB7 by the 83rd Legislature is charged with advising HHSC on the implementation of acute care and long-term services and supports for individuals with IDD. The committee strongly recommended that HHSC delay the transition of IDD LTSS to a managed care model until necessary systems changes are accomplished. The committee requested HHSC evaluate the lessons learned from the STAR Kids IDD acute care carve-in and use those lessons to improve the system before any additional waivers are carved into Medicaid managed care.

Recommendations:

i. Delay inclusion of all additional IDD waivers such as Texas Home Living, Home and Community-Based Services (HCS), Community Living Assistance and Support Services (CLASS), and Deaf Blind Multiple Disabilities (DBMD) into STAR Kids unless and until related evaluations and the IDD assessment pilot are completed, and access to and quality of care are resolved in current managed care programs and operational systems and providers are in place for a successful transition.

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2.10 Topic/Issue: Evaluation of whether to move to STAR Kids to statewide MCO

Background: HHSC recently released a Request for Information asking for feedback on whether STAR Kids should move to one statewide service delivery area served by 2 or 3 statewide MCOs.

Recommendations:

i. Do not implement a statewide service delivery region for STAR Kids. A statewide model would potentially prevent community-based plans and small plans from participating and have a potential negative impact on promising practices. HHSC should continue to encourage competition among non-profit and for-profit models and the development of quality standards of care for vulnerable children.

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Subcommittee on Transition from Pediatric System to Adult System

According to the American Academy of Pediatrics, American Academy of Family Physicians, and the American College of Physicians 2018 Clinical Report on supporting health care transition (HCT) from adolescence to adulthood, evaluation studies document beneficial outcomes of a structured transition process in terms of quality of care, appropriate service use, and improved patient and family experience.[1] The goals of HCT are to 1) improve the ability of youth and young adults, including those who have special health care needs and those who do not, to manage their own health and effectively use health services, and 2) ensure a planned process for transition preparation, transfer of care, and integration into adult care. The recommended process called for by these medical professional organizations is the Six Core Elements of Health Care Transition, developed by Got Transition.[2]

3.1 *Topic/Issue:* Medicaid fee schedule gaps impede the provision of recommended Health Care Transition services and collaboration between pediatric and adult providers for our STAR Kids population. It is important to have a mechanism to allow pediatric and adult providers to bill for professionally recommended health care transition-related services.[3]

Background: The medical complexity of our STAR Kids population necessitates a formal structured transition process from pediatric to adult health care with corresponding payment to recognize the added work and collaboration involved.

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[1] White P, Cooley C, Transitions Clinical Report Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. 2018;142(5):e20182587.

[2] Six Core Elements of Health Care Transition 3.0. Washington, DC: Got Transition. Available from: https://www.gottransition.org/six-core-elements/

[3] McManus M, White P, Schmidt A, Kanter D, Salus T. *2020 Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care.* Washington, DC: Got Transition, March 2020. Available at https://www.gottransition.org/resource/2020-coding-tip-sheet

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According to Texas' 2020 Medicaid fee schedule, the transition-related CPT codes that are currently covered for **all** patients include prolonged services with direct patient contact (99354, 99355). For physicians caring for **individuals under 21**, covered codes include care plan oversight services (99339, 99340) and prolonged services before and/or after direct patient contact (99358, 99359). The current Texas Medicaid fee schedule does **not** recognize several transition-related codes listed below in the recommendations. In addition, Medicaid does not allow a medically complex child to have both pediatric and adult providers for a limited period of time to ensure a smooth and continuous handoff nor does it allow for payment for joint telehealth or in-person visits with the pediatric and adult provider and the transferring patient/caregiver.

Recommendations

i. Recommend recognition of the following transition-related CPT codes in Texas' Medicaid fee schedule.
   a. Health and behavior risk assessment (96160)
   b. Care plan oversight services for physicians caring for patients ages 21 and older (99339, 99340)
   c. Prolonged services before and/or after direct patient contact for physicians caring for patients ages 21 and older (99358, 99359)
   d. Interprofessional telephone/internet/electronic health record consultations (99446-99449, 99451, 99452)
   e. Care management services (99487, 99489, 99490, 99491)
   f. Transitional care management services (99495, 99496)

ii. Allow for two assigned pediatric and adult providers to bill for the same patient to facilitate shared care management and a smooth handoff.

iii. Recommend a new HCPCS code for joint pediatric/adult/enrollee visit prior to the initial adult visit (in-person or virtual).

3.2 ***Topic/Issue:*** **Limited time to coordinate services with STAR Plus plans when a non- MDCP, PDN or Prescribed Pediatric Extended Care Center (PPECC) member ages out of STAR KIDS at age 21.**

Background: Currently, members receiving MDCP, PDN or PPECC services receive STAR Plus Home and Community Based Services enrollment information approximately 6-9 months prior to their 21st birthday while all other STAR Kids members receive their STAR Plus enrollment information packets just 30 days prior to their 21st birthday. Members are given a 14-

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day window to make an MCO selection and then both the losing STAR Kids MCO and the gaining STAR Plus MCO learn of enrollment selections just days before the transition occurs. This does not allow for adequate collaboration and coordination of services to ensure there are no gaps in care.

Recommendations:

i. Update the age out process to allow **all** members to receive STAR Plus enrollment information packets 6-9 months prior to their 21st birthdays thus extending the window of opportunity for STAR Kids and STAR Plus MCO's to collaborate and coordinate services to better prevent any gaps in care or services.
ii. The age out preselection of a STAR Plus plan should be transmitted to the receiving STAR Plus plan at the time of enrollment broker receipt. This early selection and notification to the current STAR Kids MCO and receiving STAR Plus plan can be used to allow the STAR Kids and STAR Plus plans to share HIPAA information by supporting coordination of transition of care prior to the STAR Plus effective date. This HIPAA barrier removal would be beneficial to the plans, families and physicians involved in the transition of care and allow more time to process transfer related requests prior to the age out effective date.

3.3 Topic/Issue: Limited coordination of services between STAR Kids and STAR Plus plans to ensure member receipt of recommended services for transition planning, transfer or care, and integration into adult care.

Background: Currently, STAR Kids contract has several requirements for the role of transition specialists in addition to and separate from their service coordination requirements. The STAR Plus receiving plans do **not** include any contract requirements related to transfer and integration into adult care to help support the member/family upon their 21st birthday and to coordinate with STAR Kids for an effective transitional care process, ensuring continuity of care between pediatric and adult providers during this vulnerable period of time. Research shows that when Youth and Young Adults with Special Health Care Needs do not have access to a planned transition process, they have a higher likelihood of gaps in care, higher ER and hospital use, high levels of worry and stress, and higher rates of morbidity and even mortality.

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Recommendations:

i. Add transition specialists to the STAR Plus waivers to coordinate with the STAR Kids transition specialist and support the 21-year-old member up to age 23. The receiving transition specialist for STAR Plus can help the member navigate the changes of adulthood, employment, higher level education supports, etc. and be the recipient of the plans of care from the STAR Kids transferring plan to subsequently update over time.

ii. Add additional HCT contract requirements for both STAR Kids and STAR Plus plans, consistent with the 2018 AAP/AAFP/ACP Clinical Report and the Six Core Elements of HCT and include the elements in MCO performance reports. These include: maintaining up-to-date listings of adult clinicians available to care for young adults with medically complex conditions, ensuring coordination between pediatric and adult providers regarding transfer to adult care and timely exchange of transfer package with a current plan of care and medical summary/emergency care plan, welcoming and orienting new members to adult practices and tracking completion of initial visits, conducting periodic transition readiness/self-care skills assessments and creating a plan for addressing prioritized self-care skill needs, and helping members identify adult public program services they are eligible for and facilitating connections.

3.4 *Topic/Issue*: Improve the healthcare transition of children from childhood to adulthood through the adoption of transition standards and best practices.

Background: Currently, only the STAR Kids contract has a requirement for the role of transition specialists. However, the standardization of Health Care Transition processes for these transition specialists requires additional training and support to ensure a consistent knowledge and application of transition requirements. With additional transition requirements in the STAR Plus plans, new training will be needed for all transition specialists and plans.

Recommendations

i. Adopt and implement the 2018 AAP/AAFP/ACP Clinical Report on transition and Got Transition's Six Core Elements of HCT as best

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practices, as summarized in the side-by-side.[4] This HCT approach can be customized for use by MCO plans and participating pediatric and adult provider networks. MCOs and provider networks can annually assess their level of HCT implementation using Got Transition's easy-to-use Current Assessment of HCT Activities.

ii. Develop a standardized template for transition plans that can be used across plans and that includes all required HCT elements.

iii. Ensure durable medical equipment is ordered and secured well before a transition to STAR Plus, preferably 12 months prior to the young adults 21st birthday.

iv. Require training of MCO transition specialists on
    a. Got Transition's Six Core Elements (for use in STAR Kids and STAR Plus)
    b. Alternatives to guardianship
    c. Supported decision making
    d. Creative housing options including shared living arrangements and host homes
    e. Supported employment
    f. Utilization of the Navigate Life web reference

v. Promote best practice sharing among MCOs by hosting regular transition planning conferences and trainings for MCO transition specialists and care coordinators.

3.5 ***Topic/Issue***: **Lack of Medicaid *adult primary and specialty care providers available to care for complex patients aging out of pediatric care*.**

Background: The geographic size and rural composition of much of Texas has created barriers for some children transitioning from pediatric to adult physicians. Rural areas often lack physician availability to accept complex medical cases while those who do often have lengthy new patient wait times. These barriers have negatively impacted the member's ability to receive care timely, make adult provider selections, and have a seamless transition to adult services. As a result, many young adults are remaining with pediatric providers when they should be seeing adult care providers. In addition, many adverse and preventable complications for medically complex individuals

[4] Six Core Elements of Health Care Transition 3.0: Side-by-Side Comparison. Washington, DC: Got Transition, July 2020. Available at https://www.gottransition.org/6ce/?side-by-side

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result when the handoff to adult care is not carefully coordinated and planned for.

Recommendations:

i. Design, pilot, and evaluate innovative value-based transition payment pilots to 1) increase the availability of participating adult physicians in the geographic areas of concern, 2) strengthen the coordination and communication between pediatric-sending and adult-receiving practices, 3) expand the level of HCT support available to medically complex youth and young adults and their caregivers in both pediatric and adult sites, and 4) improve appropriate use of health care among this vulnerable population. Such innovative VBP transition pilots shall consider the payment and quality options in The National Alliance to Advance Adolescent Health's Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems: A Leadership Roundtable Report.[5]

ii. HHSC should require MCOs to regularly survey their adult provider network to assess the availability of open panels for transitioning youth/young adults with medical complexity, intellectual and developmental disability, and serious mental/behavioral health conditions.

[5] McManus M, White P, Schmidt A. *Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems: A Leadership Roundtable Report*. Washington, DC: The National Alliance to Advance Adolescent Health, 2018.

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TO: Medical Care Advisory Committee

DATE: February 11, 2021

FROM: Michelle Erwin, Deputy Associate Commissioner, Policy and Program

SUBJECT: Coordination of Benefits and Specialty Providers

Agenda Item No.: 11

Amendments to: §353.4, concerning Managed Care Organization Requirements Concerning Out-of-Network Providers and new §353.7, concerning Coordination of Benefits with Primary Health Insurance Coverage, in the Texas Administrative Code, Title 1, Chapter 353 Medicaid Managed Care.

BACKGROUND: ☐ Federal Requirement ☒ Legislative Requirement ☐ Other:

The purpose of the proposal is to implement Texas Government Code, Section 533.038(g), added by Senate Bill 1207, 86th Legislature, Regular Session, 2019. Section 533.038(g) requires HHSC to establish a process for a Medicaid health care managed care organization (MCO) to allow a member with complex medical needs, who has established a relationship with a specialty provider through the member's primary health benefit plan, to continue receiving care from that specialty provider, whether or not that provider is in the health care MCO's network.

The proposed rules require a health care MCO to allow a member to remain under the care of a Medicaid enrolled specialty provider with which the member currently receives care through a primary health benefit plan—even if the specialty provider is an out-of-network provider for the health care MCO—if at the time of enrollment into the health care MCO, the member: (1) has complex medical needs, and (2) has and maintains healthcare coverage under a primary benefit health plan.

In reimbursing an out-of-network specialty provider acting within the scope of new Section 353.7, the proposed rules require a health care MCO to utilize the existing reimbursement methodology for authorized services performed by an out-of-network provider in renumbered Section 353.4(f)(2) (previously Section 353.4(e)(2)), until: (1) an alternate reimbursement agreement is reached with the member's specialty provider; (2) the member is no longer enrolled in a primary health benefit plan; (3) the member or the member's legally authorized representative agrees to select an alternate specialty provider; or (4) the member is no longer enrolled in the health care MCO.

Proposed new Section 353.7 also defines "primary health benefit plan," "complex medical needs," and "specialty provider" when used in the proposed new rule.

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TX-AG-22-0325-A-000536

ISSUES AND ALTERNATIVES:

Some stakeholders have commented that the rules should apply to any Medicaid member, not only to certain Medicaid enrolled children with third party insurance. Additionally, some provider types who consider themselves to be a "specialty provider" have requested that they be included in the rule as a "specialty provider."

HHSC drafted the proposed rule after thorough review of the statutory language, its context, and the legislative intent of Section 533.038 of the Texas Government Code. In addition to general comments regarding the proposed rule, HHSC is requesting comments on how to distinguish a subset of durable medical equipment suppliers or of other provider types that might possibly be considered specialty providers based on the services they provide. HHSC staff will continue to review and consider any public comments received to decide if any changes should be made.

STAKEHOLDER INVOLVEMENT:

Providers, family members, and advocates have provided public comment regarding Texas Government Code, Section 533.038(g) at the STAR Kids Managed Care Advisory Committee (STAR Kids MCAC) and State Medicaid Managed Care Advisory Committee (SMMCAC). HHSC solicited written comments on draft contract language from the STAR Kids MCAC, SMMCAC, and the Texas Association of Health Plans (TAHP). The STAR Kids MCAC requested HHSC apply the change to all STAR Kids members, not to limit "specialty provider" to physicians, and not to limit the application of the change to the date of enrollment with the MCO. TAHP requested HHSC limit the change only to new members, limit "specialty provider" to physicians, have the change go into effect as of the date of the contract change, and have the change apply only at a member's initial selection of a plan. The SMMCAC expressed support for the proposed language and two commenters recommended the change be limited to STAR Kids and asked HHSC to make corresponding changes so MCOs are not penalized for increased out-of-network utilization. This feedback was taken into consideration during the development of the rules.

Additionally, HHSC provided an overview of the timeline for development of the contract language and rules at the November 2020 Medical Care Advisory Committee and the SMMCAC meetings. During the SMMCAC meeting, HHSC received one public comment from Parent to Parent who asked HHSC to apply the rule to adults and to involve their organization in the draft rule development.

FISCAL IMPACT:

☒ None

RULE DEVELOPMENT SCHEDULE:

February 11, 2021 Present to the Medical Care Advisory Committee
February 18, 2021 Present to HHSC Executive Council
February 2021 Publish proposed rules in Texas Register
April 2021 Publish adopted rules in *Texas Register*

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TX-AG-22-032527 3rd Supp 000027

April 2021 Effective date

REQUESTED ACTION:

☐ The MCAC recommends approval of the proposed rules for publication.

☒ Information Only

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TX-AG-22-032[illegible] 3rd Supp 2025-A 000538

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

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.4, concerning Managed Care Organization Requirements Concerning Out-of-Network Providers; and new §353.7, concerning Coordination of Benefits with Primary Health Insurance Coverage.

BACKGROUND AND PURPOSE

The purpose of the proposal is to implement Texas Government Code, §533.038(g), added by Senate Bill (S.B.) 1207, 86th Legislature, Regular Session, 2019. Senate Bill 1207 requires HHSC to establish a process for a Medicaid health care managed care organization (MCO) to allow a member with complex medical needs, who has established a relationship with a specialty provider through the member's primary health benefit plan, to continue receiving care from that specialty provider, whether or not that provider is in the health care MCO's network.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.4 adds new subsection (d) which sets forth the reimbursement methodology for a Medicaid health care MCO to pay out-of-network specialty providers performing services in accordance with proposed new §353.7. The proposed amendment also reformats the section and updates references.

Proposed new §353.7 sets forth the requirements imposed on Medicaid health care MCOs relating to certain out-of-network specialty providers. Subsection (a) clarifies that the rule applies to a member age 20 or younger who has complex medical needs and who has and maintains healthcare coverage under a primary health benefit plan. Subsection (b) defines "primary health benefit plan" in a manner consistent with Texas Human Resources Code, §32.0422(a). Subsection (c) defines "complex medical needs." Subsection (d) defines "specialty provider" in a manner consistent with the specialty provider list already established in Chapter 3.1 of the Uniform Managed Care Manual (UMCM). Subsection (e) requires a health care MCO to utilize the reasonable reimbursement methodology for authorized services performed by out-of-network providers described in renumbered §353.4(f)(2) (previously §353.4(d)(2)), until: (1) an alternate reimbursement agreement is reached with the member's specialty provider; (2) the member is no longer enrolled in a primary health benefit plan; (3) the member or the member's legally authorized representative agree to select an alternate specialty provider; or (4) the member is no longer enrolled in the health care MCO.

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FISCAL NOTE

Trey Wood, HHSC Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:
(1) the proposed rules will not create or eliminate a government program;
(2) implementation of the proposed rules will not affect the number of HHSC employee positions;
(3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;
(4) the proposed rules will not affect fees paid to HHSC;
(5) the proposed rules will create a new rule;
(6) the proposed rules will expand an existing rule;
(7) the proposed rules will not change the number of individuals subject to the rules; and
(8) the proposed rules will not affect the state's economy.

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The rules apply to health care MCOs, which are not small businesses, micro-businesses, or rural communities.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to implement legislation that does not specifically state that §2001.0045 applies to the rules.

PUBLIC BENEFIT AND COSTS

Stephanie Stephens, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public benefit will be that a member with complex medical needs who has established a relationship with a specialty provider will be able to continue receiving care from that provider when the criteria outlined in the rules are met.

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TX-AG-22-032540 3/25/2022

Trey Wood has also determined that for the first five years the rules are in effect, there may be an economic cost to persons who are required to comply with the proposed rules. A health care MCO may need to train staff to implement the requirement to allow a member to continue seeing a specialty provider as described in the new rule. However, HHSC lacks sufficient information to determine cost to comply.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC HEARING

A public hearing is scheduled for February 26, 2021 starting at 3:00 pm (central time) to be held virtually. You can register for the meeting at:

https://attendee.gotowebinar.com/register/8673928896775152139

The webinar ID is: 273-729-803.

Persons requiring further information, special assistance, or accommodations should contact Mary Valente at (512) 438-4387.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4900 North Lamar Boulevard, Austin, Texas 78751; or e-mailed to HHSRulesCoordinationOffice@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 21R032" in the subject line.

In addition to general comments regarding the proposed rule, HHSC is requesting comments on how to distinguish a subset of durable medical equipment suppliers or of other provider types that might possibly be considered specialty providers based on the services they provide.

STATUTORY AUTHORITY

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TX-AG-22-032541 3rd Supp 000241

The amendment and new section are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas and to adopt rules and standards for program administration; and Section 8 of S.B. 1207, in implementing Texas Government Code, §533.038.

The amendment and new section implement Texas Government Code §531.0055 and Texas Government Code, §533.038.

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

ADDITIONAL INFORMATION

For further information, please call: (512) 221-6857.

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TX-AG-22-032542 3rd Supp 202542

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language
(No change.) = No changes are being considered for the designated subdivision

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

§353.4. Managed Care Organization Requirements Concerning Out-of-Network Providers.

(a) Network adequacy. HHSC is the state agency responsible for overseeing and monitoring the Medicaid managed care program. Each managed care organization (MCO) participating in the Medicaid managed care program must offer a network of providers that is sufficient to meet the needs of the Medicaid population who are MCO members. HHSC monitors MCO members' access to an adequate provider network through reports from the MCOs and complaints received from providers and members. Certain reporting requirements are discussed in subsection (g) [~~(f)~~] of this section.

(b) MCO requirements concerning coverage for treatment of members by out-of-network providers for non-emergency services.

(1) Nursing facility services. A health care MCO must reimburse an out-of-network nursing facility for medically necessary services authorized by HHSC [~~the Texas Department of Aging and Disability Services (DADS)~~], using the reasonable reimbursement methodology in subsection (f) [~~(e)~~] of this section. Nursing facility add-on services are considered "other authorized services" under paragraph (2) of this subsection, and are authorized by STAR+PLUS MCOs.

(2) Other authorized services. The MCO must allow referral of its member(s) to an out-of-network provider, must timely issue the proper authorization for such referral, and must timely reimburse the out-of-network provider for authorized services provided if the criteria in this paragraph are met. If all of the following criteria are not met, an out-of-network provider is not entitled to Medicaid reimbursement for non-emergency services:

(A) Medicaid covered services are medically necessary and these services are not available through an in-network provider;

(B) a participating provider currently providing authorized services to the member requests authorization for such services to be provided to the member by an out-of-network provider; and

(C) the authorized services are provided within the time period specified in the MCO's authorization. If the services are not provided within the required time

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period, a new request for referral from the requesting provider must be submitted to the MCO prior to the provision of services.

(c) MCO requirements concerning coverage for treatment of members by out-of-network providers for emergency services.

(1) An MCO may not refuse to reimburse an out-of-network provider for medically necessary emergency services.

(2) Health care MCO requirements concerning emergency services.

(A) A health care MCO may not refuse to reimburse an out-of-network provider for post-stabilization care services provided as a result of the MCO's failure to authorize a timely transfer of a member.

(B) A health care MCO must allow its members to be treated by any emergency services provider for emergency services, and services to determine if an emergency condition exists. The health care MCO must pay for such services.

(C) A health care MCO must reimburse for transport provided by an ambulance provider for a Medicaid recipient whose condition meets the definition of an emergency medical condition. Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition, as defined in §353.2 of this subchapter (relating to Definitions), is not available at the first facility and the MCO has not included payment for such transports in the hospital reimbursement.

(D) A health care MCO is prohibited from requiring an authorization for emergency services or for services to determine if an emergency condition exists.

(3) Dental MCO requirements concerning emergency services.

(A) A dental MCO must allow its members to be treated for covered emergency services that are provided outside of a hospital or ambulatory surgical center setting, and for covered services provided outside of such settings to determine if an emergency condition exists. The dental MCO must pay for such services.

(B) A dental MCO is prohibited from requiring an authorization for the services described in subparagraph (A) of this paragraph.

(C) A dental MCO is not responsible for payment of non-capitated emergency services and post-stabilization care provided in a hospital or ambulatory surgical center setting, or devices for craniofacial anomalies. A dental MCO is not responsible for hospital and physician services, anesthesia, drugs related to treatment, and post-stabilization care for:

(i) a dislocated jaw, traumatic damage to a tooth, and removal of a cyst;

(ii) an oral abscess of tooth or gum origin; and

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(iii) craniofacial anomalies.

(D) The services and benefits described in subparagraph (C) of this paragraph are reimbursed:

(i) by a health care MCO, if the member is enrolled in a managed care program; or

(ii) by HHSC's claims administrator, if the member is not enrolled in a managed care program.

(d) Health care MCO requirements concerning coverage for services provided to certain members by an out-of-network "specialty provider" as that term is defined in §353.7(d) of this subchapter (relating to Coordination of Benefits with Primary Health Insurance Coverage).

(1) A health care MCO may not refuse to reimburse an out-of-network "specialty provider" enrolled as a provider in the Texas Medicaid program for services provided to a member under the circumstances set forth in §353.7 of this subchapter.

(2) In reimbursing a provider for the services described in paragraph (1) of this subsection, a health care MCO must use the reasonable reimbursement methodology in subsection (f)(2) of this section.

(e) [~~(d)~~] An MCO may be required by contract with HHSC to allow members to obtain services from out-of-network providers in circumstances other than those described in subsections (b) - (d) [~~(c)~~] of this section.

(f) [~~(e)~~] Reasonable reimbursement methodology.

(1) Out-of-network nursing facilities.

(A) Out-of-network nursing facilities must be reimbursed:

(i) at or above ninety-five percent of the nursing facility unit rate established by HHSC for the dates of service for services provided inside of the MCO's service area; and

(ii) at or above one hundred percent of the nursing facility unit rate for the date of services for services provided outside of the MCO's service area.

(B) The nursing facility unit rate refers to the Medicaid fee-for-service (FFS) daily rate for nursing facility providers as determined by HHSC. The rate includes items such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The nursing facility unit rate also includes professional and general liability insurance and applicable nursing facility rate enhancements. The nursing facility unit rate excludes nursing facility add-on services.

(2) Emergency and authorized services performed by out-of-network providers.

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(A) Except as provided in §353.913 of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Outpatient Pharmacy Services) or subsection (j)(2) [~~(i)(2)~~] of this section, the MCO must reimburse an out-of-network, in-area service provider the Medicaid FFS rate in effect on the date of service less five percent, unless the parties agree to a different reimbursement amount.

(B) Except as provided in §353.913 of this chapter, an MCO must reimburse an out-of-network, out-of-area service provider at 100 percent of the Medicaid FFS rate in effect on the date of service, unless the parties agree to a different reimbursement amount, until the MCO arranges for the timely transfer of the member, as determined by the member's attending physician, to a provider in the MCO's network.

(3) For purposes of this subsection, the Medicaid FFS rates are defined as those rates for providers of services in the Texas Medicaid program for which reimbursement methodologies are specified in Chapter 355 of this title (relating to Reimbursement Rates), exclusive of the rates and payment structures in Medicaid managed care.

(g) [~~(f)~~] Reporting requirements.

(1) Each MCO that contracts with HHSC to provide health care services or dental services to members in a service area must submit quarterly information in its Out-of-Network quarterly report to HHSC.

(2) Each report submitted by an MCO must contain information about members enrolled in each HHSC Medicaid managed care program provided by the MCO. The report must include the following information:

(A) the types of services provided by out-of-network providers for the MCO's members;

(B) the scope of services provided by out-of-network providers to the MCO's members;

(C) for a health care MCO, the total number of hospital admissions, as well as the number of admissions that occur at each out-of-network hospital. Each out-of-network hospital must be identified;

(D) for a health care MCO, the total number of emergency room visits, as well as the total number of emergency room visits that occur at each out-of-network hospital. Each out-of-network hospital must be identified;

(E) total dollars for paid claims by MCOs, other than those described in subparagraphs (C) and (D) of this paragraph, as well as total dollars billed by out-of-network providers for other services; and

(F) any additional information required by HHSC.

(3) HHSC determines the specific form of the report described in this subsection

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and includes the report form as part of the Medicaid managed care contract between HHSC and the MCOs.

(h) [~~(g)~~] Utilization.

(1) Upon review of the reports described in subsection (g) [~~(f)~~] of this section that are submitted to HHSC by the MCOs, HHSC may determine that an MCO exceeded maximum out-of-network usage standards set by HHSC for out-of-network access to health care services and dental services during the reporting period.

(2) Out-of-network usage standards.

(A) Inpatient admissions: No more than 15 percent of a health care MCO's total hospital admissions, by service area, may occur in out-of-network facilities.

(B) Emergency room visits: No more than 20 percent of a health care MCO's total emergency room visits, by service area, may occur in out-of-network facilities.

(C) Other services: For services that are not included in subparagraph (A) or (B) of this paragraph, no more than 20 percent of total dollars for paid claims by the MCO for services provided may be provided by out-of-network providers.

(3) Special considerations in calculating a health care MCO's out-of-network usage of inpatient admissions and emergency room visits.

(A) In the event that a health care MCO exceeds the maximum out-of-network usage standard set by HHSC for inpatient admissions or emergency room visits, HHSC may modify the calculation of that health care MCO's out-of-network usage for that standard if:

(i) the admissions or visits to a single out-of-network facility account for 25 percent or more of the health care MCO's admissions or visits in a reporting period; and

(ii) HHSC determines that the health care MCO has made all reasonable efforts to contract with that out-of-network facility as a network provider without success.

(B) In determining whether the health care MCO has made all reasonable efforts to contract with the single out-of-network facility described in subparagraph (A) of this paragraph, HHSC considers at least the following information:

(i) how long the health care MCO has been trying to negotiate a contract with the out-of-network facility;

(ii) the in-network payment rates the health care MCO has offered to the out-of-network facility;

(iii) the other, non-financial contractual terms the health care MCO has offered to the out-of-network facility, particularly those relating to prior

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authorization and other utilization management policies and procedures;

(iv) the health care MCO's history with respect to claims payment timeliness, overturned claims denials, and provider complaints;

(v) the health care MCO's solvency status; and

(vi) the out-of-network facility's reasons for not contracting with the health care MCO.

(C) If the conditions described in subparagraph (A) of this paragraph are met, HHSC may modify the calculation of the health care MCO's out-of-network usage for the relevant reporting period and standard by excluding from the calculation the inpatient admissions or emergency room visits to that single out-of-network facility.

(i) [~~(h)~~] Provider complaints.

(1) HHSC accepts provider complaints regarding reimbursement for or overuse of out-of-network providers and conducts investigations into any such complaints.

(2) When a provider files a complaint regarding out-of-network payment, HHSC requires the relevant MCO to submit data to support its position on the adequacy of the payment to the provider. The data includes a copy of the claim for services rendered and an explanation of the amount paid and of any amounts denied.

(3) Not later than the 60th day after HHSC receives a provider complaint, HHSC notifies the provider who initiated the complaint of the conclusions of HHSC's investigation regarding the complaint. The notification to the complaining provider includes:

(A) a description of the corrective actions, if any, required of the MCO in order to resolve the complaint; and

(B) if applicable, a conclusion regarding the amount of reimbursement owed to an out-of-network provider.

(4) If HHSC determines through investigation that an MCO did not reimburse an out-of-network provider based on a reasonable reimbursement methodology as described in subsection (f) [~~(e)~~] of this section, HHSC initiates a corrective action plan. Refer to subsection (j) [~~(i)~~] of this section for information about the contents of the corrective action plan.

(5) If, after an investigation, HHSC determines that additional reimbursement is owed to an out-of-network provider, the MCO must:

(A) pay the additional reimbursement owed to the out-of-network provider within 90 days from the date the complaint was received by HHSC or 30 days from the date the clean claim, or information required that makes the claim clean, is received by the MCO, whichever comes first; or

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(B) submit a reimbursement payment plan to the out-of-network provider within 90 days from the date the complaint was received by HHSC. The reimbursement payment plan provided by the MCO must provide for the entire amount of the additional reimbursement to be paid within 120 days from the date the complaint was received by HHSC.

(6) If the MCO does not pay the entire amount of the additional reimbursement within 90 days from the date the complaint was received by HHSC, HHSC may require the MCO to pay interest on the unpaid amount. If required by HHSC, interest accrues at a rate of 18 percent simple interest per year on the unpaid amount from the 90th day after the date the complaint was received by HHSC, until the date the entire amount of the additional reimbursement is paid.

(7) HHSC pursues any appropriate remedy authorized in the contract between the MCO and HHSC if the MCO fails to comply with a corrective action plan under subsection (j) [~~(i)~~] of this section.

(j) [~~(i)~~] Corrective action plan.

(1) HHSC requires a corrective action plan in the following situations:

(A) the MCO exceeds a maximum standard established by HHSC for out-of-network access to health care services and dental services described in subsection (h) [~~(g)~~] of this section; or

(B) the MCO does not reimburse an out-of-network provider based on a reasonable reimbursement methodology as described in subsection (f) [~~(e)~~] of this section.

(2) A corrective action plan imposed by HHSC requires one of the following:

(A) reimbursements by the MCO to out-of-network providers at rates that equal the allowable rates for the health care services as determined under §32.028 and §32.0281, Texas Human Resources Code, for all health care services provided during the period:

(i) the MCO is not in compliance with a utilization standard established by HHSC; or

(ii) the MCO is not reimbursing out-of-network providers based on a reasonable reimbursement methodology, as described in subsection (f) [~~(e)~~] of this section;

(B) initiation of an immediate freeze by HHSC on the enrollment of additional recipients in the MCO's managed care plan until HHSC determines that the provider network under the managed care plan can adequately meet the needs of the additional recipients;

(C) education by the MCO of members enrolled in the MCO regarding the proper use of the MCO's provider network; or

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(D) any other actions HHSC determines are necessary to ensure that Medicaid recipients enrolled in managed care plans provided by the MCO have access to appropriate health care services or dental services, and that providers are properly reimbursed by the MCO for providing medically necessary health care services or dental services to those recipients.

(k) [~~(j)~~] Application to Pharmacy Providers. The requirements of this section do not apply to providers of outpatient pharmacy benefits, except as noted in §353.913 of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Outpatient Pharmacy Services).

§353.7. Coordination of Benefits with Primary Health Insurance Coverage.

(a) A health care MCO must allow a member age 20 or younger, who at the time of the member's enrollment into the health care MCO has complex medical needs and has and maintains healthcare coverage under a primary health benefit plan, to remain under the care of a Medicaid enrolled specialty provider with which the member is receiving care through the primary health benefit plan, even if the specialty provider is an out-of-network provider.

(b) For the purpose of this section "primary health benefit plan" has the meaning assigned by Texas Human Resources Code, §32.0422(a) but does not include a Medicaid plan.

(c) For the purpose of this section "complex medical needs" means a member receiving:

(1) Level 1 Service Coordination as authorized in the STAR Kids managed care contract; or

(2) Service Management as authorized in the STAR Health managed care contract.

(d) For the purpose of this section "specialty provider" means one of the following provider types:

(1) a physician licensed under the Texas Occupations Code, Chapter 155, who has and maintains a specialty in:

(A) Adolescent Medicine (Teenagers);

(B) Allergist (Allergies);

(C) Ambulatory Medicine (General Non-Emergency Care);

(D) Cardiology, Cardiovascular (Heart, Blood Vessels);

(E) Colon/Rectal (Bowels);

(F) Dermatology (Skin);

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(G) Endocrinology (Glands);

(H) Family Medicine (General Family Medical Care);

(I) Gastroenterology (Stomach, Digestion);

(J) Genetics (Inherited Diseases, Birth Defects);

(K) Hematology (Blood);

(L) Hepatology (Liver);

(M) Immunology (Immune System);

(N) Infectious Diseases (Viral/Bacterial Infections);

(O) Internal Medicine (General Medical Care);

(P) Neonatology/Perinatology (Fetus and Newborns);

(Q) Nephrology (Kidney);

(R) Neurology (Brain, Nervous System);

(S) Neurosurgery (Operations of the Brain, Spinal Cord);

(T) Nuclear Medicine (Testing, e.g., MRI, CAT scan);

(U) Obstetrics/Gynecology (Pregnancy, Women's Health);

(V) Occupational Medicine (Work-Related Injuries);

(W) Oncology (Cancer);

(X) Ophthalmology (Eyes);

(Y) Oral-Maxillofacial Surgery (Jaw and Mouth);

(Z) Orthopedics (Bones and Joints);

(AA) Otolaryngology (Ear, Nose, and Throat);

(BB) Otology (Ears);

(CC) Pediatrician (Babies, Children);

(DD) Perinatology (Fetus);

(EE) Physical Medicine (Rehabilitation);

(FF) Plastic Surgery (Corrective Surgery);

(GG) Psychiatry (Mental Illness);

(HH) Pulmonology (Lungs, Breathing);

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(II) Radiology (X-Rays);

(JJ) Reproductive Endocrinology (Reproductive System Diseases);

(KK) Rheumatologist (Joints, Muscles, Tendons);

(LL) Sports Medicine (Sports Injuries);

(MM) Surgery (Operations);

(NN) Thoracic Surgery (Chest Surgery);

(OO) Urology (Urinary Tract); or

(PP) Vascular Surgery (Operations of the Blood Vessels);

(2) an audiologist, as that term is defined in Texas Occupations Code, §401.001(1-a), licensed under the Texas Occupations Code, Chapter 401;

(3) a chiropractor that holds a license issued by the board created under the Texas Occupations Code, Chapter 201;

(4) a dietitian licensed under the Texas Occupations Code, Chapter 701;

(5) an optometrist licensed under the Texas Occupations Code, Chapter 351; or

(6) a podiatrist licensed under the Texas Occupations Code, Chapter 202.

(e) A health care MCO must comply with the reasonable reimbursement methodology for authorized services performed by out-of-network providers as described in §353.4(f)(2) of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Providers) until:

(1) an alternate reimbursement agreement is reached with the member's specialty provider;

(2) the member is no longer enrolled in a primary health benefit plan;

(3) the member or the member's LAR agree to select an alternate specialty provider; or

(4) the member is no longer enrolled in the health care MCO.

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The State of Texas
House of Representatives
District 63

December 18, 2019

Dr. Courtney Phillips
Commissioner
Texas Health and Human Services
P.O. Box 13247
Austin, Texas 78711-3247

Dear Commissioner Phillips:

During the 86th Legislative Session, I was honored to be a lead House sponsor of SB 1207, an important public policy measure to ensure the continuity of care and services for Medicaid eligible medically fragile children in our state. Due to their highly complex and specialized needs, it was paramount that the Texas Legislature take decisive action to make certain that the network of service and equipment providers is sufficient to preserve their lives. I am very pleased that lawmakers were able to accomplish this legislative priority while at the same time, preserving maximum usage of primary commercial coverage to ultimately save Texas taxpayer dollars.

Today, I am writing to you about one of the principal, and also most important, goals of SB 1207. In Section 6/Sec. 533.038(g), we were purposefully clear and unambiguous in our objective for the Texas Health and Human Services Commission to quickly "develop a clear and easy process…that allows a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider." It was my legislative intent for the term "specialty provider" to mean any entity or person, including a DME or any other type of provider, that provides goods or services to the patient/recipient.

It is critical that none of these families have to face unnecessary hardships and risk their care by having a gap in services or equipment from a provider that they have an existing relationship with and trust to care for their child. Your prompt and careful consideration in this matter is greatly appreciated. Should you have any questions, please never hesitate to contact me directly at 214.886.4699.

Best regards,

Tan Parker

Tan Parker
State Representative
House District 63

cc: Stephanie Muth
Deputy Executive Commissioner
Medicaid & CHIP Services



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The State of Texas
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Best regards,

Tan Parker

Tan Parker
State Representative
House District 63

cc: Stephanie Muth
Deputy Executive Commissioner
Medicaid & CHIP Services



AMERICAN OVERSIGHT

CHARLES PERRY
TEXAS STATE SENATOR
DISTRICT 28

December 11, 2019

Dr. Courtney Phillips
Commissioner
Texas Health and Human Services
P.O. Box 13247
Austin, TX 78711-3247

Attn: Stephanie Muth
Deputy Executive Commissioner
Medicaid & CHIP Services

Dear Commissioner Phillips:

I am writing you today as the lead author of Senate Bill 1207 to encourage you to follow one of our principal legislative goals in enacting this important bill. We distilled one of our most important overall legislative goals into Section 6 of Senate Bill 1207, drafting Sec. 533.038 (g) in clear and unambiguous terms. I urge the Commission to quickly "develop a clear and easy process…that allows a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider."

Our overall intent in enacting Senate Bill 1207 was to ensure continuity of care and services for medically fragile children whose cases are highly complex and specialized. We sought to achieve this important goal while preserving maximum usage of primary commercial coverage in order to save money for Texas taxpayers while simultaneously ensuring that the network of service and equipment providers was always adequate to meet the needs of the medically fragile Medicaid eligible population of children in Texas.

This is why it is so important that the Health and Human Services Commission quickly "develop a clear and easy process…that allows a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider." We want to ensure that none of these children experience a gap in the receipt of their services or equipment from a provider they know and trust based on their existing relationship.

Sincerely,

Senator Charles Perry

COMMITTEES: WATER & RURAL AFFAIRS, *CHAIR* • HEALTH & HUMAN SERVICES, *VICE CHAIR*
CRIMINAL JUSTICE • FINANCE • TRANSPORTATION • AGRICULTURE

P.O. BOX 12068 • AUSTIN, TEXAS 78711

AMERICAN OVERSIGHT

February 10, 2021

Commissioner Cecile Young
Texas Health and Human Services Commission
4900 N. Lamar Blvd.
Austin, TX 78751

Dear Commissioner Young,

As the author and sponsors of Senate Bill 1207 (SB 1207) from the 86th Legislative Session, we write to publicly comment on the proposed rules regarding Coordination of Benefits and Specialty Providers that will be presented to the Medical Care Advisory Committee on February 11, 2021.

We believe that the passage of SB 1207 was a significant victory for families with medically complex children in the STAR Kids Program. Since transitioning from fee-for-service to managed care, this population has faced numerous hurdles finding and maintaining appropriate specialty physicians and care teams. Due to the complex medical care these children need, and the thirteen regional service delivery areas in Texas, many children must see specialty providers in another or multiple service delivery areas.

The goal of the coordination of care provision in SB 1207 was to eliminate barriers to care for children with complex needs and to ensure continuity of care for specialty providers and prescriptions. Many of these changes pertained to coordination of care between primary third party coverage and Medicaid in order to eliminate duplicative prior authorizations, delays to care, and to add efficiencies to the "Medicaid wrap-around benefit." Allowing Medicaid to wrap around primary coverage maximizes primary third party coverage. It also ensures continuance of federal requirements for those with primary coverage. Since Medicaid is payer of last resort, there should be no requirement, if allowed under federal law and rule, for the wrap benefit to only apply if the provider is enrolled in the Medicaid program when they are in-network under the member's primary third party coverage. Limiting the wrap benefit to only Medicaid enrolled providers would limit the network available to families with primary benefit plans. If a child were to utilize their primary coverage, and the wrap benefit does not apply, the provider would have to balance bill the family. This coordination wrap benefit, we believe should apply to all Medicaid enrollees who

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also have primary third party coverage since it is more cost-effective for the state, without limitation.

However, there are other provisions in SB 1207 that were intended to pertain to any child under STAR Kids with complex medical needs. One such provision is continuity of care with specialty providers. This was to ensure that medically complex children could continue to be taken care of by their specialty provider(s) whom they have a relationship with and who the family trusts and believes is best suited to provide care to their child, no matter when the child was enrolled in the program. Section 533.038(g) of the Government Code reads:

> (g) The commission shall develop a clear and easy process, to be implemented through a contract, that allows a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider.

Draft rule 353.7(a) limits the above provision to only those with primary health benefit plans and further limits this benefit under draft rule 353.7(c) to only members designated a level 1. There is no contingency within Section 533.038(g) of the Government Code requiring both primary health plan coverage and Medicaid coverage, we have heard of children under the Medically Dependent Children's Program (MDCP) that have been designated a level 2 for a brief period of time. If (g) were intended to only apply to those with third party primary coverage, there would be no need for (g) since it would have been accomplished under the preceding subsections. We do have concerns regarding further restricting medically necessary continuity of care to only those with level 1 service coordination, as this limitation may adversely affect some members with complex medical needs, and may further restrict federal, statutory and contractual obligations regarding medically necessary access to care. We ask that the enrollees with complex medical needs currently qualifying for continuity of care continue to be able to access that care without any additional qualifications, requirements or restrictions, and also want to ensure that all children in the MDCP waiver program, regardless of level are included.

Further, managed care organizations, when complying with the continuity of care provisions found in this bill, should not be unfairly penalized under "out-of-network utilization," especially for MCOs simply providing wrap coverage. We ask that the commission evaluate the "special considerations" provision found in current rule.

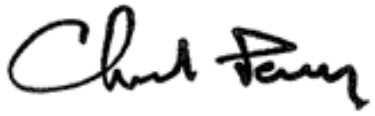
Additionally, as we have communicated previously, we are concerned that the interpretation of “specialty provider” as outlined in the draft rules is extremely narrow and exclusionary. “Specialty provider” was intended to apply broadly to specialty and sub-specialty providers providing medically necessary care and to address ongoing network adequacy issues for this complex population.

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We would also like to see clarification that enrollees, while still covered under STAR Kids, will continue to receive the same benefits through the transition period out of STAR Kids as they age out of the program.

We appreciate the work of the Health & Human Services Commission to implement the much needed provisions of Senate Bill 1207, and we look forward to seeing the improved and updated version of the proposed rules.

Thank you,



Senator Charles Perry



Representative Matt Krause



Representative Jeff Leach

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REPRESENTATIVE MATT KRAUSE

— District 93 • Tarrant County —

Executive Commission Cecile Young
Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711

July 29, 2020

Dear Commissioner Young,

Congratulations on recently being appointed to Executive Director of the Health and Human Services Commission. Your service to our state during these troubling times is truly admirable and I look forward to working together. There are a couple of reasons for my letter to you today and I ask for your help to ensure we provide assistance to Texans in need.

During the 86th Legislative Session, my office sponsored Senate Bill 1207, which was signed by Governor Abbott on June 10, 2019. Since then, we have been awaiting HHSC's pending rules implementing SB1207, in particular the rule implementing the below section which aims to ensure that a patient can stay with the specialty provider of their choice, even if that provider is out of network:

> (g) The commission shall develop a clear and easy process, to be implemented through a contract, that allows a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider

The intent of this subsection is to ensure that patients and their families have an absolute right to stay with the provider of their choice and HHSC must promulgate rules to protect this important right.

Secondly, given the national and State of Texas emergency declarations are still in effect, I ask HHSC to extend the current time period waiving the requirement that DME or other specialty providers obtain supplemental paperwork or Prior Authorization from July 31st to August 31st or until the COVID-19 Pandemic has passed.

Please feel free to reach out to my office for any questions or concerns. Thank you for your time and consideration on these two very important issues for families across the state.

Sincerely,

Matt Krause

Matt Krause
State Representative
House District 93

P.O. Box 2910 • Austin, TX 78768-2910 • (512) 463-0562 • (512) 463-2053 fax • matt.krause@house.state.tx.us

AMERICAN OVERSIGHT
TXAG-22-0325-A-000559

STATE OF TEXAS	§
	§
OUNTY OF TRAVIS	§

Declaration of Steve Aragón

My name is Steve Aragón. My birthday is September 23, 1958. I reside at 5101 Lassant Cove, Austin, Texas.

I have personal knowledge of all of the facts contained herein.

I am an attorney licensed in the state of Texas.

From November 1995 to March 2003, I served as the General Counsel to the Texas Health Human Services Commission (HHSC). In March 2003 I was appointed to the newly-created position of Chief Counsel to HHSC, which I held until March 2014. I have maintained a private law practice in Austin, Texas, since April 2014..

During my tenure with HHSC, I developed the template contracts comprising HHSC's Uniform Terms and Conditions applicable to all vendor contracts awarded by the agency, the Uniform Managed Care Terms and Conditions applicable to all managed care contracts, and the Request for Proposal template used for the STAR Kids Managed Care Request for Proposal, Version 1.12 (the "RFP"). Until March 2014, I supervised the attorneys responsible for drafting the Star Kids Contract Terms (the "Contract") and advising and approving the RFP, the terms of which terms were expressly incorporated into the final Contract terms and conditions.

I am very familiar with the language of that Contract and the program policies that it supports.

Over 90 percent of the 4.5 million Texans who receive Medicaid and CHIP benefits receive them through managed care programs. HHSC administers six (6) managed care programs for Medicaid, CHIP, and dually-eligible Medicare-Medicaid beneficiaries and contracts with 20 MCOs and health insurers to arrange and furnish medical and dental care for these beneficiaries. One such program is the State of Texas Access Reform Kids program ("STAR Kids"). HHSC established STAR Kids to address the unique and complex needs of children and young adults with disabilities.

The intended beneficiaries of the Contract are children and young adults under the age of 20 who reside in Texas, have physical and intellectual disabilities, and are enrolled in the Texas Medicaid program known as STAR Kids. These beneficiaries include some of the most vulnerable and medically fragile children with profound and often multiple disabilities. These children require a high degree of complex and intensive medical, social, and habilitative services in institutions such as nursing facilities or (for those who qualify for available slots) in their homes and communities. The services these beneficiaries receive often exceed the type, amount, scope, or duration of services generally available to Medicaid recipients and must therefore be provided under a waiver of certain provisions of the federal Social Security Act.

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I am knowledgeable of the purpose of the language in Section 8.1.23 of the RFP, entitled "Continuity of Care and Out-of-Network Providers" and incorporated in the STAR Kids contract by reference as part of Attachment B-1. The Section comprises three parts:

- Section 8.1.23.1, entitled Requirements for Individuals who become Members on the Operational Start Date," prescribes a STAR Kids plan's obligations on the date the plan is authorized by HHSC to provide covered services to members;

- Section 8.1.23.2, entitled "Requirements for Individuals who become Members after the Operational Start Date," prescribes virtually identical obligations with respect to members who either select or default into a STAR Kids plan after the operational start date; and

- Section 8.1.23.3, "HCBS LTSS Continuity of Care," which describes an MCO's obligation to a member who receives supported employment or employment assistance from a provider that is terminated from a STAR Kids plan network.

I was asked to review the language of Sections 8.1.23.1 and 8.1.23.2, both of which state in pertinent part:

> The MCO [managed care organization] must provide Members with timely and adequate access to Out-of- Network services for as long as those services are necessary and 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 Out-of-Network services if the services become available from a Network Provider. If a Member's PCP or other Provider determines that disrupting a Member's existing relationship with an Out-of-Network Provider would subject the Member to unnecessary psychological or medical risk, the MCO must provide the Member access to those Out-of-Network services through an appropriate agreement with the Out-of-Network Provider. (Emphasis added.)

HHSC administers over 50 contracts with 20 MCOs and health insurers to arrange and furnish medical and dental care for eligible Medicaid and CHIP beneficiaries. The contract between HHSC and each MCO or insurer comprises an executory contract signed by authorized representatives of each party and several attachments, including:

- A set of terms and conditions prepared for the specific managed care program;

- The procurement document issued by HHSC to solicit proposals from interested MCOs/insurers;

- The agency's Uniform Managed Care Manual;

- The proposal submitted by the successful MCO/insurer in response to the solicitation; and

- Amendments or agreed-upon modifications to each.

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Section 8.1.23 of Contract Attachment B-1 prescribes MCOs' obligation to avoid disruption or interruption of care to members who are newly-enrolled in a STAR Kids plan. It is substantially identical to similar provisions in contracts and solicitations HHSC regularly uses for its other managed care programs. It differs, however, form all other managed contracts in one respect – the underscored sentence above is unique among the contracts that HHSC issues in its managed care programs. No other managed care RFP issued by HHSC to my knowledge includes such language, and it stands as a further limitation on MCOs' ability to direct beneficiaries to in-network providers.

This distinction is, in my opinion, due to HHSC's overarching concern for the safety and well-being of its most vulnerable clients, their complex medical and behavioral health needs, and its desire to provide assurances to parents and guardians of the children and young adults who are enrolled in a STAR Kids health plan. The sentence confirms HHSC's conclusion that, the continuity of care for STAR Kids beneficiaries is of such substantial public concern that it is appropriate to place further restrictions on MCOs' ability to limit access to out-of-network providers. Further, it confirms the agency's delegation of authority to primary care physicians and other providers to render the professional judgment that a STAR Kids member's medical or psychological well-being could be jeopardized by disrupting an ongoing out-of-network provider relationship.

Consequently, the sentence underlined above should be understood to mean what it says. That is, if a STAR Kids member's primary care physician or another provider determines that disrupting a member's existing relationship with an out-of-network provider would subject the member to needless psychological or medical risk, the MCO must provide the member access to those out-of-network services through an appropriate agreement with the out-of-network provider.

An "appropriate agreement with the Out-of-Network Provider" is not defined, but it, too, should be understood to mean what it says—i.e., an MCO must offer the out-of-network provider an agreement that the MCO offers other similar providers and is sufficient to avoid the medical or psychological harm that the member's primary care physician or other provider has professionally determined may occur if the relationship is disrupted.

In summary, if a STAR Kid health plan member's primary care physician or other treating provider determines that disrupting the member's existing relationship with an out-of-network provider would subject the member to unnecessary psychological or medical risk, the MCO must provide the member access to the out-of-network provider's services through an appropriate agreement that the MCO uses with similar providers and that avoids the harm or risk identified by the member's primary care physician or other provider.

I declare under the penalty of perjury that the forgoing is true and correct

Executed in Travis County, Texas, on November 12, 2020.



Steve Aragón

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SB1207 clarification and definitions

- This amendment simply reinforces existing law, and is absolutely essential because **HHSC has still not implemented one of SB 1207's most important requirement -** that HHSC and MCOs **must** guarantee a medically fragile patients' continuity of care and choice to maintain existing relationships with specialty medical providers.
- On average, an individual with complex medical needs requires at least 10 different specialty medical providers, and often has as many as 25+ chronic healthcare needs.
- Many Texas children who rely upon home & community-based service waiver programs to remain at home with their families have complicated and rare disorders, requiring a hospital-level of care, and require access to tertiary and subspecialty care from birth. Evidence-based research shows that **access to appropriate tertiary specialists and specialty centers substantially changes outcomes and significantly improves mortality rates**, thereby also improving the child's health, stability and reduces long-term costs to the state.
- HCBS waiver programs allow families to provide an institutional-level of care in the home and community at enormous cost savings to the state: normally at 1/6-1/10 of the cost of institutional care, but these programs are only successful if the fragile patient maintains access to appropriate specialty providers who can treat rare conditions. Timely access is the only way to ensure that patients can preserve vital life-stabilizing care in their home or community.
- Specialty providers are absolutely essential to properly care for fragile patients with complex medical needs. Many physicians and specialty providers do not have experience with these rare diseases and conditions, or the highly specialized services, equipment, and supplies necessary to treat them. These medically fragile patients must have ready access to the specialty providers who know best how to treat their unique conditions in order to keep them stable and at medical baseline and at home. **This is also far more cost-effective for the state in the long-term.**
- Lack of access to critical, life-affirming services results in increased risk of hospitalization, institutionalization, increased ER visits, and other preventable events for children with disabilities and complex medical needs.
- **This is literally the job of the managed care organizations, as an agent of the state of Texas.** In order to fulfill their contractual duties, the MCOs are required to cover all medically necessary expenses.
- **The MCOs have a long-standing statutory and contractual obligation to provide full coverage of all medically necessary care**, therefore, this amendment reaffirming legislative intent and ensuring continuity of care for vulnerable Texans with complex medical needs, **will NOT increase costs to the state of Texas.**
- For Texas taxpayers, the structure of the Texas Medicaid managed care model establishes a fixed, no-risk, capitated rate program **whose overall costs cannot increase.** Per Section 8.1.3 and Attachment B-2 of the STAR Kids Managed Care Contract, "Medicaid MCOs are responsible for providing all medically and functionally necessary services that were previously covered under traditional fee-for-service programs. MCOs must ensure the provision of covered services meet the specific preventive, acute care, community-based services, long-term support and services, **and specialty healthcare needs appropriate for the treatment of the individual member(s) condition.** "

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- The 2018 LBB Report on the STAR Kids Program found that **"patients with the highest needs experience the largest gaps in access to services" under the managed care model.** The same report also found that claims data indicated that **managed care networks are inadequate for this population**, and that **utilization of critical services had declined for the highest needs patients since the transition to managed care**.

- Over the past couple of years, **16 of the 20 Texas Medicaid MCOs have been placed on "corrective action plans" for failing basic network adequacy requirements across the state**.

Despite claims by insurance industry lobbyists, **managed care has NOT been more efficient or cost effective** for the state of Texas amongst certain high-needs populations:

- The recently published FY2020 External Quality Review (EQRO) of the Texas Medicaid and CHIP Programs confirmed that **access to care has decreased for highest-needs members** in the STAR Kids/Medically Dependent Children's Program (MDCP) under the managed care model, **while costs have actually increased**. According to the latest EQRO report, average monthly member health care expenditures for STAR Kids members increased by $176 per member.

- State Auditor (SAO) and Inspector General's Reports found that **potentially avoidable admissions and complications *increased* for individuals with complex medical needs following implementation of managed care** for this population.

- At the same time, SAO reports found that **managed care organizations used millions of taxpayer funds appropriated to provide medically necessary care for our most vulnerable Texans to throw parties, provide executive bonuses, gifts, and lobbying expenses with "no identifiable benefit to the Texas Medicaid Program."**

- The2018 Dallas Morning News "Pain & Profit Investigation" found that **denials of care have more than tripled under managed care for the most fragile Texans**, and that **access to care and network adequacy, for even the most basic of care, was even further lacking** far beyond findings from elemental standards.

- A 2019 survey of affected families with medically fragile children found that g**reater than 50% of families are experiencing increased delays and denials** in accessing or obtaining medically necessary services under managed care.

Medicaid MCO contractual obligations and costs to the State are fixed. The MCOs are currently receiving full capitated rates for ALL members, but are failing to deliver on their contractual and statutory obligations to provide all medically necessary services.

- The MCOs have signed a risk-based contract with the state, **committing to "provide comprehensive healthcare services to all program recipients".** As part of that contract, the MCOs are contractually obligated to provide "**full coverage of all necessary services to support members with ongoing or chronic conditions**" in order to deliver on their statutory and contractual requirements to the state.

- CMS currently recommends that states utilizing a managed care model either:

    1. Pay lower capitation rates for those members who have private commercial insurance coverage; OR

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2. Allow members with commercial coverage to opt out of managed care and remain under traditional Medicaid.

- Texas does not currently allow either option—which means that **the managed care insurance companies are receiving full capitated rates for even the greater than 50% of high-acuity waiver program members who are covered by commercial insurance.**

Ensuring continuity of care and access to appropriate specialty providers who best know how to treat the patient and keep them at baseline ***will actually be far more cost-effective for the state of Texas, a better use of taxpayer dollars, will improve patient outcomes, reduce risks of ER visits, hospitalizations, and other institutional admissions***.

Codifying a definition of Complex Medical Needs as it relates to SB1207 is critical to ensure enforcement of original legislative intent.

- This amendment codifies the definition of complex medical needs as defined by the American Academy of Pediatrics, and as outlined in SB1207.
- **It is consistent with the intent of SB1207,** which made no exclusions based on program or status, and does not expand or change the definition of "complex medical needs". SB1207 was intended to be an inclusive definition to ensure equal access to medical care for MCO members with complex medical needs. This prevents discrimination by the MCOs based on age, program, waiver status, medical needs, or medical condition of the members with complex medical needs.
- The restrictive definition of "complex medical needs" (e.g., limited to level 1 case management of MDCP only) originated with HHSC creating their own definition of 'complex medical needs,' as influenced by biased input from the MCOs, who did not want to implement SB1207 as enacted by the legislature. **This definition was not in keeping with legislative intent,** and excluded continuity of care for other children with very complex medical needs, such as those children with complex medical needs in the foster care system, and the small fragments or pockets of individuals who meet this criteria in the other waiver programs (for example: CLASS, HCS, DBMD, STAR Plus, there are a couple hundred children in SSI who have a level of need that requires private duty nursing, etc.).
- **Notably, less than 1% of all Medicaid members have complex medical needs and disabilities.**

Codifying a definition of Durable Medical Equipment, Services and Supplies is critical to ensure continuity of care and appropriate access to life-sustaining medical care.

- **DME is approximately 1.09% of total Medicaid spend for the entire Texas Medicaid program.**
- Unfortunately, there has been a great deal of misinformation disseminated regarding this type of provider, their purpose, and what DME services entail. This is not simply "drop shipping of disposable diapers".

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- DME providers are specialty providers of critical, timely, life-sustaining home health medical equipment, services and supplies such as ventilators, enteral feeding supplies, etc., which enable a patient to access a hospital-level of care in the home with their family and loved ones. DME providers ensure appropriate access to vital medical equipment, services and supplies, and eliminate delay of care by providing therapeutic items that are often difficult to access.
- Access to medically necessary home medical equipment, services, and supplies (DME), not only directly affects quality of life, **it is also the only way for patients with complex medical needs to maintain and support life in the home and community outside of a hospital or institution at a fraction of the cost of institutionalized care.**
- **56% or 142 Texas counties do not have a traditional DME supplier location.**
- **There has been a 32% reduction in DME supplier locations in Texas since 2013.**
- **144 Texas counties do not have a traditional respiratory supplier location and have seen a 39% reduction in respiratory locations since 2013.**
- Further, just because a DME provider is contracted with an MCO **does not mean they are actively accepting and servicing all patient types, nor that they can provide all specialty needs.**
- As with many other specialty medical providers, many DME providers have their own niche subspecialty, providing items not readily available through other DME providers. Often there are only a couple of specific providers in the state who can provide specialty medical nutrition, certain specialty technology, complex rehab technology, communication devices, respiratory equipment, and other associated specialty services.
- **Despite false representations regarding DME being used inappropriately and high risk for fraud, waste, and abuse, the facts do not support this allegation**. Texas Medicaid OIG quarterly report for FY21-Q1 identified that only 3% of DME merited preliminary investigations and only 0% of those merited full investigations. The Texas OIG quarterly report for FY21-Q2 identified that only 1% of DME merited a preliminary investigation, and only 5% of those merited full investigations.

Codifying a definition of Specialty Provider as it relates to SB1207 is critical to ensure enforcement of original legislative intent.

- **The right to continuity of care with specialty medical providers for individuals with complex medical needs is one of the most critical and fundamental protections guaranteed as part of SB1207.** Unfortunately, although it was intended to be an inclusive definition encompassing all specialty provider types, SB1207 did not define specialty provider. This amendment codifies the definition of specialty provider as outlined in SB1207.
- SB1207 was not limited to specific provider types or certain specialty physicians, but also specialty DMEs, pharmacies, medical equipment providers, specialty therapists, and other subspecialty areas of care that have become so challenging for families to find and maintain under the current managed care program. .
- The restriction on provider types originated with HHSC's proposed rules, as influenced by biased input from the MCOs, who did not want to implement SB1207 as enacted by the legislature. This

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restrictive definition is inconsistent with the language and intent of SB1207, and would have effectively removed access and continuity of care for numerous critical specialty providers.

- Access to specialty and subspecialty providers and the ability to maintain existing relationships with specialty providers is vital and indispensable to preventative care for individuals with complex medical needs, to improving outcomes, preventing ER visits, hospital admissions, institutionalization, and other preventable events, and are integral to keeping these individuals at medical baseline and in the home and community
- For example, when A needed feeding therapy, it took years (in a major metropolitan area) to find a therapist with this sub-specialty who could help address his swallowing dysfunction and some of the underlying causes of his aspiration (food going into his lungs instead of his stomach). Because of the regional nature of the MCO networks, this feeding therapist is no longer considered in network with the county-based mco assigned to A. There is no one else in the metroplex who has this exact expertise. This therapist has helped A to not only learn to chew and swallow and eat some by mouth, but has improved his ability to swallow properly without choking or aspirating. This has not only prevented hospitalizations and costly illness, it has helped A to maintain a medical baseline, remain at home, and has reduced A's sole reliance on enteral feeding supplies.
- **Maintaining access to specialty care is critical to improving quality of life and dramatically affects long-term health outcomes.**

Clarifying legislative intent is critical to ensure appropriate and effective implementation.

- Pg. 2, lines 9-26, Sections (2)-(6): clean up language to clarify intent and implementation.
- Pg. 2., beginning at line 27, Section (7)(j): clarifying that the MCO cancelling or refusing to renew a contract does not remove the obligation to provide continuity of care for individuals with complex medical needs (this is in response to a number of situations which have taken place over the past couple of years).
- Pg. 3., section (8): this section simply codifies the continuity of care provision in the Insurance Code to ensure no future contradictions or misunderstandings.

While the MCOs have inexplicably argued that continuity of care provisions somehow encourage providers to move out of network to access out-of-network rates via single case agreements, it is important to note that:

- Disincentives for providers to enter MCO networks are based on unfair and unsustainably low MCO provider reimbursement rates at a fraction of the Medicaid fee schedule. **These rates do not allow providers to be reimbursed at rates that will cover the basic costs of providing medical care to MCO members.**
- Out-of-network rates are also **capped to a certainty by the administrative code and limited to the existing Medicaid fee schedule**.

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- In fact, in many cases, **Medicaid rates even under the standard fee schedule still result in losses for the overwhelming majority of providers**, as Medicaid rates are generally not in keeping with standard market rates nor commercial insurance rates. As one specialty provider recently pointed out, maintaining single case agreements for multiple patients would have required that they hire an administrative person solely to deal with the associated administrative burden, and it simply was not cost effective for them in any way**.**
    - If Medicaid MCOs are actually paying provider reimbursement at higher rates that the Medicaid fee schedule, then there would be **absolutely no incentive whatsoever for providers to leave the network to receive out-of-network rates at a percentage of the Medicaid fee schedule**.
    - The administrative burden of dealing with out-of-network provisions and single case agreements on an individual, case-by-case, patient-dependent basis **creates an enormous burden for providers**, and a situation that is not cost-effective, practicable, or sustainable on a broad scale.
    - Every specialty provider or DME in Texas will not suddenly decide to go out of network. If they did, **the MCOs are not doing an adequate job managing their networks.**

The much-touted MCO cost savings (based on 61.32% of FFS rates *[per 2019 paid contract rates]*) **were created by reducing quality of care and access to care for MCO members, reducing provider networks, restricting access to appropriate medically necessary care, and cutting provider reimbursement rates to unsustainable levels,** which violates the rights of MCO members to appropriate medical care, and increases potentially preventable events.

"***This amendment is not needed as Texas does NOT have any access problems with DME or therapy providers.***

- MCO members have filed numerous complaints regarding **lack of network adequacy and access to care problems directly related to an inadequate number of DME, therapy and other specialty providers** as contractually obligated.
- MCO members have filed numerous complaints regarding **the lack of access to highly specialized DME and therapy providers who can meet the complex medical needs of MCO members**.

"This amendment is a rate increase for providers outside of the budget process, and is not accounted for in the budget."

- Cuts in MCO provider reimbursement rates to achieve "cost savings" actually undermine the ability of private and community medical providers to deliver appropriate medical services to MCO members.
- Providers who experience rate cuts are likely to leave the MCO networks or reduce access for patients, which decreases MCO member access to appropriate services, while increasing MCO profits under a capitated rate model.
- **The MCO goal is to cut DME and therapy rates while increasing MCO profits, not to save the state of Texas money or improve care to Medicaid recipients.** MCO administrative costs, built into capitation rates, **have far exceeded TMHP administrative costs to administer the Texas**

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Medicaid program while further reducing and restricting access to essential care for members with complex medical needs.

- Per the 2018 LBB Report on the STAR Kids Program, **historical figures show that Texas MCOs spend much more on their administrative costs than were previously expended under the Fee-for-Service Program**, and many of the Texas Medicaid MCOs do not align with federal guidance regarding percentage of premiums expended on medical expenses.

Eliminating patient choice does not help reduce fraud, waste, and abuse. In fact, **eliminating patient choice enables MCO abuse of power to maximize their own profits.** Patient choice creates a check and balance for the Texas Medicaid system, and also improves long-term outcomes and cost-effectiveness of the program.

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RECEIVED
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TEXAS HOUSE *of* REPRESENTATIVES

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I.D.# **48990**

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

August 16, 2021

The Honorable Ken Paxton
Office of the Attorney General
Attn: Opinion Committee
PO Box 12548
Austin, TX 78711-2548
opinion.committee@oag.texas.gov

Re: Whether the public or a legislator may inspect anonymous voted ballots

Dear General Paxton,

In order to promote public confidence in Texas elections, members of the public as well as members of the legislature are interested in auditing the results of Texas elections. However, election administrators have cited certain sections of the Election Code as preventing the release of materials necessary to conduct such an audit. The materials include voted ballots that by their nature in how Texas conducts its elections are anonymous and voted ballots that are not anonymous but have had any voter-identifying data contained on the ballots redacted (referred to herein as "anonymous voted ballots.").

Texas Election Code Section 66.058 prescribes a 22-month period for the preservation of precinct election records, which includes voted ballots, and provides that it is a criminal offense if the custodian of election records makes an unauthorized entry to the records.

Election Code Section 1.012 states that, except as provided by the Election Code or the Public Information Act, all election records, including voted ballots, are public information. Under that section, election records that are public information shall be made available to the public.

Texas Government Code Chapter 552, the Public Information Act, prescribes the procedures for the public to request public information. Separately, Government Code Section 552.008 provides authority and procedures for members of the legislature to request public information for legislative purposes, including confidential information.

In a question of first impression over thirty years ago, Open Records Decision No. 505, dated September 2, 1988, opined that "voted ballots from a primary election become public information available for public inspection after the 22-month retention period."

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Members: *Stephanie Klick, Leo Pacheco, Reggie Smith*
Darren Keyes, Committee Clerk & General Counsel
Darren.Keyes_hc@house.texas.gov

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Technology and conditions have changed since 1988. Open Records Decision No. 505 did not consider the anonymous nature of voted ballots and was not apparently limited to anonymous voted ballots. Moreover, the opinion referenced portions of the Public Information Act that exempt disclosure of records that are "confidential" in light of sections of the Election Code that use the same term and equated the requirement in Election Code Section 66.058(b) to keep voted ballots preserved securely with requirements that the records must be kept confidential. If voted ballots are not confidential simply because they are secure, especially if they are anonymous voted ballots the release of which would not cause the secrecy of any person's votes to be revealed, then Election Code Section 1.012 appears to require that these records be made available to the public so that the public can adequately audit the results of elections.

Accordingly, if a member of the public, or a legislator, in their capacity as a member of the public, requests to inspect or to obtain copies of anonymous voted ballots, is the custodian of election records authorized to access such records for purposes of fulfilling the request? Is the member of the public entitled, generally, to inspect or receive a copy of such anonymous voted ballots?

Even if Open Records Decision No. 505 is interpreted to mean that the requirement in Election Code Section 66.058(b) requiring voted ballots to be kept secure means they also are confidential and cannot be accessed for purposes of fulfilling requests under the Public Information Act, legislators may examine the voted ballots in light of Texas Government Code Section 552.008 granting a special right of access to legislators for legislative purposes, even to confidential records.

Thus, if a legislator requests to inspect or to obtain copies of anonymous voted ballots for legislative purposes, is the custodian of election records authorized to access such records for purposes of fulfilling the request?

Thank you for your attention to this matter. Please contact my office if we can be of assistance to you in rendering an opinion on this important question regarding individual and legislative access to public information and the ability of the legislature and the public to audit Texas elections.

Respectfully,



Matt Krause
State Representative, District 93
Chairman, Texas House Committee on General Investigating

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COMMITTEE ON VETERAN AFFAIRS & BORDER SECURITY, *CHAIR*
COMMITTEE ON TRANSPORTATION

RECEIVED
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COMMITTEE ON FINANCE
COMMITTEE ON NATURAL RESOURCES &
ECONOMIC DEVELOPMENT

The Senate of The State of Texas

SENATOR KELLY HANCOCK

September 28, 2021

FILE# **RQ-0424-KP**
I.D.# **49037**

The Honorable Ken Paxton
Office of the Attorney General
Attn: Opinion Committee
P.O. Box 12548
Austin, TX 78711-2548

Re: Legislative Information Requests for Ballots

Dear Attorney General Paxton,

I respectfully request your opinion related to access by legislators to certain election records that may or may not be confidential, including voted ballots and other similar records which are submitted during the course of an election.

Members of the Legislature have expressed interest in researching the results of certain Texas elections in order to promote public confidence in Texas elections. However, election administrators and district attorneys have cited certain sections of the Election Code as preventing the release of materials necessary to conduct such an audit.

Texas Election Code § 66.058 prescribes a 22-month period for the preservation of precinct election records, which includes voted ballots, and provides that it is a criminal offense if the custodian of election records makes an unauthorized entry to the records. Texas Government Code § 552.008 provides authority and procedures for members of the legislature to request public information for legislative purposes, including confidential information.

If a member of the legislature requests to inspect or to obtain regular photocopies of the physical, original voted ballots or related election records for legislative purposes, is the custodian of election records authorized to access such records for purposes of fulfilling the request? Is the member of the legislature entitled, generally, to inspect or receive regular photocopies of physical, original, voted ballots or similar records that are asserted to be confidential?

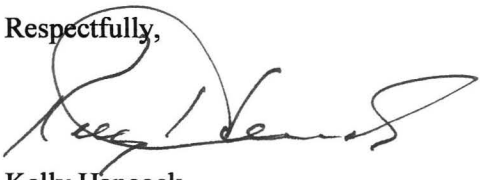
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TX-AG-22-0325-A-000572

Thank you for your attention to this matter. Please contact my office if we can be of assistance to you in rendering an opinion on this important question regarding legislative access to election records and the ability of the legislature to conduct research into Texas elections.

Respectfully,



Kelly Hancock
Texas Senate, District 9
Chairman, Veteran Affairs & Border Security

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TEXAS HOUSE *of* REPRESENTATIVES

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I.D.# **48993**

COMMITTEE ON GENERAL INVESTIGATING

Chair Matt Krause • Vice Chair Victoria Neave

August 23, 2021

Office of the Attorney General
Attention Opinion Committee
P.O. Box 12548
Austin, Texas 78711-2548
opinion.committee@oag.texas.gov

Re: Whether sex change procedures performed on children without medical necessity constitute child abuse

Dear General Paxton:

On August 6, 2021, Governor Abbott requested the Commissioner of the Texas Department of Family and Protective Services ("DFPS") to issue a determination of "whether genital mutilation of a child for purposes of gender transitioning through reassignment surgery constitutes child abuse." On August 11, 2021, the Commissioner of DFPS replied that "genital mutilation of a child through reassignment surgery is child abuse." Genital mutilation is not defined in either letter. The Governor's letter states, "This broad definition of 'abuse' should cover a surgical procedure that will sterilize the child, such as orchiectomy or hysterectomy, or remove otherwise healthy body parts, such as penectomy or mastectomy." However, the Commissioner's letter does not reciprocate by defining "genital mutilation" or specifying what procedures constitute "abuse." The Commissioner's letter may unintentionally create ambiguity on an issue that needs clarity.

According to legislative testimony and other sources, medical practitioners perform various sex-change procedures on children. These procedures include (1) sterilization through castration, vasectomy, hysterectomy, oophorectomy[1], metoidioplasty[2], orchiectomy[3], penectomy[4], phalloplasty[5], and vaginoplasty[6]; (2) mastectomies; and (3) removing from children otherwise healthy or non-diseased body part or tissue. Do these procedures constitute "genital mutilation" as referenced in the Commissioner's letter and thus constitute "abuse" under Texas Family Code Chapter 261?

Additionally, medical practitioners are providing, administering, prescribing, or dispensing drugs to children that induce transient or permanent infertility, including: (A) puberty-suppression or puberty-

[1] Surgical removal of one or both ovaries.
[2] Surgical "creation" of a penis using existing genital tissue after the clitoris has been enlarged through the use of testosterone therapy.
[3] Surgical removal of one or both testicles.
[4] Surgical amputation of the penis.
[5] Surgical "creation" of a penis.
[6] Surgical "creation" of a vagina involving removal of the penis, as well as the testicles and scrotum, if an orchiectomy was not previously performed.

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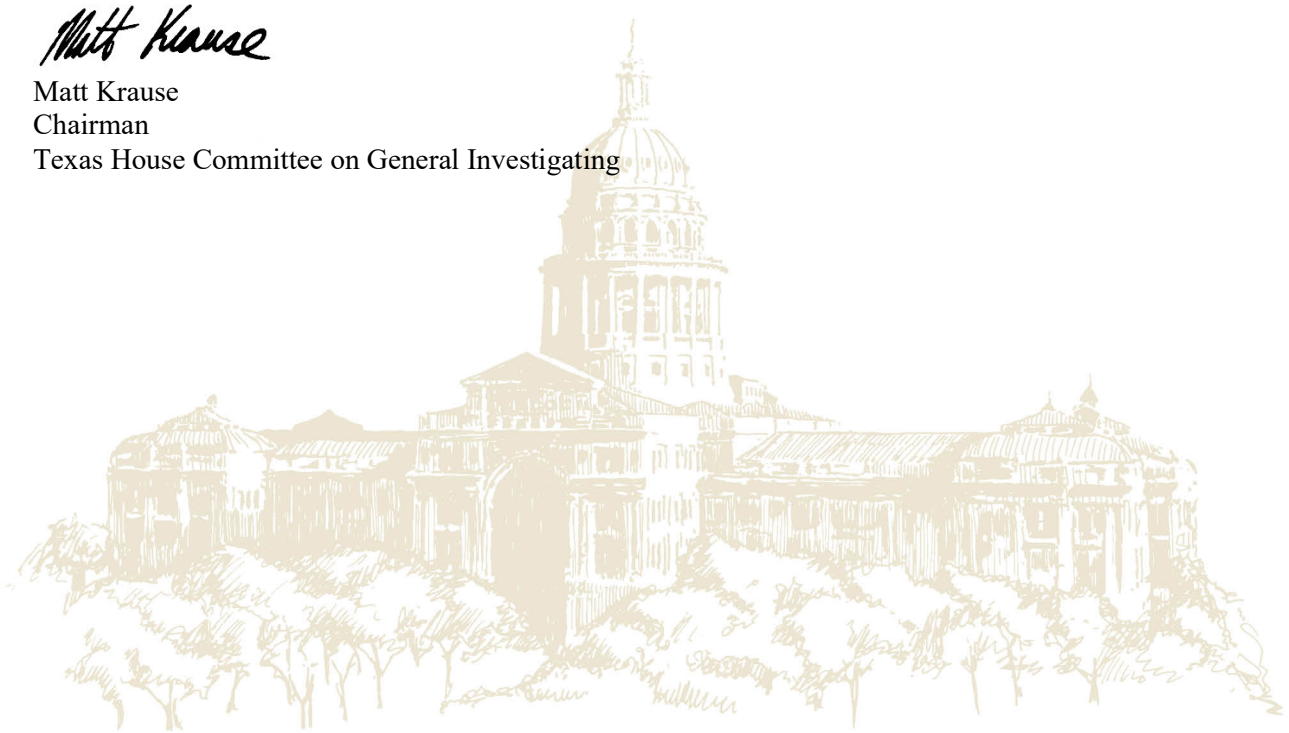
blocking drugs, (B) supraphysiologic[7] doses of testosterone to females; and (C) supraphysiologic doses of estrogen to males. Do these chemical procedures constitute "abuse" under Texas Family Code Chapter 261?

Some children have a medically verifiable genetic disorder of sex development or do not have the normal sex chromosome structure for male or female as determined by a physician through genetic testing that require procedures similar to those described in this request. Any clarification should consider whether an exception exists for instances of medical necessity.

Thank you for considering this request.

Sincerely,

Matt Krause
Chairman
Texas House Committee on General Investigating



[7] Supraphysiologic means exceeding what is normally found in healthy individuals. The term is usually used to refer to a hormone or medication given in a stronger dose than the amount the body can produce on its own.

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